Healthcare-Home Initiative

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ABSTRACT

Non-clinical determinants of health is one of the leading causes of increased morbidity and mortality from chronic diseases in the United States of America. In addition, the healthcare system carries a significant cost burden for those with chronic diseases who are uninsured and/or experiencing homelessness. Studies show that many healthcare seekers of this demographic reside in low-income and underserved communities where access to healthcare is limited. Healthcare-Home Initiative (HHI) was a 2-year project implemented in partnership with Hosea Helps. Hosea Helps host events on most major holidays to assist Atlanta residents in need by providing a variety of services including medical screenings and first aid care. The screenings allowed the staff to successfully refer patients to Morehouse School of Medicine H.E.A.L. student-run clinic, Grady Memorial Hospital, and local government funded clinics. The continued goal of HHI was to promote patient centered medical homes for homeless and uninsured residents of Atlanta, GA.

BACKGROUND

- Hosea Helps created the medical division to provide health screenings; increasing access to healthcare for low-income, uninsured residents of Atlanta, GA.
- Seasoned physicians precept medical students during medical screenings.
- Many participants are homeless or uninsured; suffering from chronic conditions w/o a healthcare home to consistently treat them.

OBJECTIVES

1. Increase awareness of the services offered
2. Increase patient’s knowledge and awareness about chronic conditions
3. Assist in establishing a patient-centered healthcare homes

METHODS

- First step was to perform a Needs Assessment (September). It revealed that increased volunteer visibility, changes in the demographics sheet, and qualitative evaluations were needed.
- Recommendations from the needs assessment were adopted during implementation.
- Outcome #1: To increase awareness of services provided at the events, volunteers were asked to interact with participants at the venue, and announcements were made over the loud speaker.
- Outcome #2: Increasing patient knowledge of their chronic conditions was accomplished through counseling sessions with the precepting attending. Qualitative evaluations were performed to assess patients understanding pre- and post-counseling.
- Outcome #3: Helping participants establish patient-centered healthcare homes was targeted by first locating and compiling a list of referral sites. The list was distributed to attending preceptors who used them to refer patients based on their proximity to the site.
- Demographic forms were analyzed for patient information and referral sites.

Table 1: Sign in Sheet Results

<table>
<thead>
<tr>
<th>Event</th>
<th>Morning</th>
<th>Afternoon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back-to-School</td>
<td>40</td>
<td>26</td>
</tr>
<tr>
<td>Thanksgiving</td>
<td>53</td>
<td>98</td>
</tr>
<tr>
<td>Christmas</td>
<td>41</td>
<td>103</td>
</tr>
<tr>
<td>MLK Jr. (Cancelled)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Easter</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

RESULTS

- Implementation took place during the months of August, November, December, and April.
- Data was collected using sign-in sheets, qualitative patient responses, and demographic forms.
- A total of 84 demographic sheets collected.

CONCLUSIONS

The goal of this project was to implement a cost effective model to aid in the management of chronic conditions for underserved and uninsured. Despite challenges with participant turnout and event marketing, the program has become a standard of care for volunteers working with the Atlanta-based Hosea Helps medical division. It will continue to help those in need as Reverend Hosea L. Williams and his organization have always done.