NATIONAL HEALTH CARE for the HOMELESS COUNCIL

MEDICAL RESPITE CARE PROGRAMS & THE TRIPLE AIM FRAMEWORK FOR HEALTH

Wednesday, June 5, 2019

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

HRSA DISCLAIMER

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TODAY'S PRESENTERS

Rhonda Hauff, Chief Operating Officer & Deputy CEO, Yakima Neighborhood Health Services, Yakima, WA

Jessica Savara, LCSW, QMHP, CADC II, Recuperative Care Program Supervisor, Central City Concern, Portland, OR

David Munson, MD, Medical Director, Barbara McInnis House, Boston, MA

Jordan Wilhelms, Complex Care Program Manager, Central City Concern, Portland, OR

Moderator: Barbara DiPietro, PhD, Senior Director of Policy, National HCH Council

DISCUSSION AGENDA

- Brief program overviews, to include performance measures
- Brief overview of recent policy brief
- Panel discussion with programs
- Audience Q&A

LEARNING OBJECTIVES

- Describe the **three components** of the Triple Aim framework for health.
- Identify at least **five possible outcome measures** appropriate for medical respite programs.
- Identify **two possible steps** that local programs can take to better align with the interests of larger health care stakeholders in their community.

YAKIMA NEIGHBORHOOD HEALTH SERVICES

Our mission is to provide accessible, affordable, quality health care, provide learning opportunities for students of health professions, end homelessness and improve quality of life in our communities.

Rhonda Hauff, COO / Deputy CEO, Yakima Neighborhood Health Services

Chair, Respite Care Provider Network, National Health Care for the Homeless Council

Yakima Neighborhood Health

WHO WE SERVE – FINE LINE BETWEEN RESPITE, SNF, & HOSPICE

- Homeless or in Emergency Shelter
- Independent in Activities of Daily Living (ADLs)
- Continent and Independent in mobility
- No IV lines
- Can administer own medications

WHAT HAPPENS WHERE

- Respite:
  - Transition of Care (from hospital or SNF)
  - Daily health checks
  - Meals On Wheels (3 per day)
  - Wound care
  - Behavioral health assessments & counseling
  - Transport to PCP & Specialty appointments
  - SSI / SSDI / SNAP application assistance.
  - Housing Stabilization Plan
  - Discharge planning for exit.

- CHC:
  - Provides direction of primary care needs – medical, dental, behavioral health.
  - Referrals to Specialists.
  - Key Communicator with Health Plans and Managed Care Organizations (payers)
  - Oversees medications / changes to medications
  - Determines when patient is safe for respite discharge.

2007 TO 2018

ADMISSION VS. RE-ADMISSION

Referrals from PCP
35% to 60%

Providers Understand the Value of Medical Respite Care

Referrals from Hospitals
70% to 28%

Referrals from Same Day Surgery
0% to 13%

Yakima Neighborhood Health

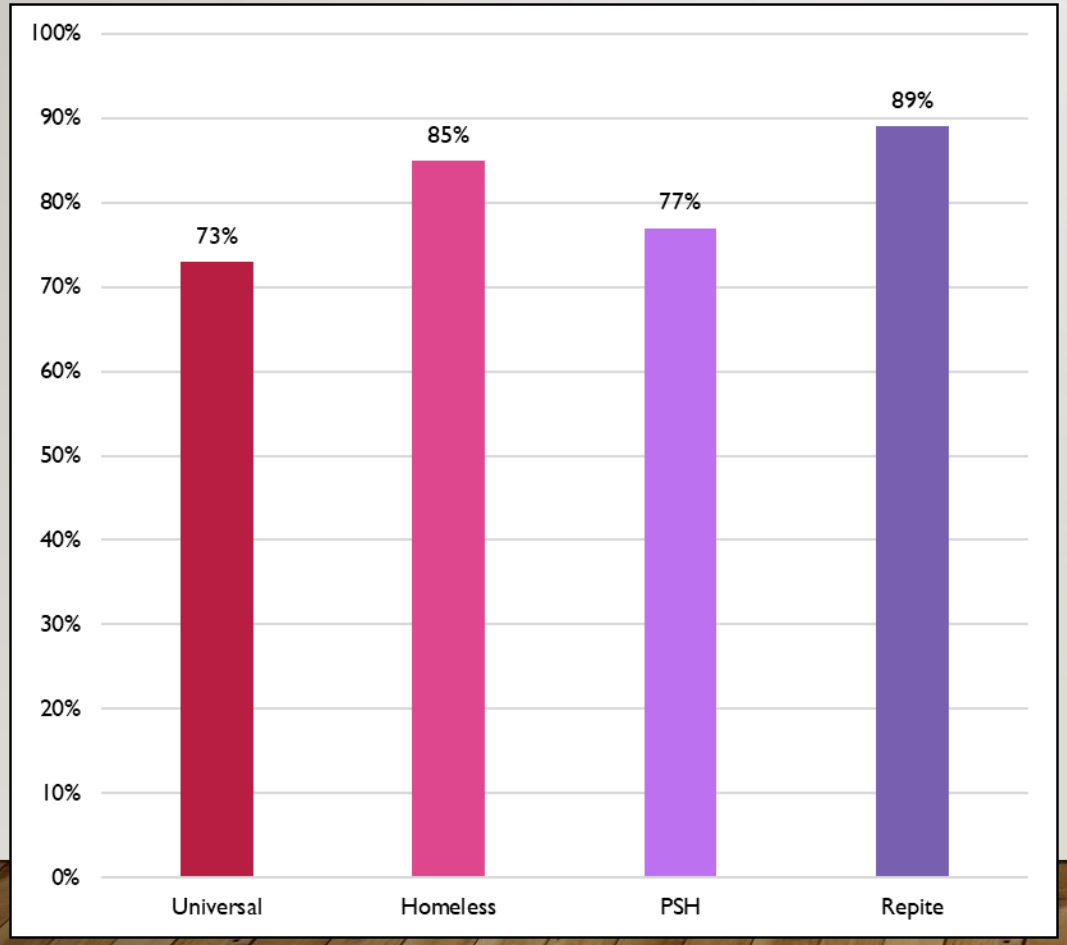
Drink the Kool-Aid
Housing is Health Care

Outcomes tied to the IHI Triple AIM

- Improving rate of successful connection to primary care
- Increasing rate of compliance with care plans
- Improvement in chronic disease measures (e.g. A1c scores, BP measure)
- Reduction in communicable disease (e.g. TB, STDs, Hep C)
- Reduction in behavioral health crisis episodes
- Medications are better managed
- More likely to obtain and maintain employment or education
- Greater success for recovering SUD recovering patients in supportive housing

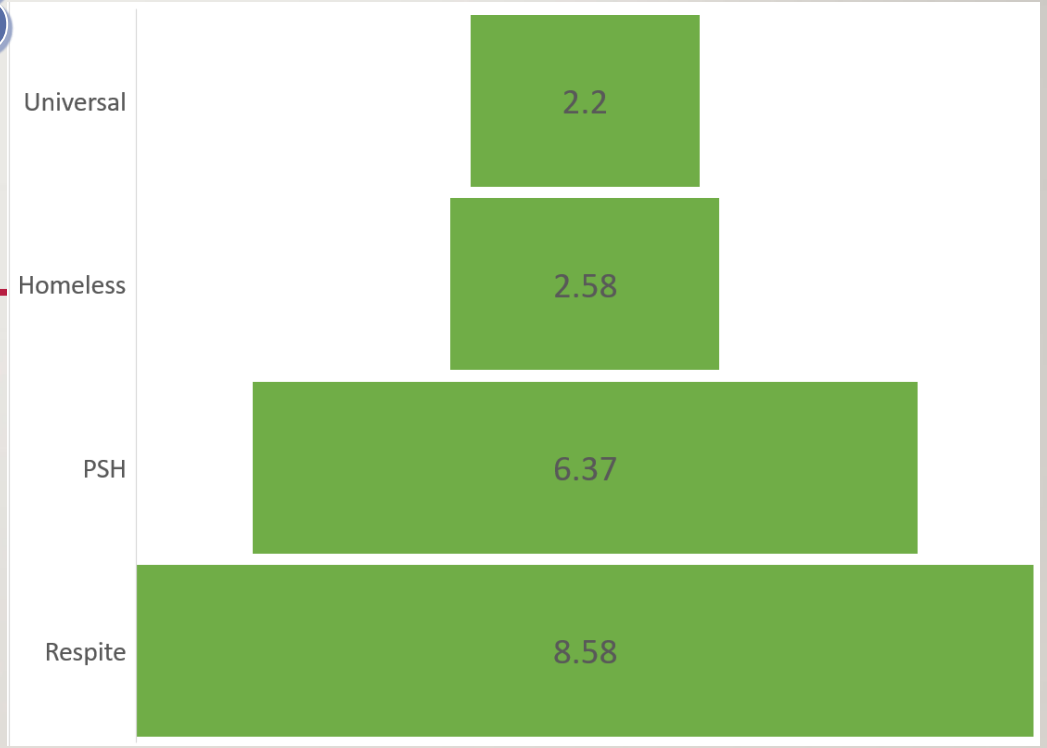
INCREASING ACCESS TO CARE 2018

Health Coverage



Visits Per User

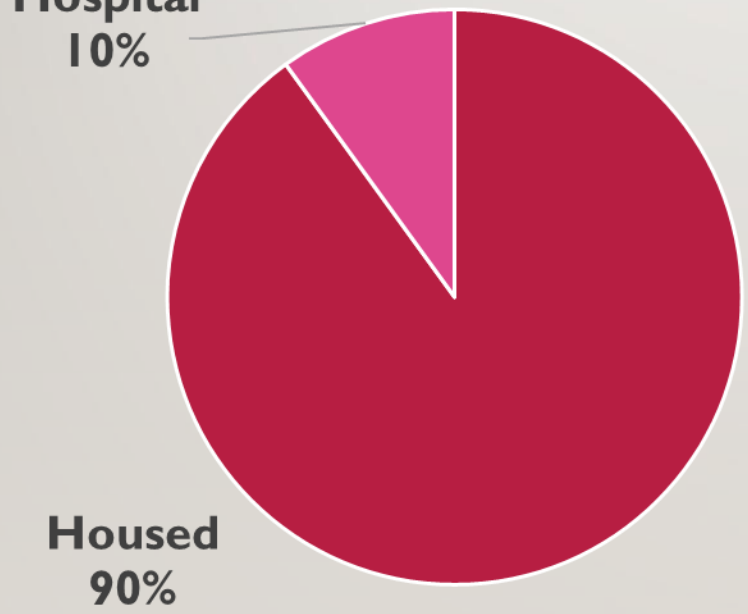
2018



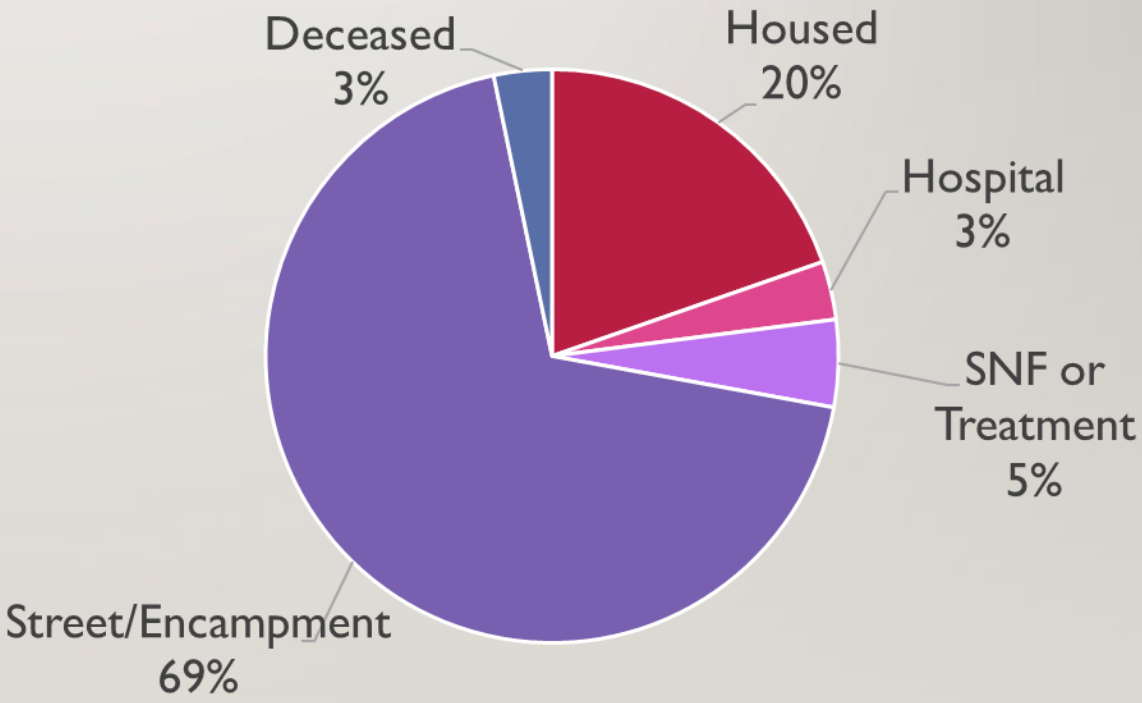
IMPROVING CONNECTION TO PRIMARY CARE
MEDICAL VISITS PER USER

RESPITE EXITS

2010



2018



MEDICAL RESPITE CARE SAVES $$

HOSPITAL STAFF REPORT A SAVING OF 53 INPATIENT DAYS IN 2018

($65,773 FOR DEPRESSION OR $190,800 FOR REHAB)

- Respite care reduces public costs associated with frequent hospital utilization.

	Average Hospital Charge for Depression*	Average Hospital Charge for Rehab*	Average Respite Program
Average Length of Stay	13 days	8.1 days	20 days
Average Charge Per Patient	$16,133	$29,166	$2,191 (not including primary care)
Average Charge / Cost per Day	$1,241	$3,600	$111.28 (not including primary care)

Yakima Neighborhood Health

Medical Respite in Boston

Medical Respite for in Boston

- Began with 20 beds in Shattuck shelter in 1985
  - Required by original BHCHP charter
  - “Grew up” during AIDS crisis in late 80s/90s
- Now with two stand alone programs with 124 total beds
  - Barbara McInnis House
  - Stacy Kirkpatrick House
- Unique Context
  - Early Medicaid expansion in Massachusetts
  - MassHealth recognizes medical respite as a billable entity

Barbara McInnis House

- 104 bed stand alone facility in Boston's South End
  - 24/7 nursing care
    - Medication administration
  - Daily NP/PA Visit
  - Integrated case management and BH (SW) care

- Level of Care
  - Detox (alcohol, opioid, sedative)
  - IV antibiotics
  - Wound care, perioperative care, end of life care
  - Decompensated chronic disease

Barbara McInnis House

- FY 18 Admissions
  - 2,335 total admissions (1,224 unique patients)
  - LOS 14.3 days
  - Most patients return to shelter

- Patients Must
  - Be independent with ADLs
  - Have a stable clinical trajectory
  - Be able to tolerate a structured setting

Stacy Kirkpatrick House

- Level of care in between BMH and shelter
  - Opened in 2016

- Model of care
  - 24/7 case management/millieu support
  - 14 hours/day of RN
  - 12 hours per week of NP/PA – 1 patient visit/week

- Patients must
  - Be independent with ADLs
  - Be relatively independent with their care plan
    - Meds are self-administered with assistence.

Quality Metrics

- External (for payers) vs internal (for QI)
  - BHCHP joined BMC accountable care organization (BACO) in 2018

- Internal
  - Medication errors/day
  - Falls/day and total falls/month with injury
  - Reported out in monthly quality meeting

- External
  - BACO tracks revisit (inpatient + EDOU) and readmission (inpatient) after BMH stay
  - Have not looked at total cost of care (yet)

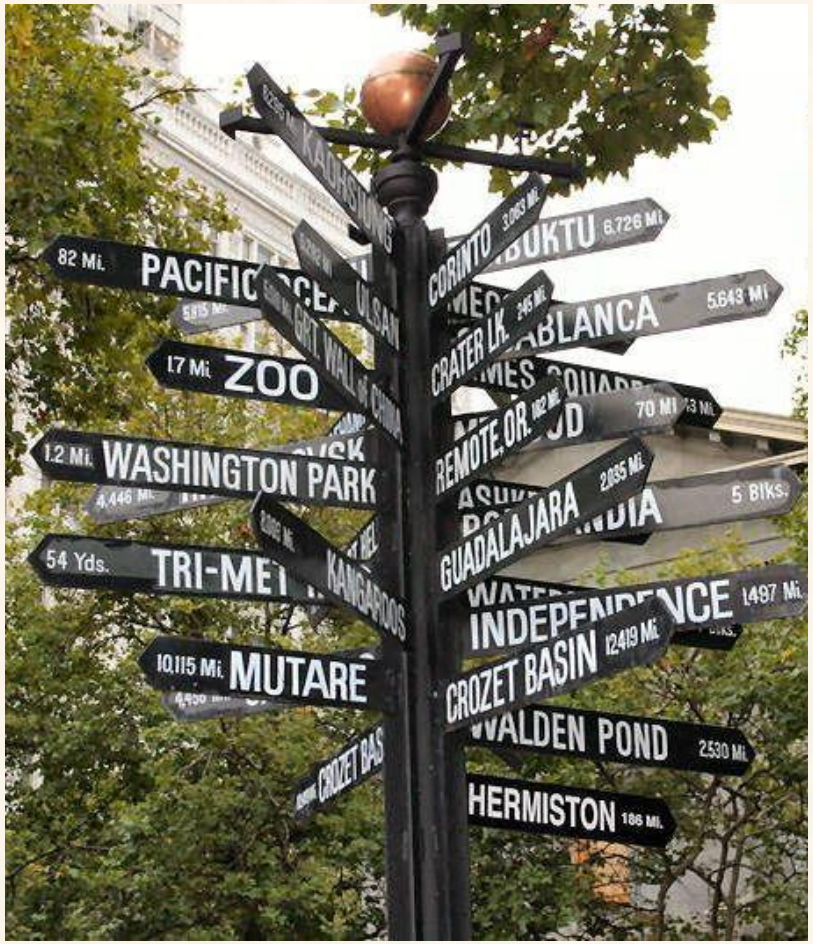
Essential Recuperative Care Program Model

- **Intensive, trauma-informed and person-centered case management**, including daily client monitoring.
- **Dedicated access to medical care** and ancillary services at CCC's Old Town Clinic.
- **Secure transitional housing**, including personal hygiene supplies, food boxes and nutritional support.

Comprehensive Recuperative Support

RCP participants also receive:

- Support in making and keeping appointments
- Transition planning
- Complex care coordination across health, housing, treatment, employment and benefits systems
- Tailored, person centered interventions
- Daily social contact and peer support



Recuperative Care Program – July 2019

- Staffing:
  - 24/7 Case Management
    - Mental Health
    - Social Work
    - EMT
    - Non-credentialed
  - Supervisor (LCSW, QMHP, CADCII)
  - RN
  - Housing Specialist
  - Logistics
  - Environmental Services
  - Security

Recuperative Care Program - 2005

- Started in 2005 with pilot capacity funding
- Just a few beds to start
  - Housing
  - Intensive case management
  - Primary care
- With quickly impressive housing placement, medical resolution, and cost savings results, the project expanded and other stakeholders signed on

Recuperative Care Program – 2006-2019

- Referrals from 10+ hospitals (and several MCOs)
- Increase to 35 beds
- New access points
- Expansion of service model
- Housing crisis
- Population influx

Blackburn Center – July 2019

- Blackburn Center opening July, 2019
- 175 Housing Units
  - 51 respite beds
- Integrated teams offering:
  - Health Services, Housing and Employment Services
  - Continuum of health services treatment intensity

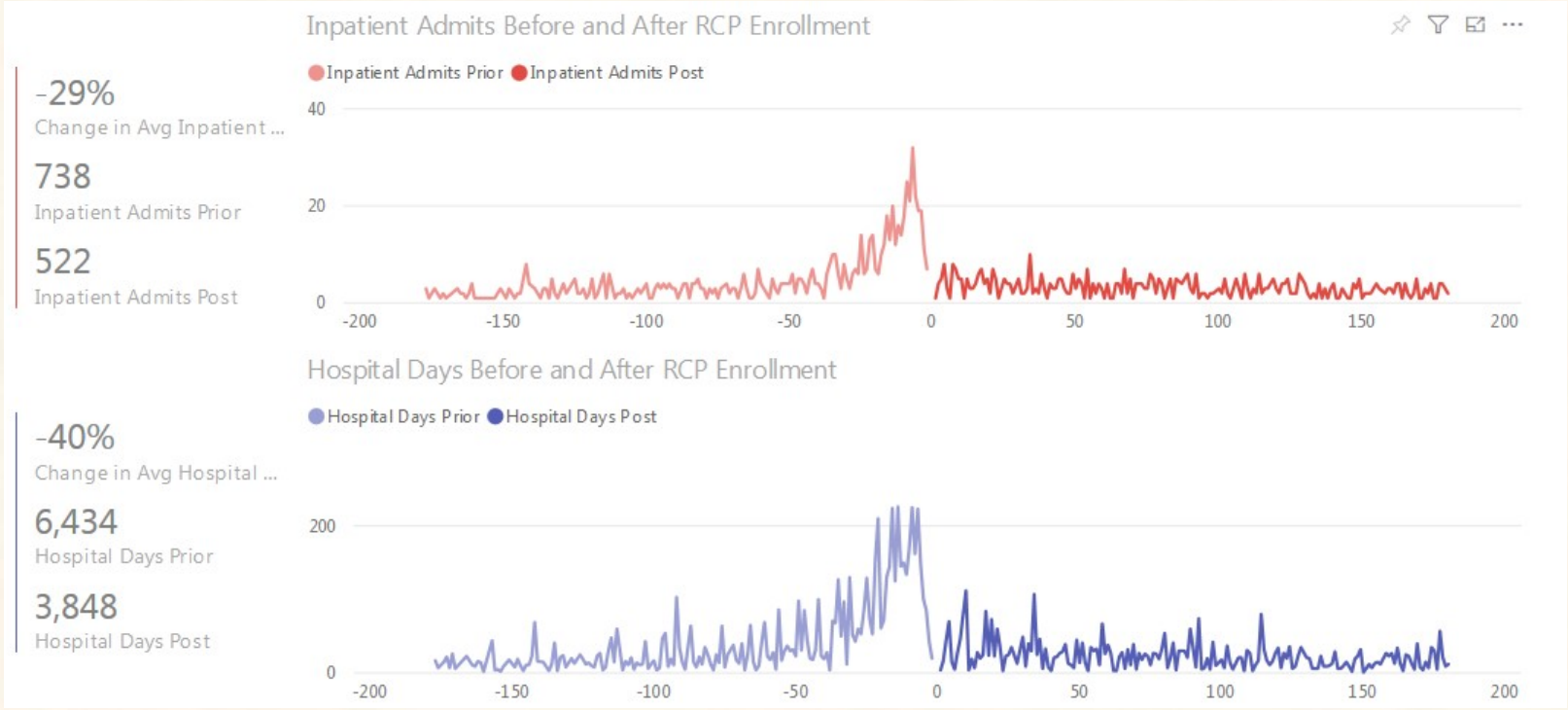
Outcomes/Performance Measures

- Formal measures:
  - % participants placed in TH or PH at exit
  - % participants resolving acute medical issue exit
  - % participants that have medical home at exit
- Informal measures (amongst many others):
  - Impact on hospitalization and ED utilization
  - Engagement in primary care

Outcomes/Performance Measures

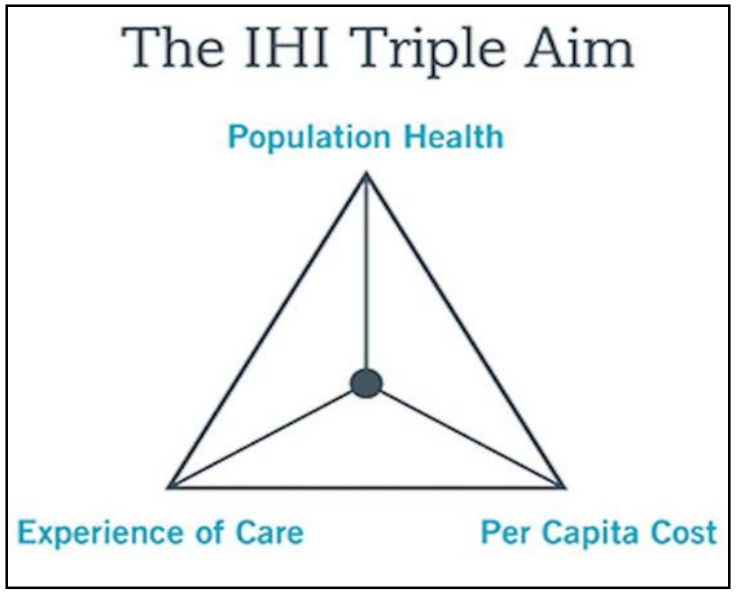
Since its inception in 2005, RCP has served thousands of individuals, with:

- Over 70% resolving their acute medical condition
- Over 95% established with primary care upon exit
- Over 60% transitioning into stable housing.



THE IHI TRIPLE AIM FRAMEWORK FOR HEALTH

- Institute for Healthcare Improvement's framework
  - → Improve population health
  - → Improve the experience of care (includes quality & satisfaction)
  - → Reduce per capita cost
- Health systems use to transform service delivery, achieve greater value, and better meet needs



MUTUAL INTERESTS AMONG KEY PLAYERS

HEALTH SYSTEMS STAKEHOLDERS

- Hospitals, health insurers, Medicaid programs, public health leaders

- Reducing cost, improving quality outcomes
- Using data to drive decision-making & demonstrate "value"
- Leveraging community partnerships

MEDICAL RESPITE PROGRAMS

- Providing a safe place for patients to rest and recuperate
- Connecting with appropriate care and support
- Serving short-term role amid longer-term goals for improved health & housing stability
- Using data to demonstrate "value"
- Achieving greater recognition and financial support

IMPROVE POPULATION HEALTH

Element of Care	Example Outcome Measures
Health outcomes	Improved rate of successful care transitions
	Increased rates of compliance with medications and care plans
Disease burden	Reduction in high-risk behaviors related to communicable disease
	Increased rate of preventive health screens
Behavioral & Physiological Factors	Increased rates of nutrition/diet management
	Increased connection to family/community supports

IMPROVE THE EXPERIENCE OF CARE

Element of Care	Example Outcome Measure
Safe	Reduce incidence of unsafe discharges
Effective	Increase in follow-up consult & education with patient
Timely	Increase in prompt appointments for care
Patient-centered	Increase in patient reporting satisfaction with care
Equitable	Satisfaction scores for patients who are homeless = those who are not homeless
Efficient	Decreased hospital staff time on care coordination with community providers

REDUCE PER CAPITA COST

Aspect of Cost	Targeted Stakeholder	Example Outcome Measure
Demand lens/ **Consumers**	Community/public health	Reduced cost related to fewer emergency response/911 transportation
	Individual	Reduced out of pocket costs due to lower service use
Intermediary lens/ **Health plans & insurers**	Health plans	Reduced costs PM/PM
Supply lens/ **Providers**	Hospitals	Reduced costs from shorter inpatient stays
	Outpatient	Increase in payments for services
	Specialists	Increase reimbursement due to better appointment adherence
	Pharmacy	Reduced costs related to poor medication management

RECOMMENDED ACTIONS

1. Discuss medical respite programs & the Triple Aim with key stakeholders
2. Meet with hospital discharge planners to discuss current needs
3. Identify data elements currently available and evaluate those measures
4. Identify gaps in available data and a process for creating new data elements
5. Identify those responsible for documenting, evaluating, and reporting outcome data at periodic intervals
6. Identify level of funding, model of payment, and funding sources
7. Develop a small program at first, and scale up from there
8. Visit other programs

PANEL DISCUSSION

1. How do you see the Triple Aim framework helping to bolster medical respite care programs?

2. How should brand new respite programs just starting out use this information, and how do you see those with more established programs benefiting from this framework?

3. How do you determine what measures to track, especially for a program that is designed to be a short-term intervention?

4. What's the tension between tracking the measures that your funders want, and creating additional measures for your own quality improvement needs?

PANEL DISCUSSION

5. How do you determine when your measures need to change?

6. For those on the call who are working in hospitals or for insurers, how would you advise them to use this information?

7. Looking ahead over the next five years or so, how do you see medical respite programs fitting into health reform efforts, especially given the increasing focus on data and value-based payments?

AUDIENCE DISCUSSION

- What more information can we provide?
- Are there issues or ideas you'd like to revisit?
- How have you incorporated these concepts into your program?
- What barriers have you faced you would like advice in overcoming?
- Other questions?

ADDITIONAL RESOURCES

- Standards for programs
- Program directory
- Tool kit with research, template contracts, planning materials, etc.
- Respite Care Providers Network (RCPN)
- Policy brief on financing models

RCPN

https://www.nhchc.org/resources/clinical/medical-respite/