August 22, 2014

Responses to questions that were not addressed during the webinar,
"Medical Respite Start Ups: Lessons Learned and Recommendations"

Has there been any success in seeking funding of less clinical care without the deferring of hospital liability?

- [Sabrina Edgington] There are some programs that provide "step down beds" for homeless patients who are discharged from hospitals. Unlike medical respite programs, these beds provide little to no clinical care but may provide case management. Generally, patients appropriate for this type of setting do not need much clinical oversight (e.g., someone with a broken or fractured leg) but need a safe environment to rest. Funding sources vary but may include the use of unrestricted private donations and hospital contributions.

What inconsistencies occur and how did you address them?

- [Melissa Fox] I'm not sure if this is referencing operational inconsistencies or the differences among the referring providers. But in general, our team communicates pretty frequently regarding the occurrences at the Respite site. Since this is new, we're all hyper-sensitive about responding to any inconsistencies or issues that could affect care or existing relationships, so we find that having an open line of communication is helpful in being proactive.

In states that did not expand Medicaid, are they maintaining their hospital level of funding?

- [Melissa Fox] In Philadelphia, we receive a per diem from our hospitals, and we are maintaining that level for now.
- [Sabrina Edgington] We haven't conducted any surveys but anecdotally, I would say that most programs in non-expansion states are maintaining their hospital level of funding.

Does either program think that it would be beneficial to have a social worker on staff?

- [Brandon Clark] Yes, Circle the City has two Case Managers who work on entitlements, income and housing related issues. I strongly recommend some sort of social service worker for every 20-30 patients cared for – certainly more if your budget is capable.
- [Melissa Fox] Yes and absolutely. A key part of the process is connecting the homeless patients to support services, and an in-house social worker is critical to success.

Do you take patients that have Alzheimer's or Dementia who might wander? If so, how do you handle care for these patients?

- [Brandon Fox] We have some patients with dementia diagnoses, but most are easily redirected by other staff or peers. Our front doors are not locked from the inside, but they are alarmed, so we know if patients come or go without authorization. Patients who have an established history of wandering – especially those who are a danger around staircases – are not always eligible for placement at CTC. The admitting clinician - with assistance from the Medical Director - makes a judgment call whenever patients are referred with any dementia history.
- [Melissa Fox] We don't currently have any patients who present an elopement risk.

Do you provide activities during the day for patients? If so what do your activities consist of?

- [Brandon Clark] We have a full-time staff member who manages both volunteers and patient activities. We have a full weekly calendar of activities – all of which are driven by community

volunteers. Highlights include arts and crafts, chair yoga, bingo, etc. We also have weekly substance abuse group therapy and AA/NA. Local churches also provide optional spiritual care opportunities such as Catholic communion, bible study, etc.
- [Melissa Fox] We don't currently have any organized activities, but our patients are able to watch television, listen to music and relax in the common areas. There is also a game room available if they are well enough to take part.

What are the main data points you collect on patients, such as return to PCP f/up visit after hospital stay, engagement in substance treatment programs, etc?

- [Brandon Clark] Circle the City primarily tracks (a) the % of patients completing primary medical goals, (b) the % of patients connected to a primary care provider prior to discharge, and (c) the % of patients discharged out of homelessness, i.e., somewhere other than the street or emergency shelter. We also keep an eye on % of patients who successfully complete, versus % of patients who are administratively dismissed or % who discharge against medical advice.
- [Melissa Fox] The key data points are: length of stay, admitting diagnosis, discharge reason (self, released, involuntary, etc.), where they were discharged (street, shelter, housing, etc.), referring partner, existing primary care provider, hospital admissions.

What is the average daily charge for each patient and does it vary based on diagnoses?

- [Brandon Clark] We discount our rates for hospitals that provide us the most volume, but our rates average between $190 and $300 per diem. The only diagnostic-specific upcharge currently in play is a daily charge for infusion maintenance. This is usually $50-$100 depending on what medication is prescribed. We are piloting an agreement with one specific hospital that includes a capitated (flat) rate for patients, depending on the specific admitting diagnosis.
- [Melissa Fox] I can't share the exact charge, but I can tell you that it is the same for everyone.

Do the respite programs have electronic health records program and if so how did they pick a program?

- [Brandon Clark] Since opening we have used a freeware EMR called Practice Fusion. The decision was based mostly on cost, but also on basic functionality needed such as e-prescribing, online physician order entry, nursing progress notes, etc. We are tentatively planning to migrate to a more dynamic EMR in the coming fiscal year. We currently do not have a practice management component to our EMR, which will prove absolutely necessary as we migrate into the Medicaid world.
- [Melissa Fox] We haven't begun using our EHR yet, but we will be soon. We are currently using Allscripts for our health centers, and expect to continue using it for the Respite program.

Melissa, are there more beds in Shelter and do patients abide by same rules as homeless clients?

- [Melissa Fox] All of our clients are homeless, same as the shelters. However, our rules are slightly different because we're offering recuperative care and patients aren't required to leave by a certain time. We also make other provisions based on their physical or health needs.

Brandon, the conditions on the right of your continuum chart require skilled nursing care. How are you providing it as a part of respite care?

- [Brandon Clark] Circle the City offers a number of services that are skilled in nature such as IV maintenance and complex wound care. We staff nurses around the clock who work under the guidance of a full-time medical director and after-hour medical coverage. Our admitting

guidelines dictate specifically what admitting diagnoses we can accommodate, and which we cannot.

Do the hospitals pay a set rate per patient day (i.e. a per diem)? If not, please explain how the hospitals reimburse you for care.

- [Brandon Clark] Circle the City has a variety of contracting options for local hospitals. We offer straight per-diems agreements, but also offer a discounted daily rate for hospitals that pre-pay for blocks of bed days. We are also piloting a capitated rate that varies by patient acuity.
- [Melissa Fox] We offer hospitals the ability to contract on a per patient/per day basis, or they can actually hold beds for their usage. The payment structure varies depending on their selection. Once finalized, we invoice the hospitals on a monthly basis for patient stays at the respite.

Have you reached out to IPAs and health plans for contracting?

- [Brandon Clark] Yes. We are in active dialogue with most of the local Arizona Medicaid health plans, and expect to have two initial contracts in place in the coming months.
- [Melissa Fox] Yes, we are at the beginning of those discussions.

What can you share as far as hotel based respite programs in terms of how successful those programs tend to be?

- [Sabrina Edgington] There are only 8 or so medical respite programs in the United States that use motel rooms either solely or for some of their patients. Motel rooms are a good option for communities that do not have a facility to house a medical respite program or when accommodations for women and/or families are otherwise unavailable. These programs are successful when program policies and protocol are established to ensure that this type of setting is safe for patients (i.e., the patient is independent in activities of daily living), the hotel staff are on board with the mission of the program and work collaboratively to address any issues, 24-hour on-call support is available to the patient.