MEDICAL RESPITE CARE PROGRAMS & THE TRIPLE AIM FRAMEWORK FOR HEALTH

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TODAY’S PRESENTERS

Rhonda Hauff, Chief Operating Officer & Deputy CEO, Yakima Neighborhood Health Services, Yakima, WA

David Munson, MD, Medical Director, Barbara McInnis House, Boston, MA

Jessica Savara, LCSW, QMHP, CADC II, Recuperative Care Program Supervisor, Central City Concern, Portland, OR

Jordan Wilhelms, Complex Care Program Manager, Central City Concern, Portland, OR

Moderator: Barbara DiPietro, PhD, Senior Director of Policy, National HCH Council
DISCUSSION AGENDA

• Brief program overviews, to include performance measures
• Brief overview of recent policy brief
• Panel discussion with programs
• Audience Q&A
LEARNING OBJECTIVES

- Describe the **three components** of the Triple Aim framework for health.

- Identify at least **five possible outcome measures** appropriate for medical respite programs.

- Identify **two possible steps** that local programs can take to better align with the interests of larger health care stakeholders in their community.
YAKIMA NEIGHBORHOOD HEALTH SERVICES

Our mission is to provide accessible, affordable, quality health care, provide learning opportunities for students of health professions, **end homelessness and improve quality of life in our communities.**

Rhonda Hauff, COO / Deputy CEO, Yakima Neighborhood Health Services
Chair, Respite Care Provider Network, National Health Care for the Homeless Council
WHO WE SERVE –
FINE LINE BETWEEN RESPITE, SNF, & HOSPICE

• Homeless or in Emergency Shelter
• Independent in Activities of Daily Living (ADLs)
• Continent and Independent in mobility
• No IV lines
• Can administer own medications
WHAT HAPPENS WHERE

• Respite:
  • Transition of Care (from hospital or SNF)
  • Daily health checks
  • Meals On Wheels (3 per day)
  • Wound care
  • Behavioral health assessments & counseling
  • Transport to PCP & Specialty appointments
  • SSI / SSDI / SNAP application assistance.
  • Housing Stabilization Plan
  • Discharge planning for exit.

• CHC:
  • Provides direction of primary care needs – medical, dental, behavioral health.
  • Referrals to Specialists.
  • Key Communicator with Health Plans and Managed Care Organizations (payers)
  • Oversees medications / changes to medications
  • Determines when patient is safe for respite discharge.
2007 TO 2018

ADMISSION VS. RE-ADMISSION

Providers Understand the Value of Medical Respite Care

Referrals from PCP: 35% to 60%

Referrals from Hospitals: 70% to 28%

Referrals from Same Day Surgery: 0% to 13%
Drink the Kool-Aid
Housing is Health Care

Outcomes tied to the IHI Triple AIM

- Improving rate of successful connection to primary care
- Increasing rate of compliance with care plans
- Improvement in chronic disease measures (e.g. A1c scores, BP measure)
- Reduction in communicable disease (e.g. TB, STDs, Hep C)
- Reduction in behavioral health crisis episodes
- Medications are better managed
- More likely to obtain and maintain employment or education
- Greater success for recovering SUD recovering patients in supportive housing
INCREASING ACCESS TO CARE 2018

Health Coverage

Visits Per User

**Visits Per User**

- **Universal**: 3.9
- **Homeless**: 5.1
- **PermSupportiveHousing**: 35.17
- **Respite**: 41.6
IMPROVING CONNECTION TO PRIMARY CARE
MEDICAL VISITS PER USER
RESPITE EXITS

2010

- Hospital: 10%
- Housed: 90%

2018

- Housed: 20%
- Street/Encampment: 69%
- Deceased: 3%
- SNF or Treatment: 5%
- Hospital: 3%
MEDICAL RESPITE CARE SAVES $$
HOSPITAL STAFF REPORT A SAVING OF 53 INPATIENT DAYS IN 2018
($65,773 FOR DEPRESSION OR $190,800 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>20 days</td>
</tr>
<tr>
<td>Average Charge Per Patient</td>
<td>$16,133</td>
<td>$29,166</td>
<td>$2,191</td>
</tr>
<tr>
<td></td>
<td>(not including primary care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Charge / Cost per Day</td>
<td>$1,241</td>
<td>$3,600</td>
<td>$111.28</td>
</tr>
<tr>
<td></td>
<td>(not including primary care)</td>
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Medical Respite in Boston
Medical Respite for in Boston

• Began with 20 beds in Shattuck shelter in 1985
  • Required by original BHCHP charter
  • “Grew up” during AIDS crisis in late 80s/90s

• Now with two stand alone programs with 124 total beds
  • Barbara McInnis House
  • Stacy Kirkpatrick House

• Unique Context
  • Early Medicaid expansion in Massachusetts
  • MassHealth recognizes medical respite as a billable entity
Barbara McInnis House

• 104 bed stand alone facility in Boston’s South End
  • 24/7 nursing care
    • Medication administration
  • Daily NP/PA Visit
  • Integrated case management and BH (SW) care

• Level of Care
  • Detox (alcohol, opioid, sedative)
  • IV antibiotics
  • Wound care, perioperative care, end of life care
  • Decompensated chronic disease
Barbara McInnis House

• FY 18 Admissions
  • 2,335 total admissions (1,224 unique patients)
  • LOS 14.3 days
  • Most patients return to shelter

• Patients Must
  • Be independent with ADLs
  • Have a stable clinical trajectory
  • Be able to tolerate a structured setting
Stacy Kirkpatrick House

• Level of care in between BMH and shelter
  • Opened in 2016

• Model of care
  • 24/7 case management/millieu support
  • 14 hours/day of RN
  • 12 hours per week of NP/PA – 1 patient visit/week

• Patients must
  • Be independent with ADLs
  • Be relatively independent with their care plan
    • Meds are self-administered with assistance.
Quality Metrics

• External (for payers) vs internal (for QI)
  • BHCHP joined BMC accountable care organization (BACO) in 2018

• Internal
  • Medication errors/day
  • Falls/day and total falls/month with injury
  • Reported out in monthly quality meeting

• External
  • BACO tracks revisit (inpatient + EDOU) and readmission (inpatient) after BMH stay
  • Have not looked at total cost of care (yet)
Essential Recuperative Care Program Model

• Intensive, trauma-informed and person-centered case management, including daily client monitoring.

• Dedicated access to medical care and ancillary services at CCC’s Old Town Clinic.

• Secure transitional housing, including personal hygiene supplies, food boxes and nutritional support.
Comprehensive Recuperative Support

RCP participants also receive:

• Support in making and keeping appointments
• Transition planning
• Complex care coordination across health, housing, treatment, employment and benefits systems
• Tailored, person centered interventions
• Daily social contact and peer support
Recuperative Care Program – July 2019

• Staffing:
  • 24/7 Case Management
    • Mental Health
    • Social Work
    • EMT
    • Non-credentialed
  • Supervisor (LCSW, QMHP, CADCII)
  • RN
  • Housing Specialist
  • Logistics
  • Environmental Services
  • Security
Recuperative Care Program - 2005

• Started in 2005 with pilot capacity funding

• Just a few beds to start
  • Housing
  • Intensive case management
  • Primary care

• With quickly impressive housing placement, medical resolution, and cost savings results, the project expanded and other stakeholders signed on
Recuperative Care Program – 2006-2019

• Referrals from 10+ hospitals (and several MCOs)
• Increase to 35 beds
• New access points
• Expansion of service model
• Housing crisis
• Population influx
Blackburn Center – July 2019

• Blackburn Center opening July, 2019

• 175 Housing Units
  • 51 respite beds

• Integrated teams offering:
  • Health Services, Housing and Employment Services
  • Continuum of health services treatment intensity
Outcomes/Performance Measures

• Formal measures:
  • % participants placed in TH or PH at exit
  • % participants resolving acute medical issue exit
  • % participants that have medical home at exit

• Informal measures (amongst many others):
  • Impact on hospitalization and ED utilization
  • Engagement in primary care
Since its inception in 2005, RCP has served thousands of individuals, with:

- Over 70% resolving their acute medical condition
- Over 95% established with primary care upon exit
- Over 60% transitioning into stable housing.
THE IHI TRIPLE AIM FRAMEWORK FOR HEALTH

• Institute for Healthcare Improvement’s framework
  → Improve population health
  → Improve the experience of care (includes quality & satisfaction)
  → Reduce per capita cost

• Health systems use to transform service delivery, achieve greater value, and better meet needs
MUTUAL INTERESTS AMONG KEY PLAYERS

HEALTH SYSTEMS STAKEHOLDERS

➢ Hospitals, health insurers, Medicaid programs, public health leaders

• Reducing cost, improving quality outcomes
• Using data to drive decision-making & demonstrate “value”
• Leveraging community partnerships

MEDICAL RESPITE PROGRAMS

• Providing a safe place for patients to rest and recuperate
• Connecting with appropriate care and support
• Serving short-term role amid longer-term goals for improved health & housing stability
• Using data to demonstrate “value”
• Achieving greater recognition and financial support
## IMPROVE POPULATION HEALTH

<table>
<thead>
<tr>
<th>Element of Care</th>
<th>Example Outcome Measures</th>
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</thead>
<tbody>
<tr>
<td>Health outcomes</td>
<td>Improved rate of successful care transitions</td>
</tr>
<tr>
<td></td>
<td>Increased rates of compliance with medications and care plans</td>
</tr>
<tr>
<td>Disease burden</td>
<td>Reduction in high-risk behaviors related to communicable disease</td>
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<tr>
<td></td>
<td>Increased rate of preventive health screens</td>
</tr>
<tr>
<td>Behavioral &amp; Physiological Factors</td>
<td>Increased rates of nutrition/diet management</td>
</tr>
<tr>
<td></td>
<td>Increased connection to family/community supports</td>
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# IMPROVE THE EXPERIENCE OF CARE

<table>
<thead>
<tr>
<th>Element of Care</th>
<th>Example Outcome Measure</th>
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</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Reduce incidence of unsafe discharges</td>
</tr>
<tr>
<td>Effective</td>
<td>Increase in follow-up consult &amp; education with patient</td>
</tr>
<tr>
<td>Timely</td>
<td>Increase in prompt appointments for care</td>
</tr>
<tr>
<td>Patient-centered</td>
<td>Increase in patient reporting satisfaction with care</td>
</tr>
<tr>
<td>Equitable</td>
<td>Satisfaction scores for patients who are homeless = those who are not homeless</td>
</tr>
<tr>
<td>Efficient</td>
<td>Decreased hospital staff time on care coordination with community providers</td>
</tr>
</tbody>
</table>
## REDUCE PER CAPITA COST

<table>
<thead>
<tr>
<th>Aspect of Cost</th>
<th>Targeted Stakeholder</th>
<th>Example Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand lens/Consumers</td>
<td>Community/public health</td>
<td>Reduced cost related to fewer emergency response/911 transportation</td>
</tr>
<tr>
<td></td>
<td>Individual</td>
<td>Reduced out of pocket costs due to lower service use</td>
</tr>
<tr>
<td>Intermediary lens</td>
<td>Health plans</td>
<td>Reduced costs PM/PM</td>
</tr>
<tr>
<td>Health plans &amp; insurers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supply lens/Providers</td>
<td>Hospitals</td>
<td>Reduced costs from shorter inpatient stays</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>Increase in payments for services</td>
</tr>
<tr>
<td></td>
<td>Specialists</td>
<td>Increase reimbursement due to better appointment adherence</td>
</tr>
<tr>
<td></td>
<td>Pharmacy</td>
<td>Reduced costs related to poor medication management</td>
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</tbody>
</table>
RECOMMENDED ACTIONS

1. **Discuss** medical respite programs & the Triple Aim with key stakeholders
2. **Meet** with hospital discharge planners to discuss current needs
3. **Identify data elements** currently available and evaluate those measures
4. **Identify gaps** in available data and a process for creating new data elements
5. **Identify those responsible** for documenting, evaluating, and reporting outcome data at periodic intervals
6. **Identify level of funding**, model of payment, and funding sources
7. Develop a small program at first, and **scale up** from there
8. **Visit** other programs
1. How do you see the Triple Aim framework helping to bolster medical respite care programs?

2. How should brand new respite programs just starting out use this information, and how do you see those with more established programs benefiting from this framework?

3. How do you determine what measures to track, especially for a program that is designed to be a short-term intervention?

4. What’s the tension between tracking the measures that your funders want, and creating additional measures for your own quality improvement needs?
PANEL DISCUSSION

5. How do you determine when your measures need to change?

6. For those on the call who are working in hospitals or for insurers, how would you advise them to use this information?

7. Looking ahead over the next five years or so, how do you see medical respite programs fitting into health reform efforts, especially given the increasing focus on data and value-based payments?
AUDIENCE DISCUSSION

• What more information can we provide?

• Are there issues or ideas you’d like to revisit?

• How have you incorporated these concepts into your program?

• What barriers have you faced you would like advice in overcoming?

• Other questions?
ADDITIONAL RESOURCES

- Standards for programs
- Program directory
- Tool kit with research, template contracts, planning materials, etc.
- Respite Care Providers Network (RCPN)
- Policy brief on financing models

https://www.nhchc.org/resources/clinical/medical-respite/