NATIONAL HEALTH CARE for the HOMELESS COUNCIL

USING DATA TO TELL THE STORY

Outcome and Data Recommendations for Medical Respite Programs

May 27, 2020

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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www.nhchc.org

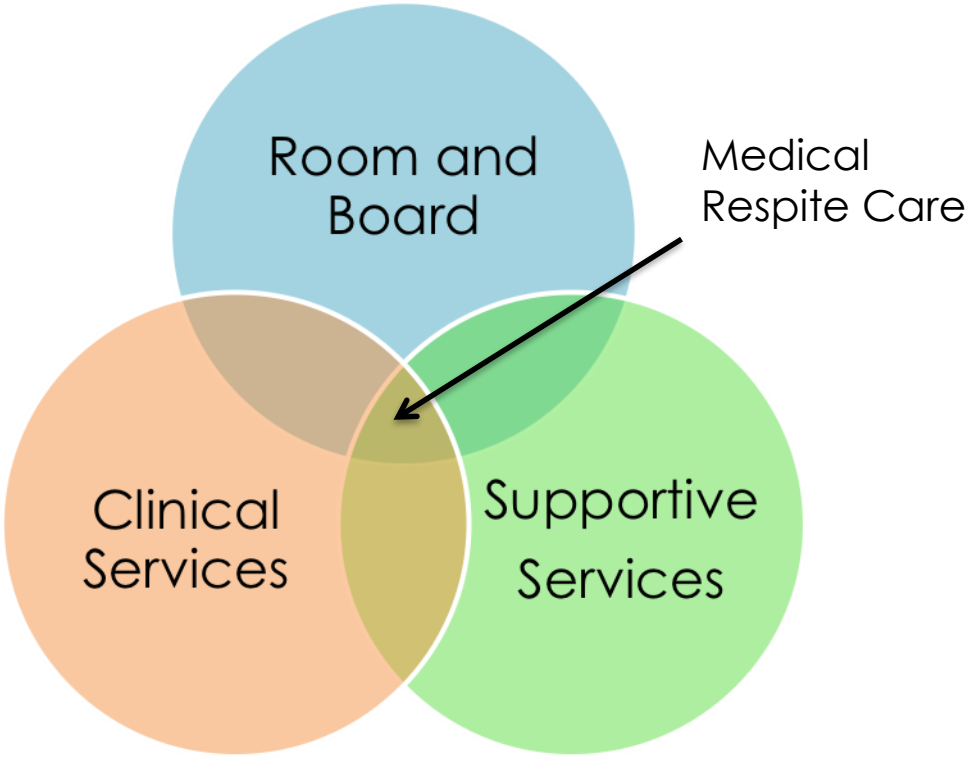
MEDICAL RESPITE: DEFINITION

- Acute & post-acute care for people who are homeless who are too ill or frail to recover from sickness or injury on the street, but not sick enough to warrant hospital level care
- Short-term residential care that allows people who are homeless to rest in a safe environment while accessing medical care and support services
- **NOT:** skilled nursing facility, nursing home, assisted living, BH step-down, or supportive housing

Diversity of Programs

- Size
- Facility
- Length of stay
- Staffing & services
- Admission criteria

MEDICAL RESPITE CARE



LEARNING COLLABORATIVE

Bethlehem Haven Medical Respite	Pittsburgh, PA
Bridgewell/ LCHC RCC	Peabody, MA
Center for Respite Care	Cincinnati, OH
Central City Concern	Portland, OR
Cottage Health RCP	Santa Barbara, CA
Heading Home	Albuquerque, NM
HOPE Adult Shelter & Recuperative Care Center	Pontiac, MI
Sister Mavis Jewel Medical Respite	Albany, NY
National Health Foundation	Los Angeles, CA
Valley Homeless Healthcare Medical Respite	San Jose, CA

SPEAKERS

Matthew Cotter, MSW

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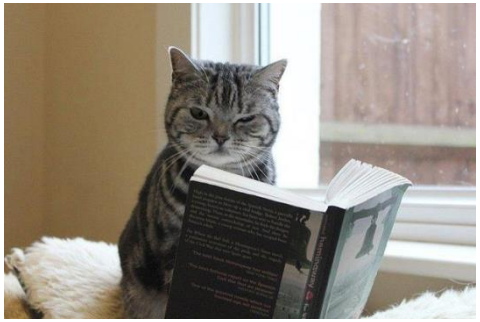
Laurie Nelson

Chief Executive Officer, Center for Respite Care, Cincinnati, OH

Maddy Frey, MPH

Director of Population Health, Evaluation, Cottage Health, Santa Barbara, CA



Monica Ray

Pop. Health Strategic Development Manager, Cottage Health, Santa Barbara, CA

Bethlehem Haven Medical Respite: CY 2019

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BethlehemHaven

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Bethlehem Haven and Allegheny Health Network Pilot

- Started in 2016
- 10 Beds (5 at 1410, 5 at Wood Street Commons)
- AHN Provided: Nurse, CRNP, Home care services
- New Bethlehem Haven position: Respite Care Coordinator
- Pittsburgh Mercy's Mobile Medical Unit and Psychiatric Consults

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PHASE II: Adding UPMC, UPMC Health Plan and a new building

- Moved in to 905 Watson June 2018
- 29 Beds (10 UPMC, 5 UPMC Health Plan, 14 AHN)
- The role of Pittsburgh Mercy: onsite medical care from the Pittsburgh Mercy Family Health Center
- Expansion of Respite team
- AHN transitioned all onsite care to Pittsburgh Mercy in January 2019

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- Bethlehem Haven's Medical Respite Program Provides short-term residential housing coupled with post-acute medical care to support an individual's recovery from illness or injury. Individuals may be homeless, unstably housed, or do not have a family member or friend to care for them.
- Bethlehem Haven's Newly renovated Medical Respite Program offers private rooms and access to on-site dining and laundry. The Program's professional staff provide individualized case management to encourage adherence to medications, physician instructions and follow-up appointments, thus decreasing the probability of future hospitalizations

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Brief overview of referral process:

- Allegheny Health Network utilizes their Center for Inclusion Health consult service

- UPMC Hospitals send referral to Pittsburgh Mercy Medical Respite Team
  - Chart review and Nurse visits patient in the hospital to review level of care and make sure patient is appropriate for Medical Respite

- Unconventional referrals
  - Case by case basis

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Example of the format of referrals:

Respite Referral MRN (insert Medical Record number) (abbreviation for the hospital) (Date)

Example: Respite Referral MRN 000000000000 PUH 8/30/18

Body of the email:

Name:

DOB:

Insurance (carrier and policy number):

Unit/floor/room (including bldg.):

Anticipated Discharge:

Recuperative Need:

Unit contact:

Brief Summary:

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Bethlehem Haven Medical Respite Team--Staffing

- Social Worker
- 1.5 Nurses
- Housing Coordinator
- Care Coordinator
- Licensed Clinical Social Worker (Counselor)
- Medical Providers (Part-time: PA and MD)
- Residential Support Staff (24 hr coverage; 7 days/week)
- Administration
- Complemented by Home Care

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Some strategies utilized while at Respite

- Daily Huddle
- Weekly Operations Meeting
- 1:1 sessions
- Housing Plan
- Housing consults
- Weekly Community Meetings
- Groups: Art Therapy, drug and alcohol, etc.
- Medical visits with onsite Physician Assistant

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Some of the Services Linked to While in Respite

- Home Health
- Primary Care
- Medical Specialist Appointment
- Medication/Pharmacy
- Benefits Coordination
- Identification: Social Security Card, Birth Certificates, IDs
- Permanent Housing and other Housing Resources
- Outpatient Behavioral Health Treatment

- Health Plan Case Management
- Operation Safety Net
- Community Life Programs
- Employment
- Service Coordination

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DECISIONS AROUND DATA

- What Data Can We Control
- Admissions, Reasons for Admissions, Length of Stay, Disposition, Service Linkage, Satisfaction Survey, Demographic information, diagnoses while at Respite, etc.
- What Data Do We Not Have Access To
- Information about health needs and utilization pre/post Respite stay, insurance utilization information, etc.

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DECISIONS AROUND DATA

- Focus on what we can control, collaborate on the information we do not have access on.
  - Build strong partnerships, meet regularly
- Use the information we can control
  - Continuous program evaluation: we use data to learn about our program and to make improvement
- Identify barriers and plan to make adjustments
  - When we started, primarily on paper for documentation and data collection; implemented a medical record

Bethlehem Haven Medical Respite

- Total Admissions (6/15/18 to 1/31/20)
- 208
- Total Discharges (6/15/18 to 1/31/20)
- 197
- Average Length of Stay (6/15/18 to 1/31/20)
- 34.19 Days

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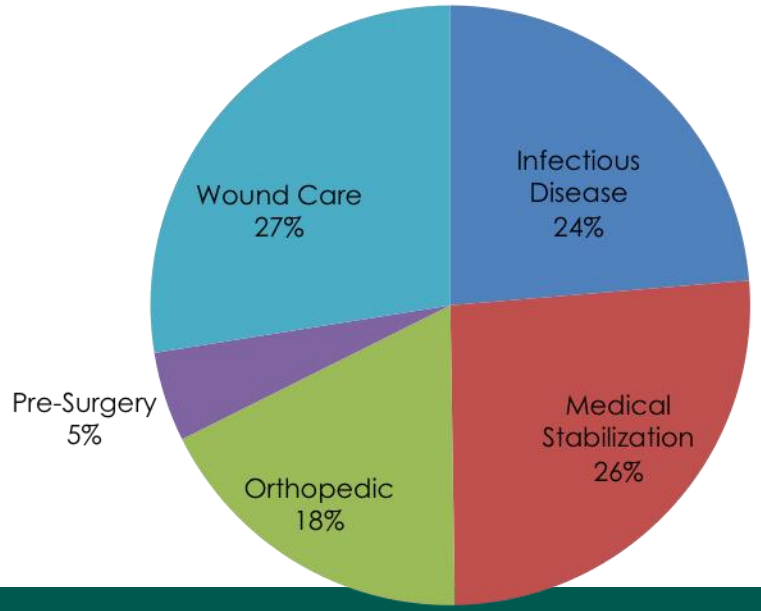
Dates: June 15, 2018 to January 31, 2020

Reason for Admission



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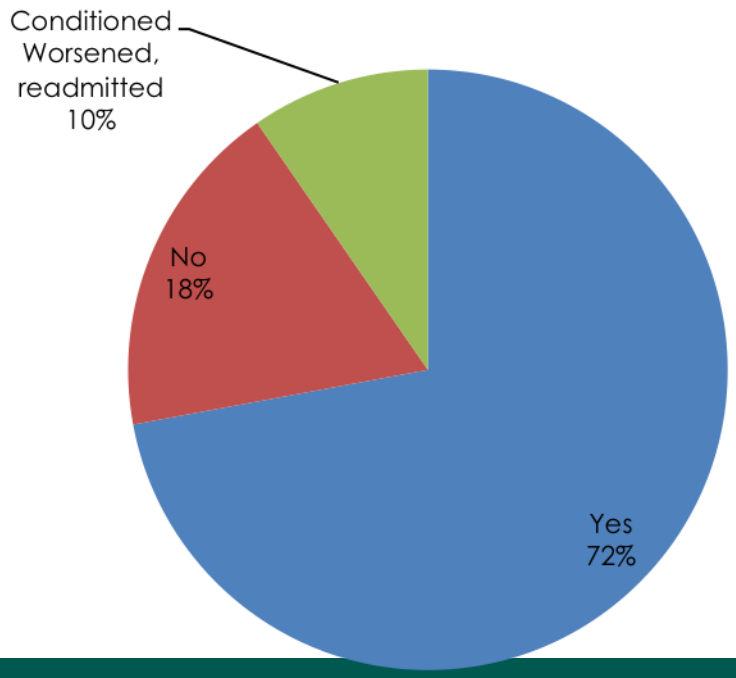
Dates: June 15, 2018 to January 31, 2020

Completed Medical Treatment



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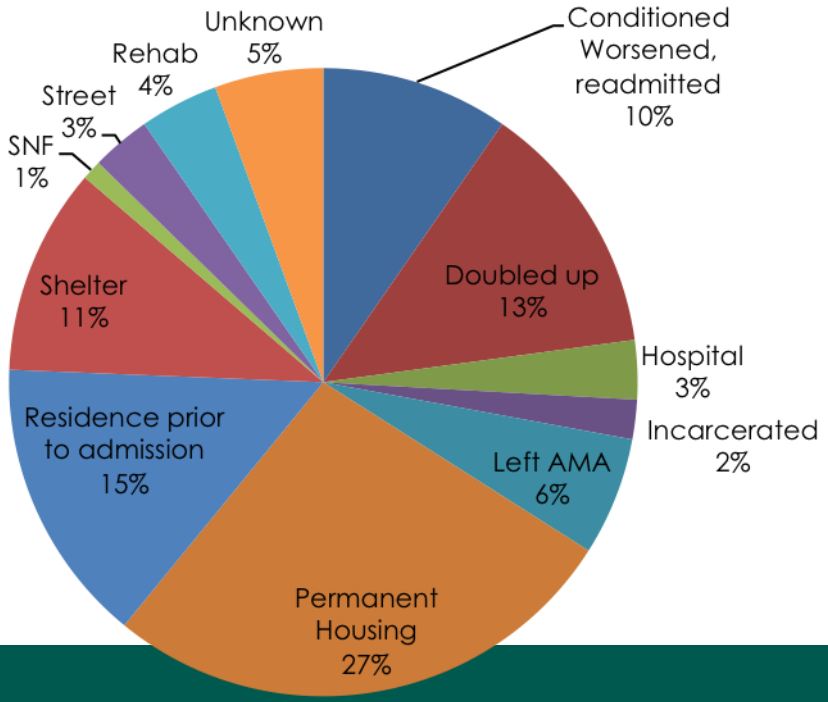
Dates: June 15, 2018 to January 31, 2020

Disposition from Medical Respite



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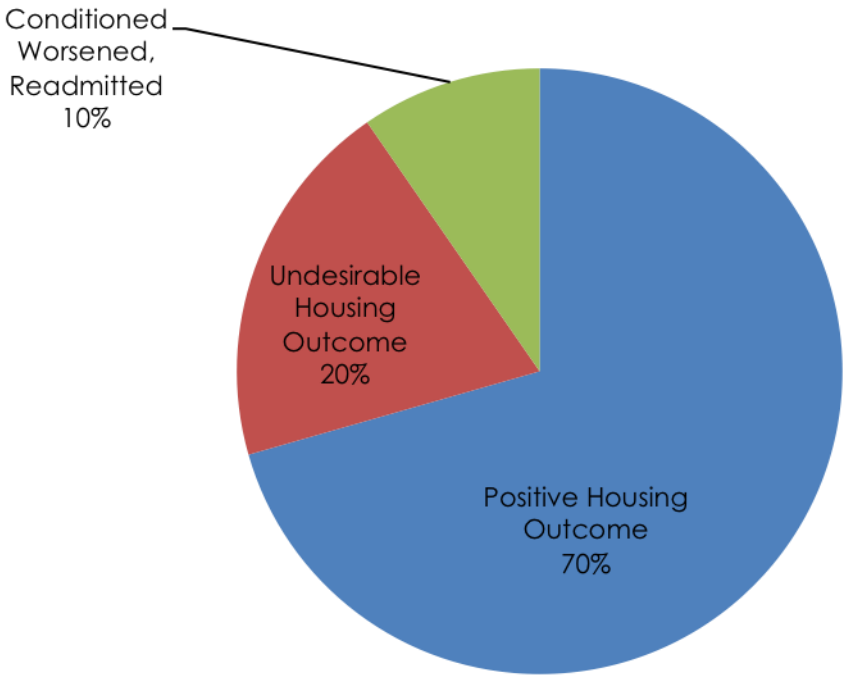
Disposition, CONT



Positive Housing Outcomes: Doubled Up, Permanent Housing, Residence Prior to Admission, Shelter, SNF, Structured Substance Abuse Treatment

Undesirable Housing Outcomes: Incarcerated, Left AMA, Street, Unknown

BETHLEHEM HAVEN MEDICAL RESPITE

Sample Client Survey

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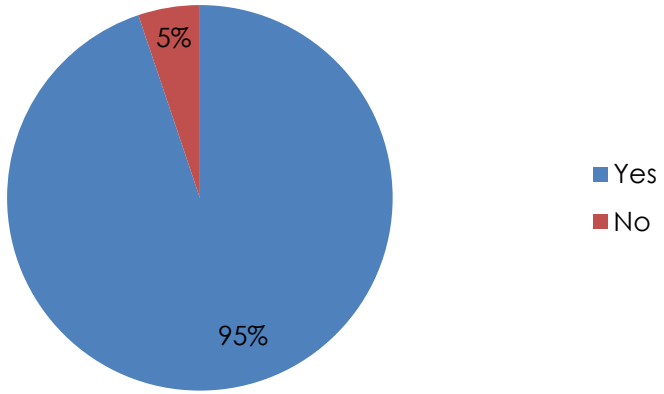
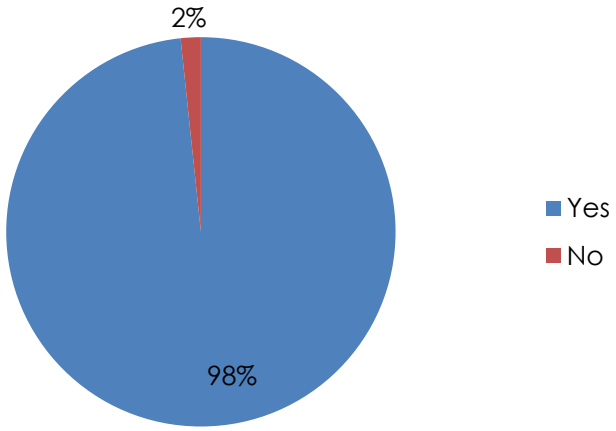
N = 63

Do you generally feel you were given enough help, advice, information and support from staff?

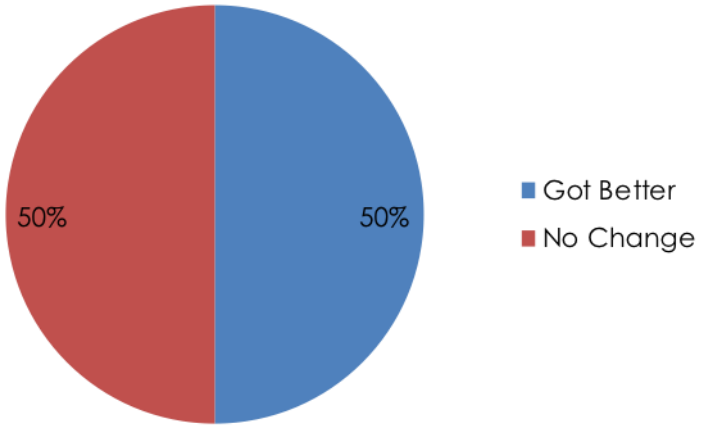


During stay at Medical Respite, I felt safe

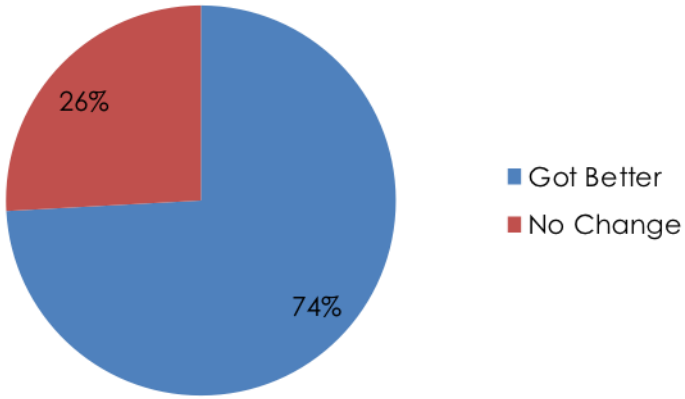


N = 63

My ability to manage my money

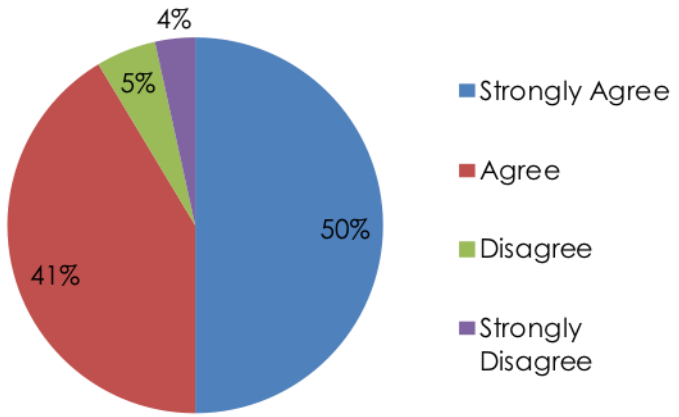


My Ability to make and keep appointments

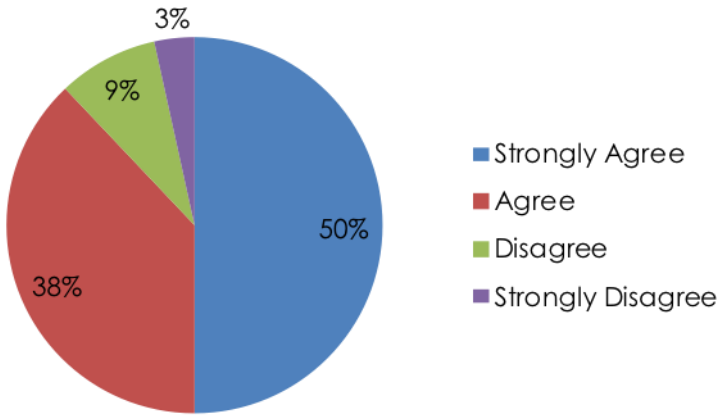


N = 63

Upon discharge I had a good understanding of how to manage my health



Upon discharge I had a better sense of well being



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Client Testimonial

"I really appreciate everything you all did to help me get situated. You guys really made a difference in my life and it means more than I could ever say. I got to say I've met a ton of people in the human services and you are one that belongs in that field. People in need def need people like you and Erin and the crew over there helping them."

Center for RespiteCare

Homeless Medical Recovery

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"THE MISSION OF THE CENTER FOR RESPITE CARE IS TO PROVIDE QUALITY, HOLISTIC MEDICAL CARE TO HOMELESS PEOPLE WHO NEED A SAFE PLACE TO HEAL, WHILE ASSISTING THEM IN BREAKING THE CYCLE OF HOMELESSNESS. "

- The Center for Respite Care, Inc. is a 24/7, 20-bed, stand-alone, medical facility serving adult women and men who are experiencing homelessness and need a place to recover after a stay in the hospital or other medical facility.
- The work of the Center is unique in the Cincinnati tri-state area. We have learned in our nearly 20 years of service that a healthy life for our clients relies on many factors. We call our core program "From Medical Recovery to Independence.

CENTER FOR RESPITE CARE

- Location: Cincinnati, OH
- Beds/Occupancy: 10 double occupancy rooms (20 beds)
- Staffing: 18 total staff (includes Admin)
- Part-time Physician (provided in-kind)
- Full time Registered Nurse
- LPN/MA staff (2.5 FTE)
- Case management team (2.5 FTE)
- Client Care Assistants (7.5 FTE)
- Licensed by the State of Ohio as a Residential Care Facility (Short Term Assisted Living)

CENTER FOR RESPITE CARE

- Outcomes & Data (what we collect and why)
- Driven primarily by funding sources:
  - Funding by demographics (age, gender, medical status (HIV), length of stay and, other factors such as military status.)
  - Funding by medical outcomes (improvement in obesity, A1C scores, smoking cessation)
  - Funding by social/program outcomes (benefits/income secured, housing/placement obtained)

- Driven by quality improvement and benefit to referral sources:
  - Establishment of medical home
  - Access to regular, preventative healthcare
  - Understanding and appropriate use of acquired benefits.
  - Reduction in use of ER/ED for medical services.
  - Connection to community supports.

COTTAGE RECUPERATIVE CARE PROGRAM

MADDY FREY
Director of Population Health, Evaluation

MONICA RAY
Population Health Strategic Development Manager

Cottage Population Health

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COTTAGE RECUPERATIVE CARE PROGRAM AT PATH SANTA BARBARA

10 patient beds

90 day maximum stay

1 medical director (part-time)

3 registered nurses (part-time)

1 social needs navigator

5 respite care monitors

- Located in Santa Barbara, California
- Hospital-led
- Onsite Public Health Care Center
- Referrals from hospital and community

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Cottage Population Health

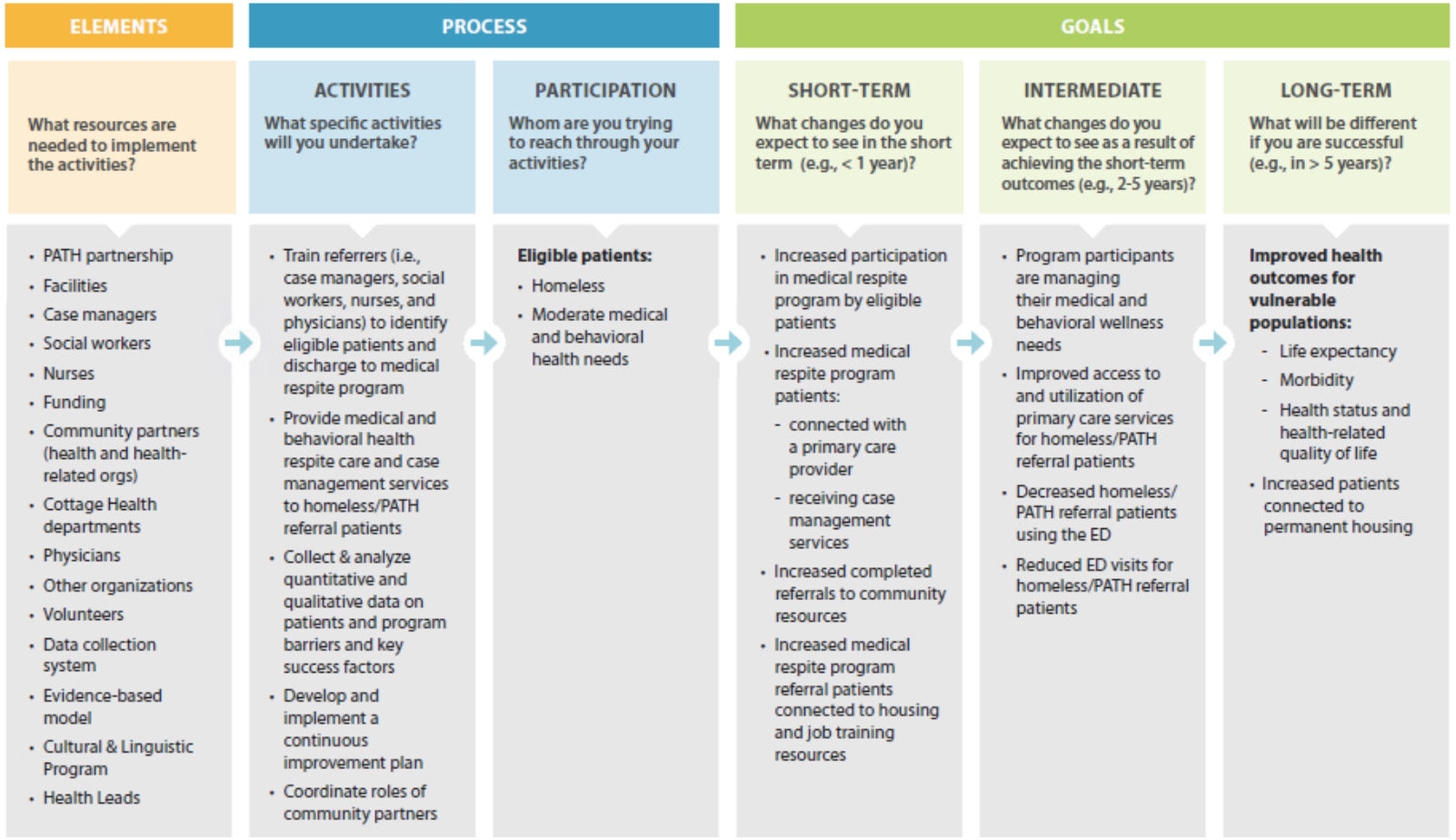
NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Cottage Population Health

RECUPERATIVE CARE PARTNERS

Patient Care	Funders	Housing
Cottage Nurse	Cottage Health	Housing Authority of the City of SB
Cottage Navigator	CenCal Health	PATH
Public Health	Private Foundation	
Local Shelter	Individual	
Monitors	Philanthropists	

RECUPERATIVE CARE LOGIC MODEL



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Cottage Population Health

EVALUATION TOP OUTCOMES

Document-ready for housing

- Patients that are document-ready for housing
- Patients in temporary and permanent housing (at exit and after)

Reduce ED and inpatient use for program participants

- Emergency department utilization rates
- Inpatient utilization rates

Referrals offered and utilized

- Patients with established care plans
- Referrals offered; appropriately identified; successfully completed
- Connection to medical home

Cottage Population Health

Recuperative Care Program

Brief Indicators Dashboard

Last Updated: April 30, 2020

cumulative indicators reflect all patients in program since October 2018

Medical & Social Needs (cumulative, includes duplicates)	Count *90-day + Current pts*	Percent *90-day + Current pts*	Count *early exit pts*	Percent *early exit pts*	Count *all pts*	Percent *all pts*	Notes
Total Patients	48	91%	5	9%	53	100%	
Visited Medical Home During Program	47	89%	2	4%	49	92%	
Average # of PCP Visits per Patient Stay	3.58	-	0.8	-	3.32	-	all PCP visits/all 90-day + current patients
Average # of On-site Public Health Visits per Patient Stay	1.77	-	0.2	-	1.62	-	all Public Health visits on-site/all 90-day + current patients
PCP to ED Visits During Program Ratio	6.62	-	0.50	-	4.89	-	
Patients Document-Ready for Housing	29	60%	3	60%	32	60%	

Exit Status (cummulative, includes duplicates)	Count	Percent	Notes
Patients who have exited program	40		
Patients at Roomkey South	2		
Patients Completing Program + Current Patients	48	91%	
Patients Exiting Program Early	5	9%	
Currently in Permanent Housing	14	40%	total housed/unique patients ever in program

Recuperative Care Evaluation
October 2018 (launch) – April 2020

PATIENT OUTCOMES: 50 patients total, 3 repeat patients, 10 current patients

98% visited medical home during stay

63% document-ready for housing at exit

9 exited to permanent housing

26 exited to transitional housing beds

15 currently in permanent housing

4 returned to prior living arrangement

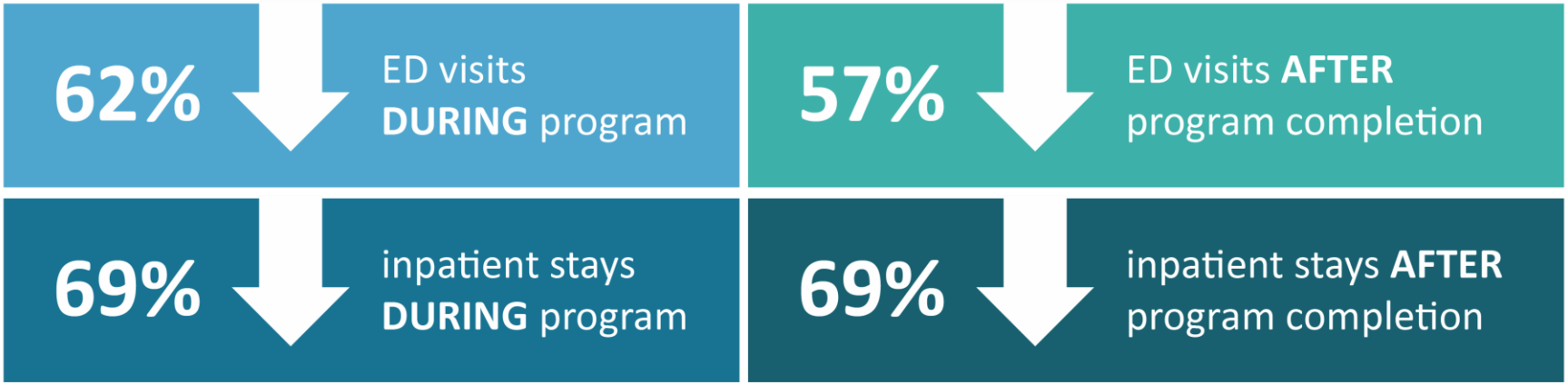
MEDICAL ACHIEVEMENTS:

Wheelchair to walker, recovery from incontinence, wounds healed, limb saved and diabetes management

Recuperative Care Evaluation

October 2018 (launch) – April 2020

PROGRAM OUTCOMES FOR ALL PATIENTS:



Compared to the 90 days before entering the program

QUESTIONS & DISCUSSION

OUTCOME MEASURES & DATA COLLECTION:
RECOMMENDATIONS FOR MEDICAL RESPITE PROGRAMS

Health Outcomes

A client's stay in a medical respite program is precipitated by a health-related event. Whether a client is injured or sick, their referral is connected to a medical condition. The following outcome recommendations focus on the health needs of clients and the clinical care provided by the program. Programs are encouraged to define the specific numerator and denominator for the identified measures and variables based on feasibility of data collection.

Outcome Measure	Variables	Considerations
Primary Care: Connection to primary care is established or strengthened	▪ Identify primary care provider (PCP) ▪ Schedule primary care appointment	Medical respite staff must be familiar with the process in which clients are connected to primary care (e.g., Do they have an assigned PCP? Who is the local Health Care for the Homeless (HCH) provider?)
Assessment: Assessment and coordination of health	▪ Assess need for health screenings based on age,	The stability of a medical respite stay provides an

Tools

Health Outcomes

Admission Procedure & Checklist – Center for Respite Care (pg. 10)
CAHPS Health Literacy Survey (Modified) (pg. 11)
Client Health Summary – Center for Respite Care (pg. 12)
Client Medication Inventory – Center for Respite Care (pg. 13)
Medical Intake Form – Center for Respite Care (pg. 14)

Social Outcomes

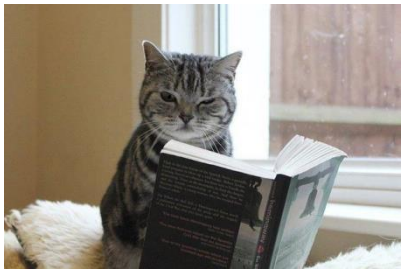
Care Transitions Measure (pg. 16)
Care Transitions Record (pg. 17)
Client Authorization Form – Center for Respite Care (pg. 18)
Discharge Planning Form – LCHC/Bridgewell RCC (pg. 19)
Self-Administered Medication Record – Center for Respite Care (pg. 20)
Self-Management Tool (pg. 21)

Program Outcomes

Client Satisfaction Survey – Barbara McInnis House (pg. 22)
Client Satisfaction Survey – Bridgewell/LCHC RCC (pg. 25)
Performance Measure Worksheet – Central City Concern (pg. 26)
Standards for Medical Respite Care – NHCHC
Standards Organization Self-Assessment – NHCHC

Data Collection & Sharing

Data Collection Protocol - Bridgewell/LCHC RCC (pg. 27)
Informed Consent for Treatment Form – Center for Respite Care (pg. 28)
Universal Informed Consent – Durham Crisis Collaborative (pg. 29)



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