FUNDAMENTS FOR ESTABLISHING MEDICAL RESPITE PROGRAMS

Policies and Procedures for an Effective Program
ESTABLISHING MEDICAL RESPITE IN YOUR COMMUNITY – FIRST STEPS

Rhonda Hauff, COO / Deputy CEO
Yakima Neighborhood Health Services
Chair, NHCHC Respite Clinicians Steering Committee
IN THE BEGINNING...

- **Relationships**
  - Joining and building a Continuum of Care
  - Needs Assessment in the Community
    - Do we have homeless in our community? Who are they and where are they?
    - What services existed and what services were needed?
  - As a Community Health Center, we look to:
    - County Government
    - City Government
    - Housing Authority
    - Community Mental Health Agency
    - Other Housing Providers
    - Chemical Dependency Providers
    - Domestic Violence Providers
    - Local hospitals
REFERRAL NETWORK AND PATTERNS

- 70% to 35% Readmission Prevention
- 35% to 70% Admission Prevention

Respite Intake
- HCH Nurse
- Behavioral Health Specialist
- Outreach Specialist
- Housing Specialist

Discharge Staff

PCP Staff
Our Admission Criteria:

- Homeless or in Emergency Shelter
- Independent in ADLs
- Independent in Medication Administration
- Independent in Mobility
- Continent
- No IV lines
- Doesn’t require Long Term Care

What We Do:

- Daily checks by Nurse / Behavioral Health / Case Manager.
- Wound care.
- Behavioral Health counseling.
- Transport / accompany to PCP and specialty and OT/PT appointments.
- Evaluate and support ADLs.
- Assist with applications for SSI/SSDI, Basic Food and other federal/state benefits.
- Facilitate family interaction when possible.
- Initiate housing stabilization.
- Provide discharge summary to patient /PCP at time of respite exit.

WHO CAN WE SERVE: THE FINE LINE BETWEEN MEDICAL RESpite, NURsING HOMES, AND HOSPICe
OUTCOMES

- First funders were Continuum of Care / local & state dollars
  - Percent of clients exiting to stable housing

- Since Affordable Care Act, some Managed Care Organizations are reimbursing for Medical Respite:
  - Percent of clients avoiding hospital admission
  - Percent of clients avoiding hospital readmission
  - Percent of clients exiting to stable housing
MEDICAL RESPITE CARE SAVES $$

HOSPITAL STAFF REPORT A SAVING OF 67 INPATIENT DAYS IN 2017
($135,269 FOR DEPRESSION OR $392,400 FOR REHAB)

Respite care reduces public costs associated with frequent hospital utilization.

<table>
<thead>
<tr>
<th></th>
<th>Average Hospital Charge for Depression*</th>
<th>Average Hospital Charge for Rehab*</th>
<th>Average Respite Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay</td>
<td>13 days</td>
<td>8.1 days</td>
<td>21.5 days</td>
</tr>
<tr>
<td>Average Charge Per Patient</td>
<td>$16,133</td>
<td>$29,166</td>
<td>$2,533</td>
</tr>
<tr>
<td>Average Charge / Cost per Day</td>
<td>$1,241</td>
<td>$3,600</td>
<td>$116</td>
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</table>

WSHA Hospital Pricing – www.wahospitalpricing.org
48 people denied respite in 2017

- Respite full-no vacancy: 26
- Too high acuity: 5
- Not capable of ADLs: 4
- Not homeless: 9
- Placed in PSH instead: 4
<table>
<thead>
<tr>
<th>Stay Length</th>
<th>first name</th>
<th>last name</th>
<th>MIN</th>
<th>Age Exit</th>
<th>Qualifying Diagnosis</th>
<th>PCP</th>
<th>Notes</th>
<th>Addi Hospital</th>
<th>HMISID</th>
<th>Exit To</th>
<th>Readmit within</th>
<th>Primary Payer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Manning</td>
<td>Catherine</td>
<td>57</td>
<td>heroin use (withdrawal)</td>
<td>Induction of Naltrexone</td>
<td>Manning ARNP, Catherine</td>
<td>Received referral from Ms An w/ YNHS &amp; has been approved for Respite by Lisa H (YNHS Nurse) &amp; has been placed in Respite Unit 2. 3 frozen &amp; 3 cold packs given to client w/ hygiene. Intake complete. Client informed of Respite rules. SBI RT &amp; PREPARE completed. Client transported from the Dept to Respite. Client transported to YNHS pharmacy to pick up meds. Clients EXIT date is set for 12/26/17. I will fu w/ client on 12/22/17.</td>
<td>Respite Exit- Permanent Supportive Housing</td>
<td>020618#590</td>
<td>YRespiteExit-Permanent Supportive Housing</td>
<td>0</td>
<td>Apple Health Adult</td>
</tr>
<tr>
<td>18</td>
<td>Hardyson</td>
<td>Marisilic</td>
<td>40</td>
<td>F11.20</td>
<td></td>
<td>Hardyson ARNP, Marisilic</td>
<td>Received referral from Laurie J w/ YNHS &amp; has been approved for Respite by Jean (YNHS Nurse) &amp; placed info until 1. 9 meals w/ hygiene given to client. Respite intake complete along w/ PREPARE. Client already HCH certified. Client informed of Respite rules. Clients EXIT date is set for 7/26/16 @ 3:30pm w/ Ms Hardyson &amp; for 7/27/16 @ 1:30pm w/ Laurie J. Clients EXIT date is set for 8/2/16. I will fu w/ client on 7/22/16.</td>
<td>Respite Exit-StreetCar/Riv w/ HomeMade Shelter</td>
<td>050433#FE</td>
<td>Respite Exit- StreetCar/Riv w/ HomeMade Shelter</td>
<td>0</td>
<td>Apple Health Medical</td>
</tr>
<tr>
<td>25</td>
<td>Manning</td>
<td>Catherine</td>
<td>25</td>
<td>withdrawal</td>
<td></td>
<td>Manning ARNP, Catherine</td>
<td>Received referral from Ms An w/ YNHS &amp; has been approved for Respite by Jeanette (YNHS Nurse). Client placed into Respite Unit 4. 3 frozen &amp; 3 cold packs given to client w/ hygiene. Intake complete. Client informed of Respite rules. SBI RT &amp; PREPARE completed. Client transported from the Dept to Respite. Clients EXIT date is set for 2/21/16. Scheduled client w/ Launie J.</td>
<td>Respite Exit- StreetCar/Riv w/ HomeMade Shelter</td>
<td>17F6E15EF</td>
<td>Respite Exit- StreetCar/Riv w/ HomeMade Shelter</td>
<td>0</td>
<td>Apple Health Medical</td>
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<tr>
<td>33</td>
<td>Hardyson</td>
<td>Marisilic</td>
<td>33</td>
<td>F11.20-MAT</td>
<td></td>
<td>Hardyson ARNP, Marisilic</td>
<td>Received referral from Ms Hardyson w/ YNHS &amp; has been approved for Respite by Jeanette (YNHS Nurse) &amp; placed in unit 4. Client transported to Respite from the Dept. 4 meals w/ hygiene given to client. Respite intake complete &amp; informed client of Respite rules. Completed PREPARE. Clients next apps are for 5/22/16 @ 10:45am w/ Oliver, Steven Ps/D &amp; for 5/24/16 @ 2:30pm w/ Ms Hardyson. Clients EXIT date is set for 6/7/18. I will fu w/ client on 5/18/16.</td>
<td>Respite Exit- StreetCar/Riv w/ HomeMade Shelter</td>
<td>019C300F7A</td>
<td>Respite Exit- StreetCar/Riv w/ HomeMade Shelter</td>
<td>0</td>
<td>Apple Health Adult</td>
</tr>
</tbody>
</table>
Relationship with CHC is Critical – Internal or External to Serve our Patients (HCH, Medical Respite, Housing Providers)
PRACTICAL CONSIDERATIONS FOR PROGRAM DEVELOPMENT

Alice Moughamian, RN,CNS
Director
San Francisco Medical Respite and Sobering Center
PROGRAMMATIC CONSIDERATIONS

- Stakeholders
- Funding stream (private vs. public)
- Location (shelter based vs free standing)
- Contract services
- Licensing
STAKEHOLDERS

- Hospitals, hospital associations
- HMO
- Medicaid Managed Care Organizations
- Safety net systems
- Communities
- People experiencing homelessness
Inpatient staff at ZSFG calling for change
Private hospitals asking for help
Stakeholders (DPH, CHA)
Redistribution of funds
Shelter based
Free standing
Placed in Dept of Housing and Urban Health under Primary Care
Licensed Satellite FQHC
Licensed Shelter
DPH vs. CBO (CATS) services provided

BACKGROUND: SAN FRANCISCO MEDICAL RESPITE
Advantages
- Stable funding stream
- Part of the community continuum of care

Challenges
- Changing political environments
- Regulations
- Multi-department engagement
More than 50% of Respite programs funded this way

Importance of multiple funding streams/diversifying

Advantages
  - Autonomy over program

Disadvantages
  - Outcomes/expectations dependent on funder
  - Funder can dictate use of beds, especially hospitals
LOCATION: SHELTER BASED VS. FREE STANDING

**Shelter Based**
- Relationship building
- Guest in another agency’s home
- Abide by shelter’s rules
- Residential needs already met
- Clinical programming

**Free Standing**
- Responsible for clinical and residential licensing
- Responsible for all residential needs
- Harm reduction principles
- Autonomy over behavioral expectations
LICENSING CONSIDERATIONS

- RCF, RCFE
- Primary Care
- Satellite FQHC
- Shelter/residential
REGULATIONS: MCO, MEDICAID, METRICS

- Care standards
- Metrics
- Documentation
- Billing
CONTRACTS: SERVICES TO CONSIDER

- Clinical
  - RNs, Providers
  - Social Workers
  - Heath at Home providers
- Hospitality/Service
  - Food
  - Transportation
  - Janitorial
  - Security
  - Linen
MEDICAL RESPITE CARE TRAINING
OCTOBER 1, 2018
LEGAL ISSUES TO CONSIDER

Henry C. Fader, Esq.
What are you and why is that important?

- Nursing home
- Group home / boarding home
- Shelter
- FQHC / Medical Clinic
- Hospital or Healthcare system affiliate
- State/local government owned facility
What other legal impediments might arise?

• Zoning
• Fire safety
• Food inspections
• ADA
• Life Safety Code for renovations
Medical Care in Medical Respite Facility

- Employed professionals
- Independent contractors
- Services Agreement with FQHC or other facility
- Level of malpractice exposure for negligent care / risk management
- Professional Services Agreement (PSA) with health system affiliate

PROVISION OF MEDICAL CARE
IMPORTANCE OF CONTRACT NEGOTIATIONS

MCO and Hospital / Health System / Coalition Contracts

- Licensing of providers / credentialing
- Providers not suspended or excluded from government programs
- Try not go “at-risk” financially
- Getting paid promptly
HIPAA and Interoperability Issues

- Electronic records (?
- Safely transferring PHI to medical respite care facility and uploading PHI to others
- Encryption of transmittal records / thumb drives / laptops
- Use of e-mail / texting with PHI / fax / scan
- Business Associate Agreements (BAA)
Are the RCPN Standards now the anticipated standard of care for liability issues and risk management?

- Tort liability is defensible
- Plaintiff must demonstrate a standard of care and duty which was negligent and was the resulting cause of injury
See Handout

GLOSSARY OF TERMS