

The Role of Medical Respite Care in a Patient-Centered Medical Home

The phrase Patient-Centered Medical Home (PCMH) has lately become a "buzzword" in medicine. It is a model of primary care that strives to improve patient outcomes by providing care that is **accessible, continuous, comprehensive, patient-centered, coordinated across the spectrum of medical settings, compassionate, and culturally effective**. It was first developed in the pediatric community but has since spread throughout all of primary care. As various PCMH pilots and demonstrations nationally are resulting in improved clinical outcomes and potential cost savingsⁱ, this model of care is gaining more attention from governments, health plans and employers eager to control escalating medical costs (and improve patient care). Incentivized by both the potential for quality improvement and the associated financial reimbursements, an increasing number of clinics and practices are going through the process of transforming into medical homes and applying for recognition or accreditation.

For people who work in homeless medicine, it seems intuitive that a model of care developed to improve chronic disease management and preventive care should have particularly significant health and financial benefits in high-risk patient populations. The Boston Health Care for the Homeless Program (BHCHP) decided to start the process toward PCMH recognition in July 2010, believing that the goals of PCMH paralleled our goals for quality improvement as an organization. As with any clinic or practice, we have had our own unique challenges in attempting to transform our clinic into a medical home. One of the most challenging essential components of a medical home is identifying a panel's highest risk patients and then developing proactive, individualized care plans to improve their health and decrease their overall healthcare utilization. In homeless populations, the highest risk and most complex patients can be particularly challenging (and costly). Psychiatric illnesses, substance abuse, and social issues can all be major barriers in establishing the trusting clinical relationships necessary to achieve sustainable success in the primary care setting. Often times, these obstacles may seem insurmountable and patients appear destined to continue their cycles through emergency rooms and hospitalizations while remaining out of primary care clinics. If a Health Care for the Homeless program is going to be a successful PCMH, it has to develop unique solutions to manage the highest risk patients. Medical respite care can serve as a vital component to the solution.

In the context of the severity of their underlying illnesses, the highest risk homeless patients will frequently need medical respite care admissions. Oftentimes homeless patients agree to a medical respite care stay begrudgingly, as a result of the severity of their symptoms or just sometimes out of necessity (non-weight bearing after an ankle fracture). These admissions allow medical providers unique opportunities to develop clinical relationships with patients who otherwise may never allow them the opportunity to do so. In a quiet, caring environment removed from the chaos of the streets and shelters, medical providers can truly get to know a patient and develop the trust that is so important in establishing long-term clinical relationships. Providers also are able to gain a strong understanding of the patients overall health issues. It seems wasteful not to leverage these clinical relationships into the outpatient setting upon discharge.

Starting in 2007, well before initiating the PCMH recognition process, BHCHP piloted a model of care intended to help improve continuity of care between the outpatient and medical respite care settings. Previous to this, medical providers would tend to work

either solely in medical respite care or the outpatient setting. Through the pilot, medical providers were organized into teams that co-managed patients, following them both in the outpatient and medical respite care settings. This led to improved patient and staff satisfaction, as providers were now able to follow patients across a wider spectrum of settings, resulting in better continuity of care. This model allowed for improved follow-up after medical respite care discharge. It also allowed for greater clinical benefit per patient per admission, as providers were able to focus on the acute issues leading to the admission but also effectively address preventive care and chronic disease management issues during the stay that may have been challenging in the outpatient setting. For example, a 52-year-old, newly diagnosed diabetic female patient was admitted to the medical respite care program to recover from an ankle fracture. During her stay, we worked with her to administer influenza and pneumonia vaccinations, talk about getting her mammogram, pap smear, and colonoscopy up to date, and finally initiate her on a diabetic medication and monitor for side effects. As we worked to adopt the PCMH model, we realized that we could build upon this clinical connection between the medical respite care and outpatient settings to help meet many of the standards of PCMH. Medical respite care stays can help address identified needs for chronic disease population management, assist with care transitions upon emergency department or inpatient discharges, help develop self-management goals with patients, and be a major component in the care management surrounding our highest risk patients.

The immediate health benefits and cost savings of medical respite care for an acute issue are often obvious, but what may not be as easily appreciated is the opportunity medical respite care can provide to simultaneously build clinical relationships and address primary care goals. For those of us advocating for the expansion of medical respite care programs, this can be argued for as yet another potential benefit of medical respite care. As increasing numbers of health systems and local and state governments buy into the concept of PCMH and realize the potential for the cost savings associated with improved primary care, especially in sicker patient populations, there will likely be a push for the expansion of the medical home model. Medical respite care should be advocated for as an important component to this model for homeless patient populations, as part of a unique solution to implementing the requirements for a Patient-Centered Medical Home in a unique, and costly, patient population.

This article was written by Brian Klausner, MD, former medical director of Boston Health Care for the Homeless Program's Boston Medical Center clinic and Health Care for the Homeless Clinicians' Network member. If you would like to submit an article for a future Council Newsletter, please contact Victoria Raschke (vraschke@nhchc.org).

ⁱ www.pccpc.net/files/Rogers_All-Eyes-on-PCMH_102209.ppt. Accessed November 12, 2011