Medical Respite Care: Advantages All Around

National Health Care for the Homeless
West Coast Health and Housing Training

September 18, 2013

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Homelessness and Health

- Poor Nutrition
- Lack of Hygiene
- Exposure to violence and the elements
- Exposure to communicable diseases: TB scabies, influenza, impetigo
- Lack of preventative or follow-up care
- Lack of places to recuperate
- Increased HTN, DM, COPD (Lo, West J Med 1988)
- Increased severity of chronic medical problems
- Premature health decline: geriatric health in 50’s and 60’s
- Complications of CD &/or mental illness
Barriers to Care

- Competing priorities: Food and Shelter
- Transportation
- Lack of storage
- Fear of bills
- Past experiences with judgmental providers
- Embarrassment about hygiene or dependency
- Unrealistic treatment plans
- No contact numbers
- Result: Fragmented and Crisis oriented care
How would I walk the streets?
Health Care & Housing Are Human Rights
Homelessness & Mortality

♦ Age-adjusted mortality rate is 3-4 times that of the general population (NYC, Philadelphia, Boston, Toronto)

♦ Philadelphia retrospective cohort study *(Hibbs, NEJM, 1994)*
  ♦ Mortality Rate 3 X increased for those not known to be substance abusers

♦ NYC prospective cohort study *(Barrow, AJPH, 1998)*
  ♦ Mental health or heavy CD did not differentiate survivors from non-survivors
  ♦ Mortality Predictors included: Chronic homelessness, chronic medical problems
Homelessness & Mortality

- Boston cohort study of 28,023 patients (18,606 M, 9,417 F) (Baggett et al 2012)
  - Mean age at death: 51
  - Ca and heart disease leading causes of death
  - Stereotypical homeless deaths rare (2 hypothermia and 0 TB)

- Seattle study 2005: Average age of death 47 for males, 45 for females

Homeless Medical Costs

- Increased ER use: Average 3 ER visits/year
  - (in Boston 2006, 55/75 highest ED users are homeless)
- Increased hospital utilization by 5 times
- Increased length of stay by 3-6 days
- Increased total cost of care
  - Honolulu Urban Homeless Project: $2.8 million dollars per year increased costs
  - NYC: LOS increased by 4.1 days
Impact of Homelessness on Length of Stay in NYC

“Because many excess days among the homeless could not be explained by clinical or demographic factors, it appeared that lack of discharge options was a major reason for longer stays.” (Salit, 1995)
John’s Monthly Hospital Visits
Total of 9 Area Hospitals

- Average of 19 visits per month
- Average of 3 visits per month
- 0 visits

**Note:** The majority of all homeless hospital visits are to Hospital A, the safety net hospital, which receives county funding to provide indigent care.

**John: background & hospital data**
- Male in his 50’s, chronically homeless, no Medicaid
- Severely mentally ill, untreated, substance abuser
- Averaged 19 visits to an area hospital each month
- 33% of his hospital visits were to Hospital B
- 15% of his Hospital B visits resulted in inpatient stays
- Average length of stay at Hospital B: 3.5 days

**Impact on Hospital B since John was placed in housing:**
- Estimated reduction in bed nights: 52
- Estimated reduction in emergency visits: 109

**Estimated savings to Hospital B from John’s reduced hospital visits:**
- $350,000

**Hospital B donations to Respite:**
- $150,000
Challenges for Hospitals: Sick, Homeless and . . .

- Needs surgery and/or endoscopy
- Needs place to stay connected to cancer treatment
- Repeatedly uses Emergency Department
- Undocumented
- Sex offender
- Behaviorally difficult and in need of ongoing care
- Alienated from family and supports
- Chronically ill, addicted, mentally ill
Respite Focus

- Short-term care for medically ill or injured patients experiencing homelessness and who may have MH or CD issues
- Offers low-cost, high quality and innovative care for patients with high-level and complex care needs
- Goals:
  - Resolution of acute medical process
  - Bridge the gap between hospitals and shelters
  - Window of opportunity to engage into services
  - Initiate the process of lifestyle stabilization
  - Decrease hospital utilization and costs
Respite decreases utilization and costs

♦ Interfaith House study, Chicago (Buchanan, Doblin, Garcia, JGIM 2003)
  • 2 year retrospective data review of Cook County Bureau Services for 12 mo following respite care (N=226)
  • Control group respite eligible but no beds
  • Respite clients had 60% fewer hospital days
  • Cost Savings of $5,439-$13,680/client
Results - Controlling for Gender, Race, Diagnosis, Prior use

P=0.001
NS
Respite Cost Advantage

- Decreased admissions
  - direct transfer from ED or clinics to respite

- Shortened hospital lengths of stay

- Decreased post-hospital ED & inpatient utilization
  - Influenced by provision of medical home and more stable living situation
  - Longer relationships in respite allows outcomes no longer possible in hospital settings

- Initiation of benefits for uninsured hospital utilizers

- Cost avoidance for hospitals and communities
Respite Cost Advantage

- Average hospital stay 4.6 days, nationwide
- Twice as long for patients facing homelessness
- Hospital cost per day
  - $1090 - $2967 (range)
  - Most $2000 - $2500
- Respite cost per day
  - $68 - $350
  - Varies with level of services, partnerships, staffing and facility-type
Respite = Opportunity

- Opportunity to reflect and change
- Nutrition and rest and recovery
- Prevention (Vaccines, TB/HIV/Hepatitis screening)
- Connects individuals to a Medical Home
- Housing process may begin
- Benefits (health insurance, SSI/SSDI)
- Vulnerability Assessment
- Mental health/CD assessment and intervention
Potential Roles

- Fill the service gap between hospitals and shelters
- Fill the service gap between hospitals and clinics
- Fill the service gap between SNF and shelters
- Creativity and Flexibility to adapt services to unique patient needs
Respite’s Role in Health Care Reform

- Better experience of care - Offers a safe, welcoming place for homeless adults to recuperate

- Better health - Linkage to regular primary care, behavioral health, and housing

- Lower costs – Helps reduce hospital length of stay, helps prevent readmissions, helps end homelessness
63 yo female presents to ED with nausea, chills, generally feeling poorly

- Can’t recall her medical history
- Chart indicates h/o schizophrenia and sarcoid disease
- Off all meds, disengaged from all care
SH: Staying in various emergency shelters

Exam: 5X5cm irregular breast mass, scabies rash, flat affect with delayed responses to questions

Labs: Unrevealing
What Do You Do?

- Schedule patient for outpatient mammogram/breast clinic follow-up?
- Admit patient for a inpatient work-up?
- Admit the patient to Medical Respite for a diagnostic work-up and formulation of a treatment plan?
39 yo female, poorly controlled DM in clinic.

- Erratic BG monitoring
- Erratic BG readings ranging from 50’s to 400’s
- Significant end-organ diabetic injury
- Respite can offer:
  - Diabetic education
  - Feedback to provider on diet/compliance
  - Titration of meds to avoid complications
Stretching Borders to Fill Service Gaps

- Acutely ill or injured care
- Decompensated chronic medical problems
  - DM, CHF, Cirrhosis, COPD, HTN
- Diagnostic evaluation for disenfranchised
  - CXR nodule, breast mass
- Care during intensive treatment
  - XRT, Chemotherapy, Hospice
- Pre-procedure admissions: endoscopy, ambulatory surg
- Successful care for behaviorally challenging patients
Respite Care History

- NYC Dr. Brickner’s Shelter Based Infirmary
- Barbara McInnis House, Christ House and Interfaith House 1993
- In 2000 10 Bureau of Primary Care respite programs ($ for enhancement or start-up)
- RCPN Gathering in Chicago, 2000, meets annually
- Now 60+ programs
Respite Program Models

- Dayrest shelter beds
- Nursing component, medical component
- Motel rooms with medical monitoring
- Family Respite (motel, family shelter)
- Contracted service in a board and care facility
- Free-standing program
Non-health care facility

Medical services

Motel/hotel vouchers

Refer to shelter beds

Shelter-based Respite unit

Contract with board & care facility

Free-standing respite unit

Health care facility

TYPE OF FACILITY
Shelter-Based Advantages

Uses expertise of existing programs (shelters for beds, health program for services)

Reduces facility costs by utilizing existing facility

May eliminate need for special licensing (depending on state law)

Encourages coordination and collaboration between agencies

Helps to demonstrate the argument for the need for respite care

Hospitals and other stakeholders benefit from having a safe place to discharge a patient to, may come to the table for the development of stand alone facility or expanded program

Demonstrates outcomes in making the argument for respite programs
Shelter-Based Challenges

Shelters and health programs may have differing philosophies—ongoing tension

Possible conflict over admissions policies and control of the beds

- Health care program has little control over health and safety issues in shelter environment
- Services are more limited, patients have to be quite stable, some patients are too sick to be in this model
Free-Standing Advantages

Ability to provide more comprehensive services—medical and non-medical with a more intense level of acuity

Respite program controls policies and procedures, and defines scope of care

Respite program controls environment (health and safety issues)
Free-Standing Challenges

Identifying adequate funding to support needed services and operations

Takes time

Finding an appropriate facility

Possible licensing and zoning issues

Possible conflict from neighborhoods (if a new facility)
Progression of Respite Services

- Set-aside shelter mats/beds for day rest
- Nurse &/or other provider on-site at shelter
- Designated respite space in shelter
- Meals/Laundry/case mgmt on-site
- Non-shelter respite facility with daily medical care
- Gradual enhancement of services/staffing
- Tiered system with various coexisting levels—shelter based services will always be needed
Flexibility in Respite Care

Flexible model which continually changes and adapts to the needs of our patients and the existing service gaps.
Defining Scope of Care & Range of Services

- Ideally dependent on the needs of the patients served, community needs
- Practically dependent on funding, resources, space
- Avoid redundant services, prioritize beds for those no eligible for other programs
Core Services Offered

- A safe place to recover from illness, trauma and surgery and prepare for procedures
- Recuperate with medical monitoring
- Nursing care varies from a few hours to 24/7
- Medical care varies from off-site visits to daily
- Support services may include: food, laundry, transportation, mental health and social service support, medications, security, case management, referral to specialty care
Harm Reduction in Respite

- If program is clean and sober, significant numbers of patients won’t be served
- Many not be ready/able to abstain
- Pts still deserving of care when using
- Risks of not serving chemically dependent patients (care and cost)
Operational Challenges

- Management of chemical dependency issues: using and dealing
- Safety of staff, patients and neighbors
- Behavior and Milieu Management
- Pain management
- Patients leaving AMA
- Relationships with neighbors
Hospital Collaboration

- Respite programs should be integral to hospital functioning
- Meet with discharge coordinators to start the relationship
- Discuss the unique pressures of individual hospitals and barriers to discharge
- Gather data (informal or formal)
- Offer facilitation of transition to respite care
- Meet regularly for feedback & process improvement
Know the challenges & priorities of local hospitals

- Bed capacity/census and number of homeless served
- ED capacity
- Lengths of stay
- High utilizers
- Ability to place homeless pts in SNFs
- Dispo for pts declined by SNFs--tob, MH, CD, undoc
- Lengthy IV antibiotic hospitalizations
- Behavioral management of difficult pts
Hospital Collaboration

- Address patterns of high utilizers by engaging in primary care, CD Rx, mental health services, accessing funding

- Offer expertise in behavioral management

- Respite meets goals of Health Care Reform of coordinated service delivery with smooth transition of care to increase quality of care and decrease costs

- Demand on respite beds is high: prioritize most vulnerable (medically and socially), ED referrals & High-utilizers
Referral Screening

- Ambassador role! Friendly, diplomatic, flexible, even-keeled
- Clinical skills to assess pt stability/appropriateness (review labs/x-rays, review pain meds)
- Accessibility & Timely response
- Efficient (same day admits), clear process
- Prioritizing referrals
- Ability to accept late admissions
- Provide outreach education for referring hospitals
Funding for Medical Respite

- Grants: HUD, BPHC, SAMSHA, Ryan White, HCH if respite included in scope of practice
- Hospitals: Private, County, VA
- Managed Care Organizations
- City, County or State Tax money (1/10 cent tax in King County for MH/CD)
- State Medicaid
- Private Funders—often not sustainable, staff intense
- Federal: Ideally multi-agency, sustainable funding from CMS, HUD, HRSA, SAMSHA, VA
Billing for Medical Respite

- Medical Respite is not a designated reimbursable service by CMS—RCPN working on minimum standards to standardize respite services
- FQHC can bill a once daily clinic visit
- Negotiate with state Medicaid
  - WA state per bed night pilot $
  - State can apply for a CMS waiver
- Bill for medical provider Home visits
- Bill hospitals for each referral or bed night (can create referral disincentive for some pts, consider lump sum contributions)
Resources for New Respite Programs

- nhchc.org Medical Respite Care website
- Directory of Medical Respite Programs
- Medical Respite Planning Guide
- Technical Assistance
- Medical Respite Research, Policy
- Sabrina Edgington, NHCHC Respite Support Staff
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