Transitional Housing Business Plan

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**Executive Summary**

The proposal that is being made is to open a transition house for those people who have been the victims of gang related violence that need a safe place to recover and learn ways to leave that lifestyle. This is one way that we can fulfill our mission of “being committed to providing spiritually centered, holistic care which sustains and improves the health of individuals in the communities we service, with special attention to the poor and vulnerable” (www.stjohn.org). The east side of Detroit has some of the highest gang activity in the country and St. John Hospital and Medical Center treats a large number of these victims. Many of these victims have socioeconomic situations that lead into the gang lifestyle and many do not have ways out. The use of this transition house could provide: extended care for those needing time for healing (rehab, wound care, or nursing care) which would help to decrease length of stay in the hospital. Another feature would be counseling, job training resources, and other community resources to aid the patients in adaptation of a nonviolent lifestyle.

A decision needs to be made whether or not to proceed with plans to develop a transition house for these types of patients that are seen at St. John Hospital and Medical Center. In order to start the planning process for Fiscal Year 2014, a decision needs to be made by the board no later than January 3, 2013.

**Proposal**

Service Definition

This proposed service would to provide trauma patients who were victims of gang related violence access to services that would enhance their recovery and assist them in making and maintaining lifestyle changes that would decrease the risk of violent behaviors or repeat admissions to the hospital due to multiple traumas. Often times after trauma, patients are discharged with limited resources and follow up care. This is usually as a result of lack of insurance, transportation issues, or knowledge deficits. After hospital care that would be provided for these patients would include home care visits from Reverence Home Health (the home health care agency that provides home care to our patients). This may also include physical or occupational therapy as ordered by the physician, 24 hour supervised assistance by a transitional house worker who would help to coordinate the needs of those living there. There would be additional services that would be offered and that would include: transportation, mental health services, case management, job search/job training assistance, food/clothing assistance, and support groups.

As a large healthcare organization, we have the resources to assist these patients. The options that are available at this time would involve a partnership with some of our community partners to offer these services at a low or no cost to our patients. Patients would be identified in the hospital and must meet certain criteria to qualify for this additional service. One of the vacant houses that is owned by St. John Hospital would be renovated to accommodate 3-4 patients at a time along with the transition care staff, 24 hours a day/7 days a week . They would initially be seen by a case manager and social worker who would assist the patient and set up after hospital care that is specific to the patients needs. Once the patient enters the transition house they work with the outside case manager to determine what additional needs the patient will have. This would then be set up with the patient and the plan is then communicated to the transition house staff. There is no other program in the area, at this time,that is able to provide the medical, mental, and social aspects that this program has to offer.

**Market Analysis**

Customer Definition

This service will be used by young men ages 18-24 who have been the victim of a traumatic injury such as a gunshot wound, assault, or other act of violence related to being a member of a gang that has left them with extensive medical, mental, and social needs that cannot be met by family, friends, or the community. Most of these men live on the East side of Detroit however, if needed, this program could serve other geographic locations. These patients would be identified in the hospital by nursing staff and case management/social work. The patients would also have to be motivated to make positive changes in their life. After this is determined the hospital case manager would make a referral to the intake coordinator as an attachment to our home care agency. Upon hospital discharge the patient would be transported by the free transportation van service to the transition house.

External Market Assessment

In Detroit, there has been an increase in gang related violence since the 1990’s. With the economic conditions of high unemployment combined with increase poverty numbers, the risk of gang violence has soared. St. John Hospital and Medical Center has seen a significant increase in the amount of patients that are seen as a result of this gang related activity. Detroit has one of the highest murder rates in the country and has a violent crime rate of 2,137 per 100,000 people. These numbers are staggering and this service could help to put a small dent in improving the statistics. This service helps to meet the health needs of the community that it serves by offering transitional housing, medial support, emotional support, and support to make a change in lifestyle. This will not be a well sought after program from other competitors because it is not a program that will generate income. At this time a CON is not needed and the program would be held to the same standards as other transitional housing through the state.

Competitors

No one in the metro Detroit area has a program similar to this. There are programs that offer individual parts of this program such as clothes, shelter, and job training/job search assistance. However, there is not the component that offers post trauma, medical care to the patient that would support the medical needs after a severe traumatic injury. This will provide St. John Hospital and Medical Center an advantage as it fulfils part of the community research and community education that is required by the American College of Surgeons as part of being a level 2 trauma center. There is also a possibility of conducting a research study that could go towards meeting the requirement of becoming a level 1 trauma center. As stated previously, this will not be a popular service line by other health service organizations because it is not going to provide additional income into the hospitals.

Promotion

This program fits into the current logo of “believe in better”. This statement fits for the patients that will be served by this program. We encourage our patients to believe in a better life. Often times, a tragic event such as a severe trauma, can open a person’s eyes to behaviors or issues that have gotten them to their current state. In times of crisis, we can attempt to intervene and provide the resources for the patients to heal and make the changes that are needed. However, because of the very sensitive nature of this program, we would have to use hospital referrals to capture these patients. We have a trauma unit that receives most of these patients. The nurses would be able to alert case management to a potential patient and then if the patient is agreeable, the case manager could enroll the patient into the program. We need to be mindful of rival gangs and the possibility of increased violence. The patients would also have to agree to only have contact with close family members and not disclose the location of the transition housing to prevent additional violent incidences. Being a free program will help patients to enroll in this service. There should not be additional incentives offered to use this program.

**Internal Assessment:**

Strategic Fit

Part of the strategic plan for St. John Providence Hospital is coordination of care. This means that we understand where a patient has been and what they will need in the future in, and in the next interaction with the healthcare system. Often times, victims of gang related violence return with worse injuries or death. The organization is dedicated to care of the poor and vulnerable and this program will benefit those in the community that may not have other alternatives. As part of our requirements of a level 2 trauma center, we are required by the American College of Surgeons to provide community outreach and this program will help achieve that component of our commitment to our trauma center. This program will help to save lives and help people to make positive changes that will result in decreased violence in the overall community. At St. John Providence, our trauma service is growing and if successful at St. John Hospital and Medical Center, this program could grow to other area hospitals and we could start to see a decrease in some of the violence in the area.

There are no other services like this in the area, in part due to the cost and lack of reimbursement. If this program is successful, we may be able to partner with some other metro Detroit area hospitals such as Detroit Receiving and Henry Ford in order to expand the outreach of this program. However, those other institutions do not have the same mission and values as St. John Providence and may not wish to help care for the poor and vulnerable. If we do not take on this program there will not be any benefit to the community as related to decreased cost of trauma care. We would continue to see the patients with longer lengths of stay due to lack of insurance and family/community support. We will continue to see the same patterns of violence. We will continue to see death and senseless acts of violence.

Market Position

In our current location, St. John Hospital and Medical Center is in an excellent position to start this service. We currently have the patients to gain referrals to maintain 3-4 patients throughout the year. As a new service, we do not have the experience or the resources of similar programs within the system. This is an identified deficiency as we will be starting from the beginning. However, being a new service for our patients we will be able to develop and mold our service to meet both the needs of the patients and the needs of the hospital. We must remain open to the possibilities of making a difference in the lives of the patients that we serve.

Organization

This service will be run out of the trauma department and overseen by the trauma coordinator and trauma director. As this will be a part of the trauma program, and patients that are referred to this service are victims of trauma, it would be the best place to locate this service. All aspects of patient care and community support would report back to the trauma coordinator. This would include home healthcare, physical therapy, occupational therapy, case management and social work, as well as the individuals who are employed through this service. The trauma coordinator would be responsible for the coordination of care and any potential issues. He/She would also be responsible for discharging the patient out of this service once the medical needs have improved and the patient has been given community resources. There will be some changes that will need to be made in the trauma department and on the trauma unit that will need to take place in order to accommodate the new program. The trauma unit will need to be educated about the program and have identification criteria to recruit patients for this program. The case management and social work departments will also need to be educated to screen potential patients and enroll them into the program in order to have a seamless transition into the program. The trauma coordinator will have the added responsibility of maintaining employee records for the transition housing, maintaining enrollment and discharge into the program, and providing the community resources to the patient.

Patient Service Cycle

1. Patient enters the hospital as a trauma patient. Most will be gunshot wounds from gang related activity.
2. After being stabilized the patient will be identified as a candidate for transitional housing by the trauma unit staff and a referral is placed to case management/social work.
3. Case manager/social worker on the unit will perform a formalized screening of the patient in order to identify all needs including post discharge medical needs, family support, community support, willingness/openness to change.
4. A Referral is then given to the trauma coordinator who would then meet with the patient and set up discharge into the transition housing. At that time home care, home PT, home OT would be set up as needed. Also, follow up in the trauma clinic would also be determined.
5. Patient is then admitted into the transitional house.
6. Medical support is then established for the patient and the patient continues on his/her healing process. Transportation is provided to and from doctor appointments.
7. During this time the patient participates in support groups and counseling to deal with both the post traumatic stress and identify behavior patterns that lead up to the event.
8. When medically able the patient is then transported to job training/job counseling programs in the community
9. Patient is then discharged from the program and is provided with additional community resources to continue the process of changing their lifestyle.

**Financial Analysis**

Demand Assumptions

Although the available market is large for this service, we will be limiting the volume due to the cost of providing this service. As stated earlier, this service will not provide revenue for the organization but will be a community service at a cost to the institution. We will not drive in additional volume to the organization in part due to lack of marketing. We will not be marketing this service in the same way as some of our more profitable programs. After the initial start up we will have the opportunity to apply for federal and state grant money to fund the project. We may also be able to ask the community for donations in order to provide the added support for this transitional house. It is possible to obtain growth from this service if there is additional funding placed into it from outside sources. If additional money becomes unavailable then this service will be limited.

Resource Assumptions

This program will need to have a 4 bedroom house near the hospital in order to have access to the transportation van. One of the vacant houses that are currently owned by St. John Hospital would be sufficient to meet the needs of 3-4 patients at a time. We would need to employ 1 transition house worker to staff the house 24/7. Case management and social work would be provided through the home health agency along with any medical support (RN, PT, OT, ect) as ordered by the physician. This is no different than if the patient were to be discharged home. Transportation would be supplied by the transportation van through the hospital. No additional information system requirements are needed. There will be an increased work load for the transportation van as this will be an occasional extra stop. The counseling services that will be provided will also have a slightly increased census.

Pro Forma Financial Statements

Unfortunately with this service there will not be any projected revenue due to most of these patients being uninsured. The startup cost should be minimal as the house that is currently being used is owned by St. John Hospital and Medical Center. Total start up costs for this project would be around 25,000 dollars to renovate the house and time spent researching and applying for state and federal grant money. After this initial start up cost, it is anticipated that this project can be funded by the approval of the grant money and financial donations to keep this program running. As an organization, we already utilize our home care agency to provide free service to the uninsured that are in need of home health care. We can also provide group therapy and individual counseling through Eastwood Clinics as a short-term therapy option for the patients. We would also need to cover the cost of the transition house employees and would look to fill 3 FTE’s as part of this plan.

**Implementation Plan**

Implementation Timetable

If that project is approved, this would be the established guidelines:

*January to April 2014*: Apply for grants to aid in the cost of this program. Start to set up partnerships with community programs, Reverence home health care, and Eastwood Clinics. The trauma director along with the trauma coordinator (or designee) would oversee this process.

*April 2014*: Transition house would be inspected and any maintenance or upgrades would be made at that time. We would also need to develop partnerships with our community partners to deliver the goals and objectives of this project to meet the needs of the community and the patients. Assure that we have all current resources to deliver this service. This would also be the responsibility of the trauma coordinator (or designee) to coordinate.

*May 2014:* Interview and hire all aids that will be working in the transitional house. This would be the responsibility of the trauma coordinator.

*June 2014:* Educate all members of the team as to the process of screening and enrolling patients into the program. Orient all new employees. Trauma coordinator (or designee) would oversee.

*July 2014:* Program will open up and we should be able to enroll our first patient into the program. Again, this is the responsibility of the trauma coordinator under the direction of the trauma director to oversee.

*August 2014 to January 2015:* Continue to enroll patients and evaluate the success of the patients that are enrolled into the program. This will be the responsibility of both the trauma coordinator and trauma director.

Evaluation

The objective of this transitional house program is:

1. To provide a safe environment for trauma victims to recover while providing necessary medical and emotional support. Thus decreasing readmissions to the hospital and decreasing length of stay for those with serious injury.
2. To provide counseling services to help with post traumatic stress and socio-economic factors that lead to gang related violence.
3. To provide community resources such as job training/job search assistance to become productive members of the community

If these objectives were met, we would see a decrease in length of stay for these patients. Readmission rates would also be decreased. There would be an evaluation of the patients and what they were doing at 3 months, 6 months, 1 year, and 5 years after discharge from the hospital. If successful we would see these patients with minimal post traumatic stress, \increased coping mechanisms, and they would have job training that would allow them to become productive . Most importantly, we would see that they left the gang lifestyle and have made positive choices and decisions that lead to a higher quality of life. Hopefully, through this program, those that were helped by this program will take what they have learned out into the community to assist others in making positive choices and see that the gang lifestyle leads to great physical harm or even death. If these objectives are not met, we would not see a difference in length of stay or readmissions. If after a year this program was unsuccessful, we could choose to terminate services at that time.