Providing Medical Respite for People Experiencing Homelessness during COVID-19

August 11, 2020, 1:00 – 2:30 pm ET

Made possible through support from the California Health Care Foundation
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Welcome & Introductions
Welcome and Introduction

Overview: Medical Respite Care for People Experiencing Homelessness

Medical Respite Care Programs:

» California: Illumination Foundation and Santa Clara Medical Respite Program

» Washington: Edward Thomas House Medical Respite

Moderated Q&A
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Meet Today’s Presenters

Kathy Moses, MPH, Senior Fellow, Center for Health Care Strategies

Julia Dobbins, MSW, Director of Programs & Services, National Institute for Medical Respite Care

Michelle Schneidermann, MD, Director, High-Value Care, California Health Care Foundation

Pooja Bhalla, DNP, RN, Chief Operating Officer, Illumination Foundation

Sara Jeevanjee, MD, Medical Director, Santa Clara Medical Respite Program

Leslie Enzian, MD, Medical Director, Edward Thomas House Medical Respite
National Institute for Medical Respite Care

Julia Dobbins, MSW

Director of Programs & Services, National Institute for Medical Respite Care
Director of Medical Respite, National Health Care for the Homeless Council
The National Institute for Medical Respite Care is a special initiative of the National Health Care for the Homeless Council.

Creating Places to Heal: Welcome to the National Institute for Medical Respite Care

The National Health Care for the Homeless Council (the Council) is pleased to announce the creation of the National Institute for Medical Respite Care (NIMRC), the first national institute to advance best practices, expert services, and state-of-the-field knowledge in medical respite care.

Learn More
Homelessness & Health

- **Poor health** causes homelessness

- Homelessness causes **new health problems** & exacerbates existing ones

- The experience of homelessness makes it **harder to engage in care and receive appropriate services**
Homelessness & Hospitals

- Length of stay: 4.1 days longer
- Number ED visits: 3x higher
- 30-day ED readmission rate: 6x higher
- Inpatient readmission rate: 2x higher

Acute & post-acute care for people experiencing homelessness who are too ill or frail to recover from illness or injury on the street or in shelter, but not sick enough to warrant hospital level care.

Short-term residential care that allows people the opportunity to rest, recover, and heal in a safe environment while accessing medical care and supportive services.

NOT: skilled nursing facility, nursing home, assisted living, behavioral health step-down, or supportive housing.

**Diversity of Programs**
- Bed number
- Facility type
- Length of stay
- Staffing and services
- Admission criteria
- Referral sources
The terms “medical respite care” and “recuperative care” are used interchangeably to describe the same service.

“Recuperative Care” is defined by the Health Resources and Services Administration as “short-term care and case management provided to individuals recovering from an acute illness or injury that generally does not necessitate hospitalization, but would be exacerbated by their living conditions (e.g., street, shelter, or other unsuitable places).”

The Respite Care Providers’ Network adopted the term “medical respite care” on the grounds that it is more encompassing than the literal meaning of the term “recuperative.”
Medical Respite Care

- Clinical Care
- Integration into Primary Care
- Self Management Support
- Case Management
Medical Respite Nationwide
Funding Medical Respite Care

- Room and Board
- Clinical services
- Supportive Services

Medical Respite Care
Standards of Care

- Proliferation of low-quality programs identifying as medical respite care required setting standards

- Components of a high-quality program include:
  1. Safe and quality accommodations
  2. Environmental services
  3. Safe care transitions into medical respite
  4. High quality post-acute clinical care
  5. Care coordination and wrap around services
  6. Safe care transitions out of medical respite
  7. Driven by quality improvement

Resource: NHCHC, Standards for Medical Respite Programs (October 2016)
Advantages of Medical Respite

- Officers safe and cost-effective discharge option
- Connects vulnerable patients to a broad range of community care and public benefits
- Improves health by addressing most immediate health care and social needs
- Develops more comprehensive care plan and coordinates care across venues
- Provides time and space for healing and health education
IT'S THE RIGHT THING TO DO.
Illumination Foundation

Pooja Bhalla, DNP, RN
Chief Operating Officer
Illumination Foundation
Orange, California
Origin Story

What we saw in 2007...
Illumination Foundation Programs

HOUSING IS HEALTHCARE

**HOUSING**
- Emergency
- Bridge
- Permanent Supportive

**HEALTHCARE**
- Healthcare Outreach
- Recuperative Care
- Street2Home (ER Diversion)
- Medical Bridge Housing
Recuperative Care Program Capacity

Locations:
6 Recuperative Care Sites (250 beds)

Funding Source:
Whole Person Care (funded through 1115 waiver)

Referral Source:
Hospitals and Street Outreach Teams
Chronic Care Plus (CCP)

**Age at Program Entry**

- 20-29: 20
- 30-39: 10
- 40-49: 12
- 50-59: 6

**38 Admitted to the Program**

- Male: 24
- Female: 14

**Client Profile at Program Entry**

- Average period of homelessness: 4.8 yrs
- Previous history of substance abuse: 79%
- Mental health condition: 71%
- Dual mental health and substance abuse: 63%
- Previous incarceration: 66%

**Services Provided**

- Housing placement
- Medical coordination
- Social case management
- Medical management education
- Financial literacy training
- Job readiness training
- Transportation to appointments
- Mental health connections

100% received medical coordination and intensive case management

- 10,351 bed nights of housing

84% reduction in ER visits

**Hospital Cost Avoidance**

- $3,302,741 Total 1 Year Cost for Surveyed Hospitals Prior to Entry
- 84.4%

- $14K per client/year during program
- $90K per client/year 1 year prior to entry
Recuperative Care: Triple Aim

Scope of Services

- Advocacy
- Food, hygiene and transportation
- Case Management
- Medical Care Coordination
- Access to community clinic
- Housing connections Coordinated Entry System
- Client - centered education
- Mental Health Counseling
- Advocacy

Client - centered education
**Recuperative Care Data**

### Relationship between LOS and Housing Exits

<table>
<thead>
<tr>
<th>LOS</th>
<th>Permanent/Stable</th>
<th>Self Exit</th>
<th>Unstable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7 Days</td>
<td>9%</td>
<td>31%</td>
<td>60%</td>
</tr>
<tr>
<td>8-14 Days</td>
<td>15%</td>
<td>25%</td>
<td>60%</td>
</tr>
<tr>
<td>15-30 Days</td>
<td>16%</td>
<td>15%</td>
<td>70%</td>
</tr>
<tr>
<td>31-60 Days</td>
<td>22%</td>
<td>15%</td>
<td>64%</td>
</tr>
<tr>
<td>61-90 Days</td>
<td>29%</td>
<td>11%</td>
<td>60%</td>
</tr>
<tr>
<td>91-180 Days</td>
<td>37%</td>
<td>8%</td>
<td>56%</td>
</tr>
<tr>
<td>181+ Days</td>
<td>44%</td>
<td>13%</td>
<td>44%</td>
</tr>
</tbody>
</table>

**PCP Trajectory Breakdown (803 members)**

- **81.1% Growth in PCP Encounters**

**Whole Person Care Program Reduced Healthcare Costs**

- 93.1% reduction in cost to have a person in the Whole Person Care Recuperative Program

**Growth in PCP Encounters**

- 817 PCP Encounters in 2019 compared to 977 in 2014
Recuperative Care Programs

Demographic Profile

106 individuals
- Male 76%
- Female 24%

Age
- 19-35: 45%
- 36-45: 15%
- 46-55: 20%
- 56-65: 8%
- 66+: 12%
- Other: 10%
- African American: 6%
- Latino: 5%

Ethnicity
- White: 62%
- Latino: 25%

Inpatient Care Utilization
- Reduction in inpatient care costs: 83%
- Fewer hospitalizations: 69%

Emergency Room Utilization
- Reduction in ER visits: 46%
- Reduction in ER costs: 36%

Housing
- 53% Exit to permanent or stable housing

Connections to Resources
- 74% Linked to public benefits or employment

Health & Behavioral Health Diagnosis

- 86% have a behavioral health diagnosis
- 58% have a severe and persistent mental illness (SPMI)

- 67% have a substance use diagnosis

- 62.8% have three or more comorbidities

Extending length of stay for UniHealth clients, including their initial Whole Person Care length of stay, to an average 113 days increased their connection to resources and housing.

Patients with SPMI cost the medical system 45% more in overall health cost than non-SPMI clients. $7,693,686 SPMI vs. $3,564,869 non-SPMI.
Illumination Foundation Impact

Impact: By The Numbers

- 1,364,573 safe shelter nights of stay have been provided
- 13,232 individuals have been diverted from entering the cycle of homelessness
- 10,745 families and individuals have been housed in Illumination Foundation programs
- 6,543 homeless clients received recuperative care services
- 3,150 children and parents have been served through our Family and Children’s Program

Data is current as of December 31, 2019
COVID-19 Response
Illumination Foundation was selected by the Orange County Health Care Agency to be the service provider to manage increased bed capacity for homeless individuals across Orange County during COVID-19 pandemic.
## Project Roomkey All Sites

### Homeless COVID Positive

<table>
<thead>
<tr>
<th>Number of Sites</th>
<th>Contracted Rooms</th>
<th>Current Actively Enrolled Clients</th>
<th>Total Clients Served</th>
<th>Total Bed Nights</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>780</td>
<td>620</td>
<td>1,570</td>
<td>43,351</td>
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</tbody>
</table>
Project Roomkey

- Part of the Governor of California’s Project Roomkey initiative is to secure hotel and motel rooms to protect homeless individuals from COVID-19.

- COVID-19 positive or symptomatic
  - 6 Motels - In Central Orange County and South County for client’s temporary quarantine/isolation.
Intake, Screening and Placement

1. Health screening
2. Arrange transportation
3. Determine appropriate temporary destination upon health screening
4. Complete referral and intake
COVID-19 Response: Operations Modification

- Facility Infrastructure
- Staff Safety
- Personal Protective Equipment Inventory
- COVID-19 Testing Protocol
- Daily Communication with Department of Public Health, Hospitals, Shelters, Homeless Outreach Street Teams
- 24 Hour Intake Process
Race Breakdown

County COVID Isolation Shelter, 51%

- County Vulnerable Population
- County COVID Isolation Shelter
- JOPLIN South County Unsheltered
- All Clients

Legend:
- White
- Hispanic/Latino
- Black/African
- Asian
- Other
All Population Data

Referral Source Breakdown (County)

<table>
<thead>
<tr>
<th>DataPoint</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelter</td>
<td>346</td>
<td>26%</td>
</tr>
<tr>
<td>Street</td>
<td>873</td>
<td>65%</td>
</tr>
<tr>
<td>Hospital</td>
<td>124</td>
<td>9%</td>
</tr>
</tbody>
</table>

Chronic Illness 40%

3+ Medications 70%

Mental Health & Substance Use 40%
The COVID-19 pandemic recalls once more the old truism attributed to *Winston Churchill*:

*Never let a good crisis go to waste.*

We may now have the opportunity to reform a flawed health care system that made the novel coronavirus far more damaging in the United States than it had to be.
Santa Clara County Medical Respite Program

Sara Jeevanjee, MD
Medical Director, Santa Clara Medical Respite Program
Valley Homeless Healthcare Program
San Jose, CA
Origin Story

Board of Supervisors approve BRC Proposal for Medical Respite Program

Apr 2008

Aug 2008

Nov 27, 2008

Aug 2014

Dec 2015

Medical Respite Advisory Board established

Medical Respite Program Grand Opening with 15 beds

Medical Respite expansion to 20 beds

California Association of Public Hospitals/Safety Net Institute Performance Excellence Award
Program Overview

- 20 beds
- Shelter based
- On-site FQHC
- Staffing: 2.0 RN, 0.5 MD/Medical Director, 1.5 MSW, 0.5 psychology, 0.4 pharmacist, 0.3 psychiatrist
  - Staff part of larger homeless program (VHHP)
  - 1.0 post-doc psychologist and 1.0 community health worker grant funded
  - Drug and alcohol counselor, public defender/medical-legal partnership, SSI advocate via homeless program and shelter contracts
Funding sources:

- Santa Clara County/Valley Medical Center: staffing + clinic
- HRSA: staffing and clinic overhead
- Hospitals: shelter lease
- Community Benefits Grant: staffing, additional shelter beds, case management

Referral sources: County hospitals (contracted), outpatient clinics, homeless program
Community Partners

- Santa Clara County/Valley Medical Center
- Hospital Council of Northern California
- Homefirst
- Office of Supportive Housing
- Stanford Medical Center
- El Camino Hospital
- New Directions (case management)
- Momentum (mental health programs)
- LifeMoves (transitional housing)
Data Collection

- Enroll clients in HMIS, tailored for data needs
- Contracted hospitals:
  - total referrals by hospital
  - Reasons for denial
  - Program completion status
  - Discharge location
  - Length of stay
  - Benefits obtained
- Grant reporting:
  - Psychology post-doc: cognitive testing, 1:1 therapy
  - Outreach worker: transportation services, VI-SPDAT completion
  - Case Management: referral volume, transitional and permanent housing placement
- Program development- in the works:
  - Primary care home upon enrollment
  - Exit survey data
Coordinated response

» Isolation COVID+ in hotels
» Placement medically vulnerable in motels
» De-intensification of shelters, new “pop-up” shelters
» Coordination of referrals through new hotline
» Abatement of encampment sweeps
» Hygiene stations at encampments

Client services:

* expanded mobile medical unit operations
* new tele-health team
* Screening + outreach to encampments
* Mass testing encampments and congregate sites
* Medication delivery

Partnerships

• Office of Supportive Housing
• Valley Medical Center
• Gardner Health Services
• Abode Services
• LifeMoves
• Destination Home
• City of San Jose
• SCC Dept of Public Health
• Motel Management
Medical Respite and COVID 19

- Relocated from shelter to motel
- Expanded to 40 beds in anticipation of surge
- Modifications to referral process
  - Email to personal emails
  - Coordinate with motel placement hotline for hospital discharges
  - COVID testing prior to discharge
- New Practices:
  - Daily temperature and symptom screening
  - Collaborating with partners for admissions and exits and enforcement of rules
  - Psychiatry via telehealth
  - Medical services on mobile medical unit or in motel room turned into exam room
  - Coordinating tele-visits with outside providers
- Paused practices:
  - Weekly integrated group visits, weekly recovery group
  - Transporting clients
COVID-19 and Respite: The Good and The Bad

Benefits:

» Able to accommodate partners and caregivers (no pets)

» Clients more willing to come to respite

» More dignified, safer space

» Smoother discharge process to shelter and motel beds using streamlined county process

» Diabetic diets!

» NO RESIDENTS HAVE TESTED POSITIVE (SO FAR)

Challenges:

» Monitoring patients behind close doors

  » More drug and alcohol consumption on-site

» Mixed site with other medically vulnerable clients

» Enforcing social distancing on site

» Motels not immune to lice and bed bugs

» What’s next?
Lessons Learned

- Community partnerships essential
- Single, private rooms work well for some individuals and not others
- Same gaps in care exist as pre-COVID
  » need for more supportive, supervised environments for those with cognitive impairment, physically frail, incontinence, severe mental illness
- Tele-health challenging for some, but works for others
  » New tool to expand services to select clients
- We can move ~2000 individuals indoors in the span of months!
Edward Thomas House Medical Respite

Leslie Enzian, MD, Medical Director,
Edward Thomas House Medical Respite
Seattle, WA
Shelter-Based Respite

- Limited Acuity
- Shelter oversaw behavioral management
  - Not trained in De-escalation or Trauma-informed Care
- Substance Use Disorder (SUD) prevalence
- Not Harm Reduction-based
- Patients discharged for using substances or behaviors
- Readmissions, complications
The Facility
## Respite Program Partners

### Hospital & Health Partners
- Public Health Dept
- 7 Hospitals
- Steering Committee
- Managed Care Managed Care (MCO)

### Program operator
- Harborview Medical Center

### Key Partners
- Housing Programs
- Case Management
- Methadone Programs
- Suboxone Programs
- County Med Center
- Infection Control Team
- RCPN

### Funding
- Hospitals
- MCO Billing
- MIDD-County SUD Tax
- HCHN through PHD

### Site
- Seattle
- Housing Authority
Staffing

- RN Screener, admits 7 days/week
- 4 RN Teams/12 hour shift + 1 Medical Assistant
- 5 Mental Health Professionals (1 outreach), Mon-Fri
- 2 Mental Health Specialists—Milieu Management, Meals
- 1 Nurse Practitioner/12 hour shift, 7 days/week
- 1 Security 24-7
- Program manager
- Medical Director (0.4 FTE)
- Data Analyst
- Program Coordinator—Clerical support

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- Lead Team: Manager + RN3 + MH Supervisor + Med Dir
  » Weekly meetings for program planning, process improvement
Referrals

- Medical Centers in King County
  - Not limited to contributing hospitals
  - ED Referrals—avert admissions
- Outpatient Clinics
- Shelter-Based RNs affiliated with Harborview
- Jail Health
- Prioritized based on acuity
- Specialty Follow Up arranged by referring facility
Referral Diagnoses

- Wounds: Abscesses, diabetic foot ulcers, frostbite, burn
- IV antibiotics for heart valve, bone or joint infections
- Post-op Care
- Cancer treatment
- Palliative Care
- Colonoscopy Procedures
- Expedited Malignancy Evaluations
- Transition onto hemodialysis
- High utilization patients
- Low Census protocol lower acuity admissions
Respite Offerings

- Nursing Care
- Mental Health Screening and Referral
- Psychiatric Care
- Substance Use Disorder screening and referral
- Harm Reduction counseling
- Disposition Planning, address housing barriers
- Establishing Medical Home
- Facilitation of specialty follow-up care
- Rebuild Trust in Medical System
Outcomes Data CY 2018

- 564 admits
- 10,520 bed days
- Length of Stay 22 days average (wide range)
- 13% directly placed in transitional or permanent housing—(more post-respite housing)
IV Antibiotic Data CY 2018

- 106 patients admitted for IV antibiotics
- 1,474 days of IV Rx provided
- $407/day respite vs $1200/day inpatient
- Cost Avoidance of $ 1.8 million
- Highest-risk patients, opportunity for long-term impact not available while inpatient
- Looking at ways to optimize treatment completion
Supporting Community COVID Response

- Training staff for isolation and quarantine sites
  - Harm reduction & trauma informed care practices
- Shared staff with newly opened COVID shelters
- Shared referral & admissions process, policies & procedures
- Initiated and spearheaded planning & protocol for methadone maintenance management
- Advocacy when access to county isolation beds were restricted for those with SUD or behavioral concerns
- Sharing UW Medicine Protocols and respite practices with county programs and other respite programs preparing for COVID
COVID & Respite Challenges

- Staffing
  - increased work load → limiting census
  - Staff testing requests, test pending, testing capacity
  - Staff support, education, mitigating fear
- 2 Isolation rooms, 6 beds decreased program access
- COVID-free respite could optimize inpatient bed access
- Space for test-pending patients, lengthy resulting
- PPE Supplies
- Meals, community spaces, entertainment in isolation
More Challenges

- Mixed unit with COVID (+) and (-) patients
- Patients leaving for appts and methadone, AWOL patients
- Risks to Immunocompromised patients
- Compliance with isolation in a harm reduction program
- Management of drug withdrawals & cravings
  - Smoking requests
- Surveillance
What it looks like

- Limiting Direct Care to COVID (+) Patients
  - Limits exposure, preserves PPE
  - Vitals when clinically indicated, multi-day dressings, phone visits, passing meals, sedation monitoring
- Closure of county isolation sites with nursing support
- Ongoing weekly surveillance
- Staff testing requests
County Hospital Infection Control team
  » Advocate with environmental services
  » Validate protocols
  » Troubleshoot issues

University of Washington Protocols, broadly available

Close relationships with leadership at methadone programs
Question & Answer
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