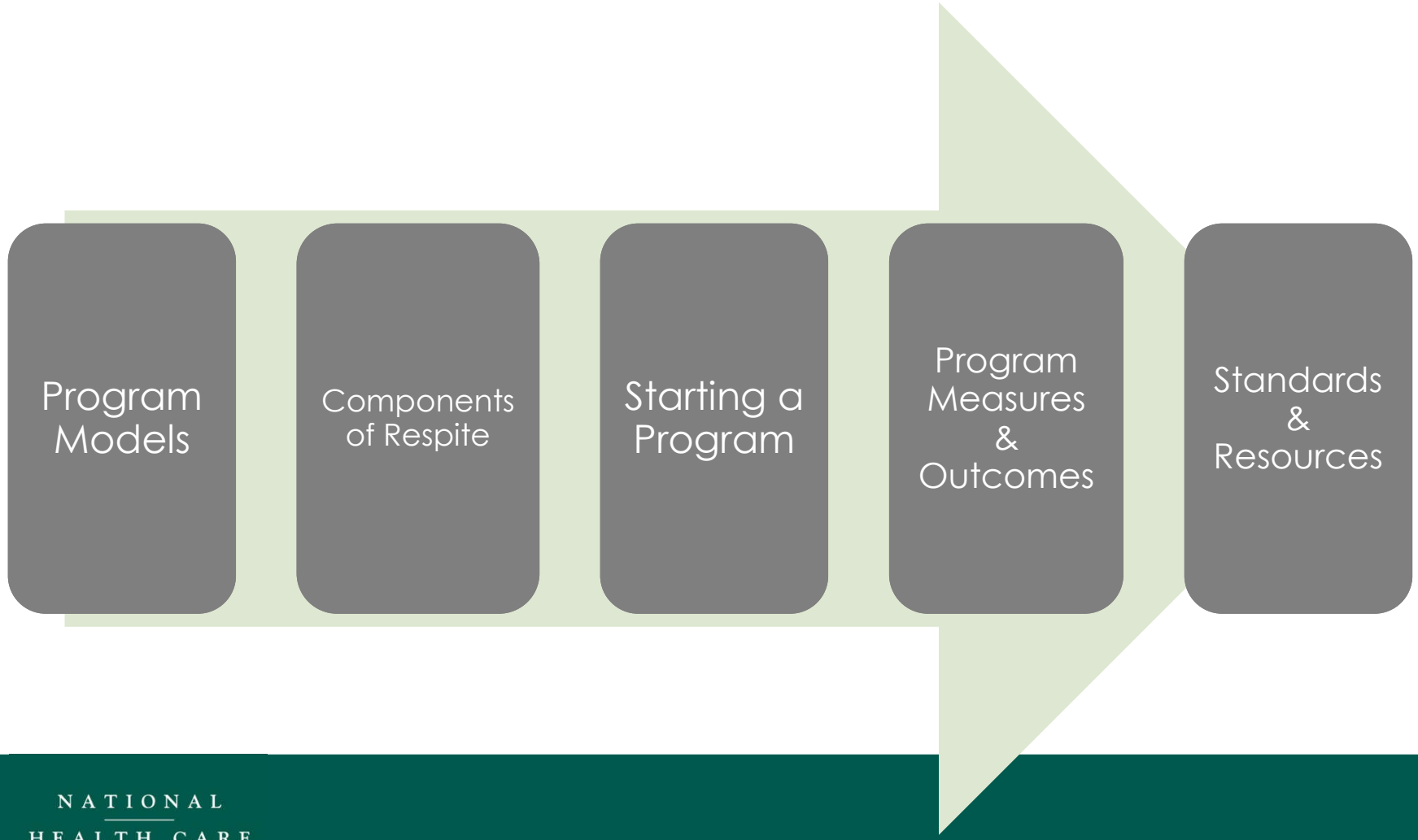
Somewhere to heal:
An Introduction to Medical respite care

March 27, 2018
12:00pm – 1:30pm Central

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

AGENDA



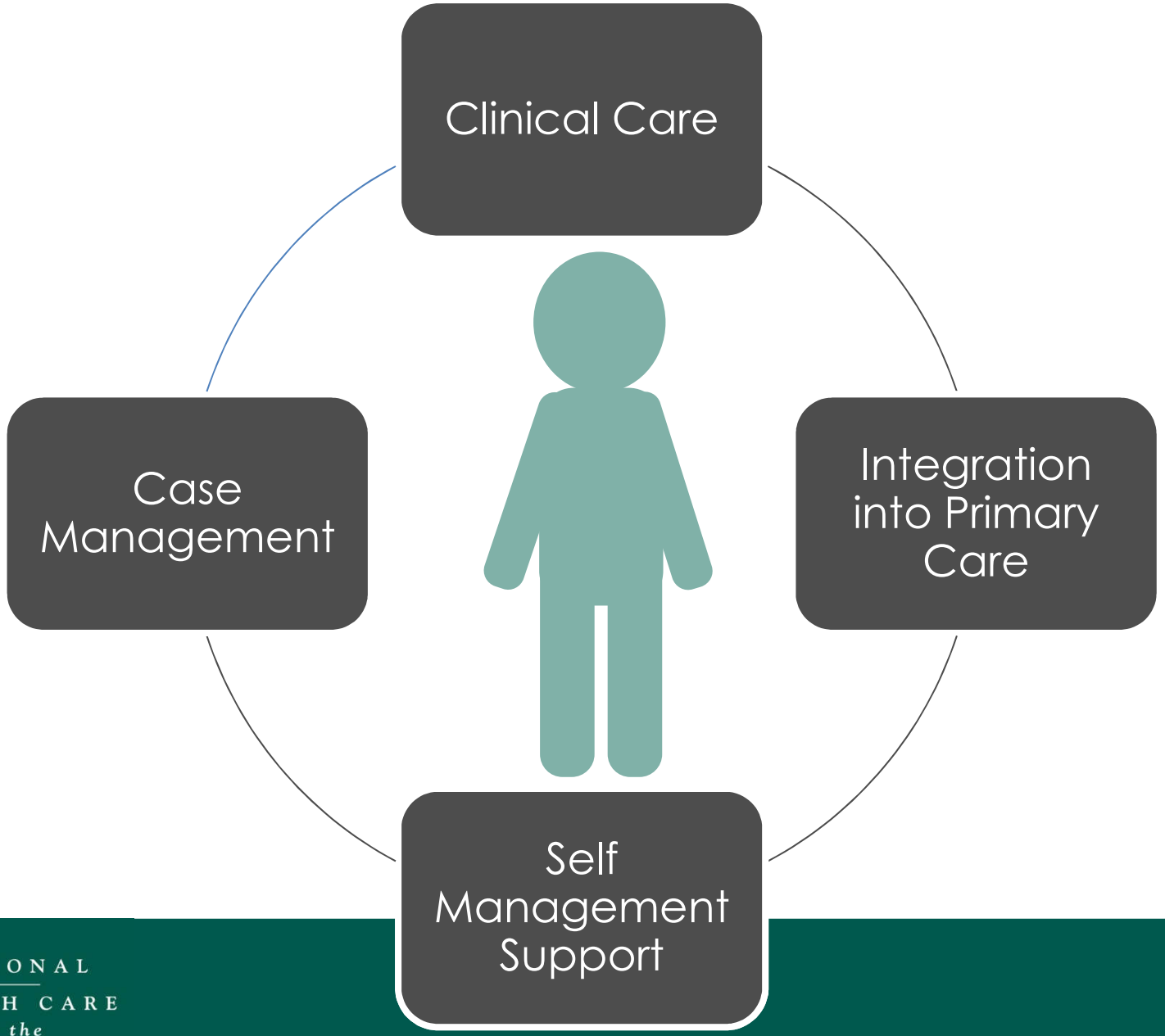
NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Speakers

- **Donna Biederman**, DrPH, MN, RN, Assistant Professor, Duke University School of Nursing, Durham, NC
- **Chauna Brocht**, LCSW-C, Director of Supportive Services, Health Care for the Homeless Baltimore, Baltimore, MD
- **Kim Despres**, DHA, RN, RN Program Director, Circle the City, Phoenix, AZ
- **Shakoya Green**, MA, MSW, Recuperative Care Director, Pathway Recuperative Care, Los Angeles, CA
- **David Munson**, MD, Medical Director, Barbara McInnis House, Boston, MA
- **Moderator: Julia Dobbins**, MSW, Project Manager, NHCHC, Nashville, TN

Medical Respite Care

- Acute and post-acute medical care for people experiencing homelessness
- "Respite" vs "Medical Respite"

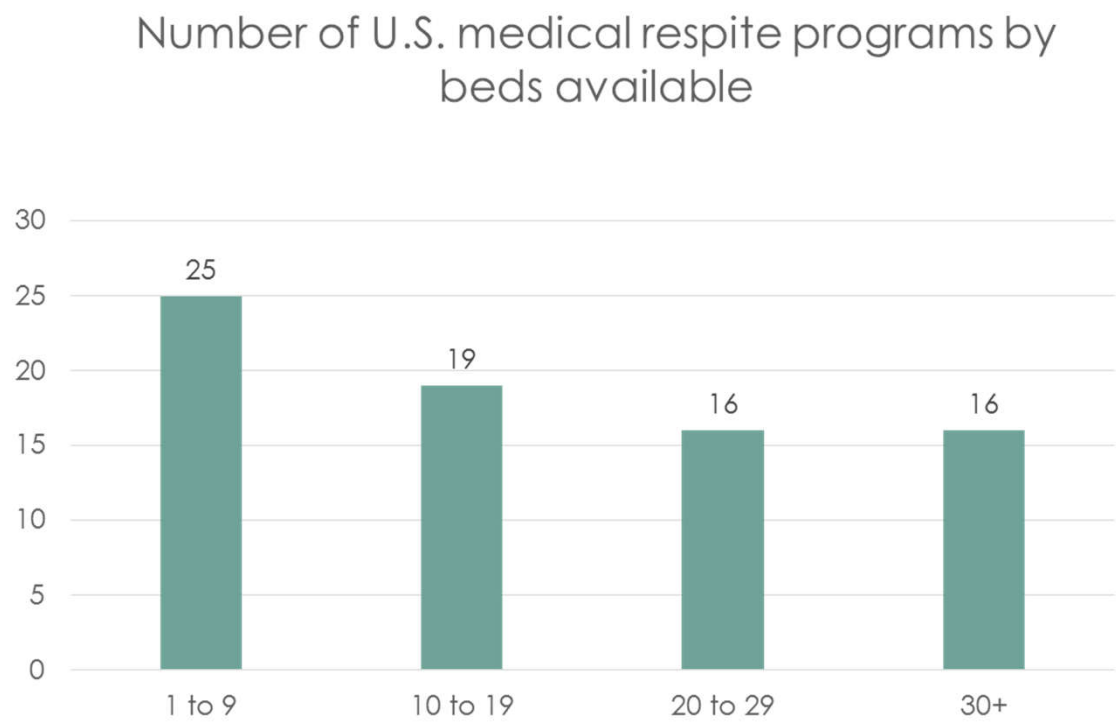


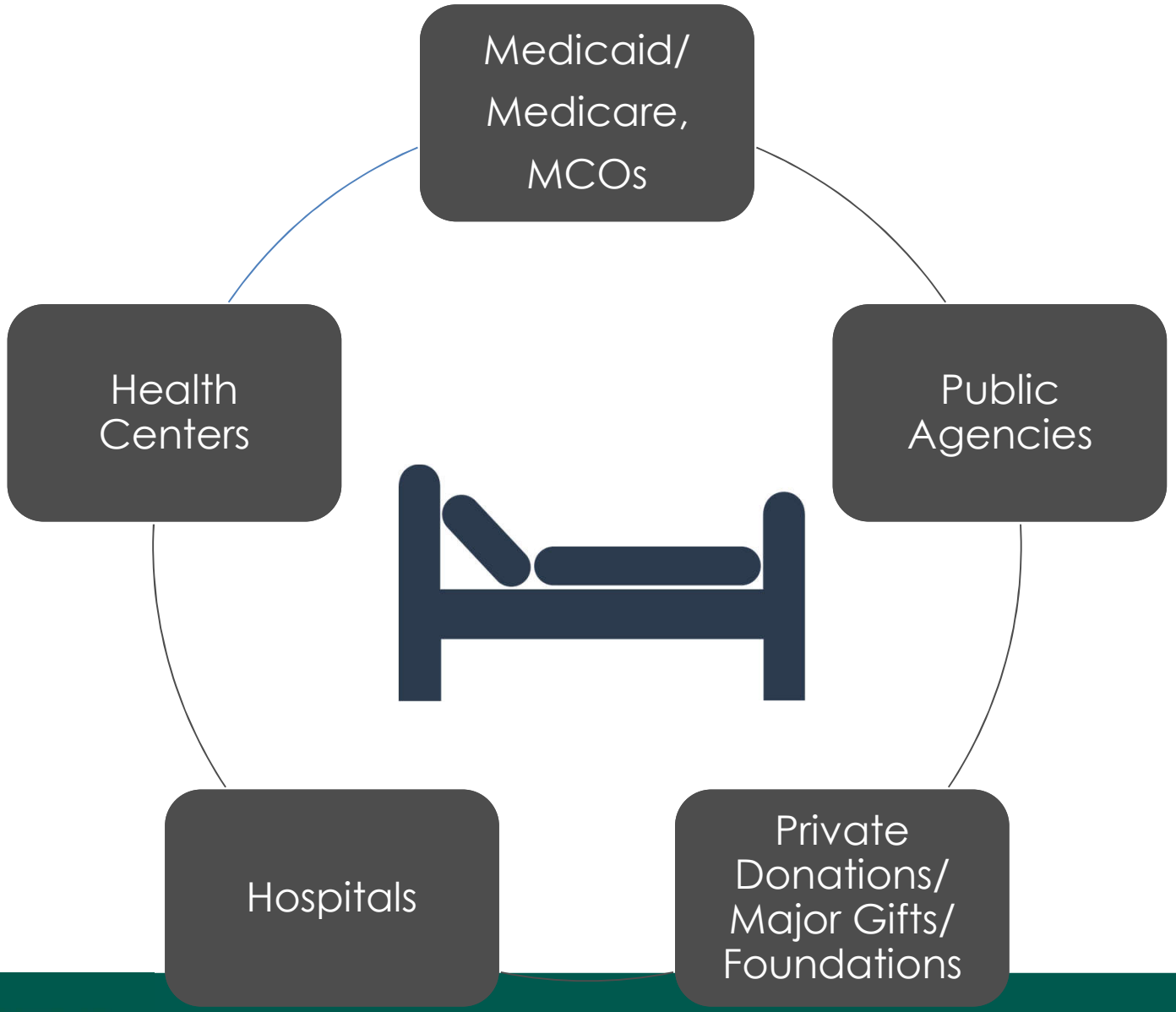
NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Medical Respite Care Nationwide

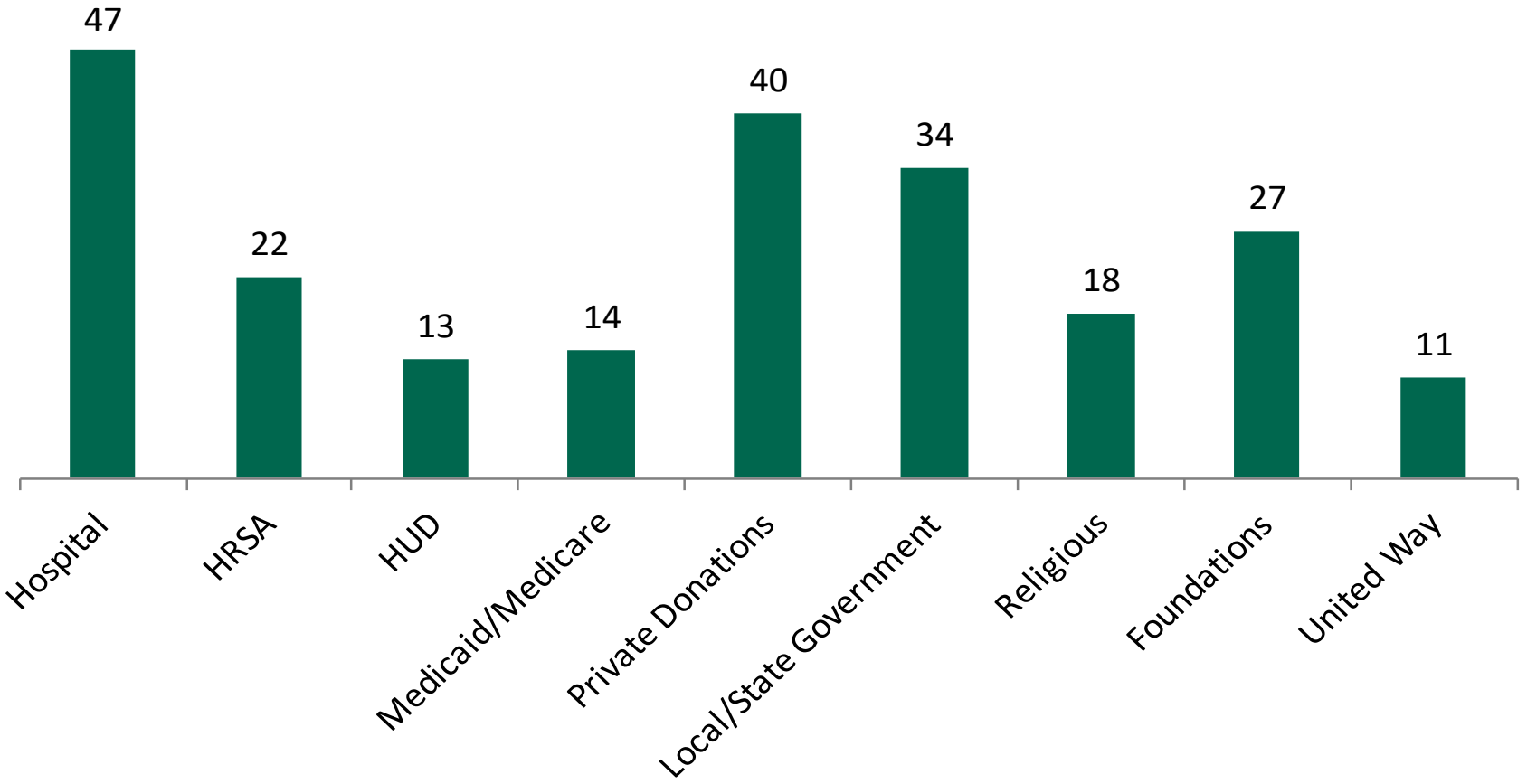
NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Medical Respite Care Nationwide

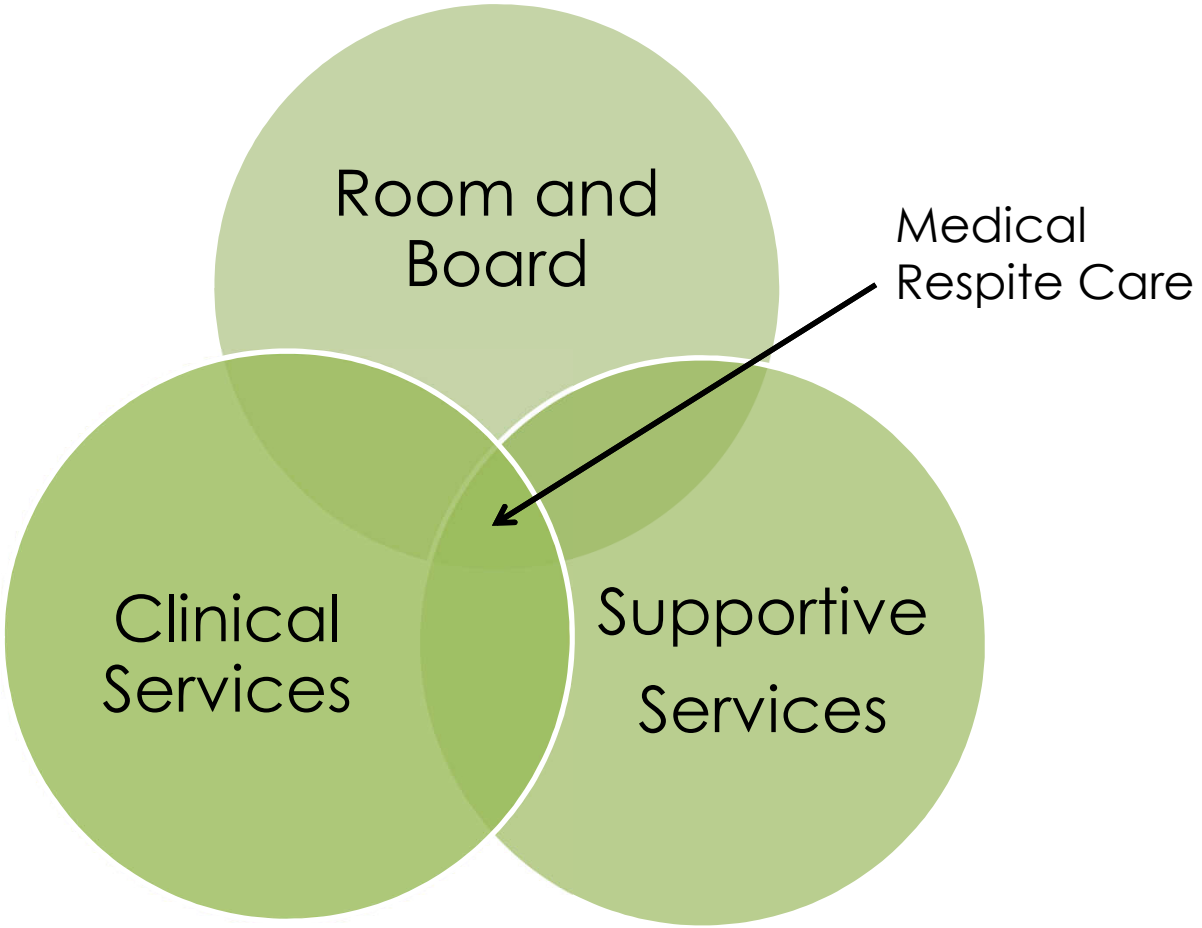



Medicaid/
Medicare,
MCOs
Public
Agencies
Private
Donations/
Major Gifts/
Foundations
Hospitals
Health
Centers

Number of Medical Respite Programs by Funding Source, 2016



NATIONAL HEALTH CARE for the HOMELESS COUNCIL


Room and Board
Medical Respite Care
Clinical Services
Supportive Services

Medical Respite Program Types & Staffing

Kim Despres, DHA, RN
RN Program Director
Circle the City, Phoenix, AZ

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Key Components of Respite

- Community need
  - → Needs assessment
  - → Survey stakeholders
- Space/location
  - → Choosing facility
  - → ADA accessible?
  - → Proximity to other services?
  - → Transportation

Key Components of Respite

- Program Model
  - → Case management: outreach, education, SSI/SSDI assistance, housing
  - → Clinical assessment: oversight, clinical interventions, and 24 hour bed rest
  - → Behavioral health
  - → Prescription medications
  - → Substance abuse services
    - Harm reduction

Key Components of Respite

- Resources
  - → Determine scope
    - Based on health needs in community
    - What already exists on the community?
- Community partners
  - → Identify key stakeholders
  - → For example: FQHCs, shelters, hospitals, social services agencies, behavioral health, day centers

Types of Respite

- Apartment/Motel rooms
- Homeless Shelter
- Transitional Housing
- Assisted Living/Nursing Home
- Substance Abuse treatment
- Stand-alone facility

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Meeting People Where They Are….

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Circle the City Stand Alone Facility

- **Room/Board**
  - → 40 men's beds
  - → 8 women's beds
  - → 2 ID isolation rooms
- **Providers on staff**
  - → 7 days week on site
  - → 24/7 on call
- **Nurses on staff**
  - → RN's 12 x 7
  - → LPN's 24 x 7
- **Physical Therapy**
- **Transportation**
- **Psychiatry**
- **Case Management**
- **Housing Assistance**
- **Peer Navigation**
- **Patient Activities**
  - → Art class
  - → Music lessons
  - → Gardening
  - → Bingo
  - → Creative writing

Clinical Care in Medical Respite

Dave Munson, MD
Medical Director, Barbara McInnis House
Boston Health Care for the Homeless Program
Boston, MA

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

HRSA Definition: Respite Care

"Short term medical care and case management provided to persons (generally homeless) recovering from an acute illness or injury, whose conditions would be exacerbated by living on the street, in a shelter or other unsuitable places. "

But What Does That Mean??

- 34M with opioid use disorder admitted from shelter with influenza A
- 68M with severe alcohol use disorder admitted for detox before surgery to remove GIST.
- 55M with asthma, depression admitted after short hospital stay for asthma exacerbation.

Barbara McInnis House

- Stand alone facility
  - → 104 beds: 8 teams of 13 patients
- 24 hour nursing care
  - → Ratio is 1 RN: 13 patients (1:26 overnight)
  - → 1 RN aide/26 patients
- Team based model
  - → NP/PA/MD sees patient each day
  - → 1 CM per 26 patients
  - → 1 SW per 52 patients

Other Staffing Examples

- Shelter based sites
  - → RN on site 12 hours per day for wound care etc
  - → Shelter staff call 911 overnight or do BLS
  - → NP/PA/MD on site 12 hours per week

Other Staffing Examples

- Scattered sites
  - → Place patients in rooms across the county
    - Coordinate with VNA, OT, PT services
  - → RN and CHW connect patients to care
  - → SW or Case management on site

Admission Criteria

- Build this around your staffing model and the needs of your partners
  - → What clinical staff do you have on site?
  - → What are the needs of your patients/clients?
  - → What is the expectation of your referring partners?

Issues To Consider

- Meds: patient independence or staff administration
- Clinical complexity/dynamism
- IV antibiotics: how many, how frequent
- ADL independence
- On site management of SUD
- On site management of mental health disorders

BMH Admitting Diagnoses FY 15

2589 total admissions
1311 unique patients

Standard ICD9 Diagnosis Description	Admission
Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	112
Cellulitis and abscess of unspecified sites	79
Chronic airway obstruction, not elsewhere classified	77
Pneumonia, organism unspecified	71
Human immunodeficiency virus [HIV] disease	59
Cirrhosis of liver without mention of alcohol	54
Pain in limb	50
Other convulsions	42
Influenza with other respiratory manifestations	42
Unspecified essential hypertension	39

Case Management & Behavioral Health

Chauna Brocht, LCSW-C
Director of Supportive Services
Health Care for the Homeless Baltimore
Baltimore, MD

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Case Management and Behavioral Health at Respite

For many respite clients, this is the first time they have engaged with a health care or service provider of any kind.

- → Some clients are newly homeless due to an illness
- → Some clients normally avoid the shelter system
- → Many respite clients highly value their independence but find they have to learn to ask for help due to their illness

Case Management and Behavioral Health at Respite

At our Baltimore respite (25 beds), we have three types of case management/behavioral health staff

- → Therapist Case Manager (2 FTE)
- → Community Health Worker (1 FTE)
- → Psychiatric Occupational Therapist (3 hours per week)

Case Management and Behavioral Health at Respite

Therapist Case Manager

We use the "Therapist Case Manager" model - a clinical social worker who:

- Completes an initial behavioral health screening (ASAM)
- Provides supportive counseling and referrals to ongoing behavioral health services
- Completes "Coordinated Access" applications for housing, starts income and benefits applications, assists with applying for IDs
- Runs psychosocial groups twice a week
- Addresses behavioral problems on the dorm

Case Management and Behavioral Health at Respite

Therapist Case Manager continued

- → We combine the two roles because some clients are reluctant to engage with behavioral health services but will engage with case management tasks.
- → This fits our funding model since we have a generous public behavioral health system in Maryland so we are able to bill for the behavioral health component.
- → Even clients without a serious mental illness or substance abuse issue experience adjustment problems due to illness or homelessness, and thus benefit from supportive counseling and are billable.

Case Management and Behavioral Health at Respite

Community Health Worker

- Coordinates transportation to specialty appointments and social service appointments
- Connects vulnerable clients to ongoing CHW services at our clinic
- Runs our residents' meeting and engages clients in improving life on the dorm

Case Management and Behavioral Health at Respite

Psychiatric Occupational Therapist

Clients are referred by any CCP staff for assessments and treatment of:

- Falls prevention
- Memory strategies
- Medication management strategies
- Organizational strategies for self-management

We are fortunate to be able to bill for OT services through our public behavioral health system, but you can also partner with an OT school for services.

Case Management and Behavioral Health at Respite

Client example – Mr. W

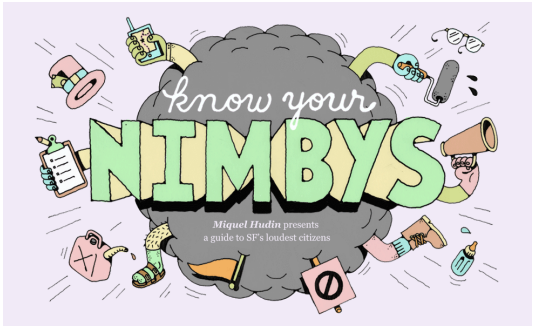
- Working under the table, became too ill to work
- Never engaged with medical care, social services or the shelter system prior to coming to respite
- Through assessment by our TCM, was referred to ongoing behavioral health services for adjustment to a disability and chronic illness
- TCM assisted client with applying for disability and finding market rate housing
- CHW assisted with transportation until he could coordinate it on his own.
- OT taught him how to manage his medications on his own, set up calendar and other organizational strategies

Starting a Program & Developing Partnerships

Shakoya Green, MA, MSW
Recuperative Care Director
Pathway Recuperative Care
Los Angles, CA

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

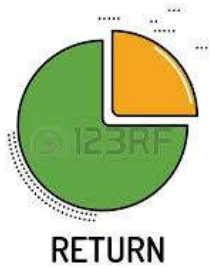
Key Considerations in Starting a Program



Hospital Partnerships

- What is your financial pitch/benefit to the hospital?

cost avoidance



Hospital Partnerships

Models

Hospital Partnerships

- Create a "Customer First" Culture (Referral Process, 1 page referral sheet).
- Give admission decision within 4 business Hours
- Continued outreach to hospitals (Marketing Manager)

Hospital Partnerships

- Establish service levels at Intake (LOS)
- Report patient outcomes To hospitals
- Assure accurate data
- Know service providers in your area for partnerships
- Be Responsive!

Program Measures & Outcomes

Donna Biederman, DrPH, MN, RN
Assistant Professor
Duke University School of Nursing
Durham, NC

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Key Considerations

- What are **reasonable expectations** of your medical respite program?
- Who are your **stakeholders** and what are their expectations and resources?
- What is the best way to **measure and document outcomes**?

Reasonable Expectations / Outcomes

- What have similar programs achieved?
  - → NHCHC Medical Respite Directory
  - → NHCHC Technical Assistance
  - → Literature: Doran, K. M., Ragins, K. T., Gross, C. P., & Zerger, S. (2013). Medical respite programs for homeless patients: A systematic review. *Journal of Health Care for the Poor and Underserved*, *24*(2), 499-524.

Stakeholder Engagement

- Develop an advisory committee of key stakeholders, including program end users.
- Assess stakeholder capacity and resources, is there anyone missing?
- Document all meeting minutes and decisions in a place assessable by stakeholders.

Measures & Instruments

- Has / Needs
  - → Helps prioritize work and document incremental progress
- Changes in physical and mental health
  - → Health Related QoL measures - SF-20, Duke Health Profile
- General Self-efficacy
- Health care utilization
  - → Inpatient admissions and days, outpatient visits, ED visits
- Satisfaction – patients and stakeholders

Documenting Outcomes

- Frameworks
  - → IHI Triple Aim
  - → Strategic Plans
  - → CHNA / Community Benefit
  - → Organizational Missions
- Data Bases
  - → Excel
  - → REDCap

Standards & Resources

Julia Dobbins, MSSW
Project Manager
National Health Care for the Homeless Council
Nashville, TN

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Standards for Medical Respite Care

1. Safe and quality accommodations
2. Environmental services
3. Safe care transitions into medical respite
4. High quality post-acute clinical care
5. Care coordination and wrap around services
6. Safe care transitions out of medical respite
7. Driven by quality improvement

Resources

Current

- Medical Respite Toolkit
- Practical Planning Guide
- Development Workbook
- Medical Respite Standards
- Financing Medical Respite Policy Brief & Webinar
- Technical Assistance from the Council

Upcoming

- Standards Resource Guide & Self Assessment
- 2018 Medical Respite Program Directory
- Trainings:
  - → 2018 National Health Care for the Homeless Conference & Policy Symposium

Save The Date

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Questions?

Donna Biederman, Duke University School of Nursing
donna.biederman@duke
Chauna Brocht, Health Care for the Homeless Baltimore
cbrocht@hchmd.org
Kim Despres, Circle the City
kdespres@circlethecity.org
Shakoya Green, Pathway Recuperative Care
sgreen@nhfca.org
David Munson, Barbara McInnis House
dmunson@bhchp.org
Julia Dobbins, NHCHC
jdobbins@nhchc.org

DISCLAIMER

This activity is made possible by the Health Resources and Services Administration, Bureau of Primary Health Care. Its contents are solely the responsibility of the presenters and do not necessarily represent the official views of HRSA.