USING DATA TO TELL THE STORY

Outcome and Data Recommendations for Medical Respite Programs

May 27, 2020
HRSA FUNDING

This resource is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of an award totaling $1,625,741, and zero percent (0%) financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the US Government. For more information, please visit https://www.hrsa.gov
Working to End Homelessness by Ensuring Health Care and Housing for All

The Council is a membership organization uniting thousands of health care professionals, people with lived experience of homelessness, and advocates in homeless health care. Join us in working to improve care and to eliminate homelessness.

Learn More
MEDICAL RESPITE: DEFINITION

• Acute & post-acute care for people who are homeless who are too ill or frail to recover from sickness or injury on the street, but not sick enough to warrant hospital level care

• Short-term residential care that allows people who are homeless to rest in a safe environment while accessing medical care and support services

• NOT: skilled nursing facility, nursing home, assisted living, BH step-down, or supportive housing

Diversity of Programs

➢ Size
➢ Facility
➢ Length of stay
➢ Staffing & services
➢ Admission criteria
MEDICAL RESPITE CARE

Room and Board

Medical Respite Care

Clinical Services

Supportive Services
<table>
<thead>
<tr>
<th>LEARNING COLLABORATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bethlehem Haven Medical Respite</td>
</tr>
<tr>
<td>Bridgewater/ LCHC RCC</td>
</tr>
<tr>
<td>Center for Respite Care</td>
</tr>
<tr>
<td>Central City Concern</td>
</tr>
<tr>
<td>Cottage Health RCP</td>
</tr>
<tr>
<td>Heading Home</td>
</tr>
<tr>
<td>HOPE Adult Shelter &amp; Recuperative Care Center</td>
</tr>
<tr>
<td>Sister Mavis Jewel Medical Respite</td>
</tr>
<tr>
<td>National Health Foundation</td>
</tr>
<tr>
<td>Valley Homeless Healthcare Medical Respite</td>
</tr>
</tbody>
</table>
SPEAKERS

Matthew Cotter, MSW
Senior Manager, Primary Care & Crisis Residential Services, Pittsburgh Mercy, Pittsburgh, PA

Laurie Nelson
Chief Executive Officer, Center for Respite Care, Cincinnati, OH

Maddy Frey, MPH
Director of Population Health, Evaluation, Cottage Health, Santa Barbara, CA

Monica Ray
Pop. Health Strategic Development Manager, Cottage Health, Santa Barbara, CA
Bethlehem Haven Medical Respite: CY 2019
Bethlehem Haven and Allegheny Health Network Pilot

- Started in 2016
- 10 Beds (5 at 1410, 5 at Wood Street Commons)
- AHN Provided: Nurse, CRNP, Home care services
- New Bethlehem Haven position: Respite Care Coordinator
- Pittsburgh Mercy’s Mobile Medical Unit and Psychiatric Consults
PHASE II: Adding UPMC, UPMC Health Plan and a new building
- Moved in to 905 Watson June 2018
- 29 Beds (10 UPMC, 5 UPMC Health Plan, 14 AHN)
- The role of Pittsburgh Mercy: onsite medical care from the Pittsburgh Mercy Family Health Center
- Expansion of Respite team
- AHN transitioned all onsite care to Pittsburgh Mercy in January 2019
Bethlehem Haven’s Medical Respite Program Provides short-term residential housing coupled with post-acute medical care to support an individual’s recovery from illness or injury. Individuals may be homeless, unstably housed, or do not have a family member or friend to care for them.

Bethlehem Haven’s Newly renovated Medical Respite Program offers private rooms and access to on-site dining and laundry. The Program’s professional staff provide individualized case management to encourage adherence to medications, physician instructions and follow-up appointments, thus decreasing the probability of future hospitalizations.
Brief overview of referral process:
- Allegheny Health Network utilizes their Center for Inclusion Health consult service
- UPMC Hospitals send referral to Pittsburgh Mercy Medical Respite Team
  - Chart review and Nurse visits patient in the hospital to review level of care and make sure patient is appropriate for Medical Respite
- Unconventional referrals
  - Case by case basis
Example of the format of referrals:

Respite Referral MRN (insert Medical Record number) (abbreviation for the hospital) (Date)
   Example: Respite Referral MRN 000000000000 PUH 8/30/18

Body of the email:
   Name:
   DOB:
   Insurance (carrier and policy number):
   Unit/floor/room (including bldg.):
   Anticipated Discharge:
   Recuperative Need:
   Unit contact:
   Brief Summary:
Bethlehem Haven Medical Respite Team--Staffing

- Social Worker
- 1.5 Nurses
- Housing Coordinator
- Care Coordinator
- Licensed Clinical Social Worker (Counselor)
- Medical Providers (Part-time: PA and MD)
- Residential Support Staff (24 hr coverage; 7 days/week)
- Administration
- Complemented by Home Care
Some strategies utilized while at Respite

- Daily Huddle
- Weekly Operations Meeting
- 1:1 sessions
- Housing Plan
- Housing consults
- Weekly Community Meetings
- Groups: Art Therapy, drug and alcohol, etc.
- Medical visits with onsite Physician Assistant
Some of the Services Linked to While in Respite

- Home Health
- Primary Care
- Medical Specialist Appointment
- Medication/Pharmacy
- Benefits Coordination
- Identification: Social Security Card, Birth Certificates, IDs
- Permanent Housing and other Housing Resources
- Outpatient Behavioral Health Treatment

- Health Plan Case Management
- Operation Safety Net
- Community Life Programs
- Employment
- Service Coordination
DECISIONS AROUND DATA

• What Data Can We Control
  - Admissions, Reasons for Admissions, Length of Stay, Disposition, Service Linkage, Satisfaction Survey, Demographic information, diagnoses while at Respite, etc.

• What Data Do We Not Have Access To
  - Information about health needs and utilization pre/post Respite stay, insurance utilization information, etc.
DECISIONS AROUND DATA

- Focus on what we can control, collaborate on the information we do not have access on.
  - Build strong partnerships, meet regularly

- Use the information we can control
  - Continuous program evaluation: we use data to learn about our program and to make improvement

- Identify barriers and plan to make adjustments
  - When we started, primarily on paper for documentation and data collection; implemented a medical record
Bethlehem Haven Medical Respite

- Total Admissions (6/15/18 to 1/31/20): 208
- Total Discharges (6/15/18 to 1/31/20): 197
- Average Length of Stay (6/15/18 to 1/31/20): 34.19 Days
Reason for Admission

- Wound Care: 27%
- Infectious Disease: 24%
- Orthopedic: 18%
- Medical Stabilization: 26%
- Pre-Surgery: 5%

Dates: June 15, 2018 to January 31, 2020
Disposition from Medical Respite

- Permanent Housing: 27%
- Residence prior to admission: 15%
- Shelter: 11%
- Street: 4%
- SNF: 3%
- Rehab: 5%
- Conditioned Worsened, readmitted: 10%
- Doubled up: 13%
- Hospital: 3%
- Incarcerated: 2%
- Left AMA: 6%
- Unknown: 5%
Disposition, CONT

Positive Housing Outcomes: Doubled Up, Permanent Housing, Residence Prior to Admission, Shelter, SNF, Structured Substance Abuse Treatment

Undesirable Housing Outcomes: Incarcerated, Left AMA, Street, Unknown
BETHLEHEM HAVEN
MEDICAL RESpite

Sample Client Survey
Do you generally feel you were given enough help, advice, information and support from staff?

During stay at Medical Respite, I felt safe

- **Yes**: 95%
- **No**: 5%

- **Yes**: 98%
- **No**: 2%
N = 63

My ability to manage my money

My Ability to make and keep appointments
N = 63

Upon discharge I had a good understanding of how to manage my health

Upon discharge I had a better sense of well being
Client Testimonial

“I really appreciate everything you all did to help me get situated. You guys really made a difference in my life and it means more than I could ever say. I got to say I’ve met a ton of people in the human services and you are one that belongs in that field. People in need def need people like you and Erin and the crew over there helping them.”
"THE MISSION OF THE CENTER FOR RESPITE CARE IS TO PROVIDE QUALITY, HOLISTIC MEDICAL CARE TO HOMELESS PEOPLE WHO NEED A SAFE PLACE TO HEAL, WHILE ASSISTING THEM IN BREAKING THE CYCLE OF HOMELESSNESS."

- The Center for Respite Care, Inc. is a 24/7, 20-bed, stand-alone, medical facility serving adult women and men who are experiencing homelessness and need a place to recover after a stay in the hospital or other medical facility.
- The work of the Center is unique in the Cincinnati tri-state area. We have learned in our nearly 20 years of service that a healthy life for our clients relies on many factors. We call our core program “From Medical Recovery to Independence."
CENTER FOR RESPITE CARE

- Location: Cincinnati, OH
- Beds/Occupancy: 10 double occupancy rooms (20 beds)
- Staffing: 18 total staff (includes Admin)
- Part-time Physician (provided in-kind)
- Full time Registered Nurse
- LPN/MA staff (2.5 FTE)
- Case management team (2.5 FTE)
- Client Care Assistants (7.5 FTE)
- Licensed by the State of Ohio as a Residential Care Facility (Short Term Assisted Living)
CENTER FOR RESPITE CARE

• Outcomes & Data (what we collect and why)
• Driven primarily by funding sources:
  • Funding by demographics (age, gender, medical status (HIV), length of stay and, other factors such as military status.)
  • Funding by medical outcomes (improvement in obesity, A1C scores, smoking cessation)
  • Funding by social/program outcomes (benefits/income secured, housing/placement obtained)

• Driven by quality improvement and benefit to referral sources:
  • Establishment of medical home
  • Access to regular, preventative healthcare
  • Understanding and appropriate use of acquired benefits.
  • Reduction in use of ER/ED for medical services.
  • Connection to community supports.
COTTAGE
RECUPERATIVE CARE PROGRAM

MADDY FREY
Director of Population Health, Evaluation

MONICA RAY
Population Health Strategic Development Manager
COTTAGE RECUPERATIVE CARE PROGRAM AT PATH SANTA BARBARA

• Located in Santa Barbara, California
• Hospital-led
• Onsite Public Health Care Center
• Referrals from hospital and community

10 patient beds
90 day maximum stay
1 medical director (part-time)
3 registered nurses (part-time)
1 social needs navigator
5 respite care monitors
## Recuperative Care Partners

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Funders</th>
<th>Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cottage Nurse</td>
<td>Cottage Health</td>
<td>Housing Authority of the City of SB</td>
</tr>
<tr>
<td>Cottage Navigator</td>
<td>CenCal Health</td>
<td>PATH</td>
</tr>
<tr>
<td>Public Health</td>
<td>Private Foundation</td>
<td></td>
</tr>
<tr>
<td>Local Shelter</td>
<td>Individual Philanthropists</td>
<td></td>
</tr>
<tr>
<td>Monitors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Recuperative Care Logic Model

<table>
<thead>
<tr>
<th>Elements</th>
<th>Process</th>
<th>Participation</th>
<th>Short-Term</th>
<th>Intermediate</th>
<th>Long-Term</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What resources are needed to implement the activities?</strong></td>
<td><strong>ACTIVITIES</strong> What specific activities will you undertake?</td>
<td><strong>Who are you trying to reach through your activities?</strong></td>
<td><strong>What changes do you expect to see in the short term (&lt; 1 year)?</strong></td>
<td><strong>What changes do you expect to see as a result of achieving the short-term outcomes (e.g., 2-5 years)?</strong></td>
<td><strong>What will be different if you are successful (e.g., in &gt; 5 years)?</strong></td>
</tr>
<tr>
<td>• PATH partnership</td>
<td>• Train referrers (i.e., case managers, social workers, nurses, and physicians) to identify eligible patients and discharge to medical respite program</td>
<td><strong>Eligible patients:</strong></td>
<td>• Increased participation in medical respite program by eligible patients</td>
<td>• Program participants are managing their medical and behavioral wellness needs</td>
<td><strong>Improved health outcomes for vulnerable populations:</strong></td>
</tr>
<tr>
<td>• Facilities</td>
<td>• Provide medical and behavioral health respite care and case management services to homeless/PATH referral patients</td>
<td>• Homeless</td>
<td>• Increased medical respite program patients:</td>
<td>• Improved access to and utilization of primary care services for homeless/PATH referral patients</td>
<td>• Life expectancy</td>
</tr>
<tr>
<td>• Case managers</td>
<td>• Collect &amp; analyze quantitative and qualitative data on patients and program barriers and key success factors</td>
<td>• Moderate medical and behavioral health needs</td>
<td>• connected with a primary care provider</td>
<td>• Decreased homeless/PATH referral patients using the ED</td>
<td>• Morbidity</td>
</tr>
<tr>
<td>• Social workers</td>
<td>• Develop and implement a continuous improvement plan</td>
<td></td>
<td>• receiving case management services</td>
<td></td>
<td>• Health status and health-related quality of life</td>
</tr>
<tr>
<td>• Nurses</td>
<td>• Coordinate roles of community partners</td>
<td></td>
<td>• increased completed referrals to community resources</td>
<td>• Increased patients connected to permanent housing</td>
<td></td>
</tr>
<tr>
<td>• Funding</td>
<td></td>
<td></td>
<td>• increased medical respite program referral patients connected to housing and job training resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community partners (health and health-related orgs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cottage Health departments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other organizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Volunteers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data collection system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evidence-based model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cultural &amp; Linguistic Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health Leads</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**National Health Care for the Homeless Council**

[Logo] Cottage Population Health
EVALUATION TOP OUTCOMES

Document-ready for housing
• Patients that are document-ready for housing
• Patients in temporary and permanent housing (at exit and after)

Reduce ED and inpatient use for program participants
• Emergency department utilization rates
• Inpatient utilization rates

Referrals offered and utilized
• Patients with established care plans
• Referrals offered; appropriately identified; successfully completed
• Connection to medical home
## Recuperative Care Program

**Brief Indicators Dashboard**

**Last Updated: April 30, 2020**

*Cumulative indicators reflect all patients in program since October 2018*

<table>
<thead>
<tr>
<th>Medical &amp; Social Needs (cumulative, includes duplicates)</th>
<th>Count 90-day + Current pts</th>
<th>Percent 90-day + Current pts</th>
<th>Count early exit pts</th>
<th>Percent early exit pts</th>
<th>Count all pts</th>
<th>Percent all pts</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patients</td>
<td>48</td>
<td>91%</td>
<td>5</td>
<td>9%</td>
<td>53</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Visited Medical Home During Program</td>
<td>47</td>
<td>89%</td>
<td>2</td>
<td>4%</td>
<td>49</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Average # of PCP Visits per Patient Stay</td>
<td>3.58</td>
<td>-</td>
<td>0.8</td>
<td>-</td>
<td>3.32</td>
<td>-</td>
<td>all PCP visits/all 90-day + current patients</td>
</tr>
<tr>
<td>Average # of On-site Public Health Visits per Patient Stay</td>
<td>1.77</td>
<td>-</td>
<td>0.2</td>
<td>-</td>
<td>1.62</td>
<td>-</td>
<td>all Public Health visits on-site/all 90-day + current patients</td>
</tr>
<tr>
<td>PCP to ED Visits During Program Ratio</td>
<td>6.62</td>
<td>-</td>
<td>0.50</td>
<td>-</td>
<td>4.89</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Patients Document-Ready for Housing</td>
<td>29</td>
<td>60%</td>
<td>3</td>
<td>60%</td>
<td>32</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exit Status (cumulative, includes duplicates)</th>
<th>Count</th>
<th>Percent</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who have exited program</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients at Roomkey South</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients Completing Program + Current Patients</td>
<td>48</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Patients Exiting Program Early</td>
<td>5</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Currently in Permanent Housing</td>
<td>14</td>
<td>40%</td>
<td>total housed/unique patients ever in program</td>
</tr>
</tbody>
</table>

---

**National Health Care for the Homeless Council**
Recuperative Care Evaluation
October 2018 (launch) – April 2020

**PATIENT OUTCOMES:** 50 patients total, 3 repeat patients, 10 current patients

- 98% visited medical home during stay
- 63% document-ready for housing at exit
- 9 exited to permanent housing
- 26 exited to transitional housing beds
- 15 currently in permanent housing
- 4 returned to prior living arrangement

**MEDICAL ACHIEVEMENTS:**
Wheelchair to walker, recovery from incontinence, wounds healed, limb saved and diabetes management
Recuperative Care Evaluation
October 2018 (launch) – April 2020

PROGRAM OUTCOMES FOR ALL PATIENTS:

- **62%** ED visits DURING program
- **57%** ED visits AFTER program completion
- **69%** inpatient stays DURING program
- **69%** inpatient stays AFTER program completion

Compared to the 90 days before entering the program
QUESTIONS & DISCUSSION
OUTCOME MEASURES & DATA COLLECTION: RECOMMENDATIONS FOR MEDICAL RESPITE PROGRAMS

**Health Outcomes**

A client’s stay in a medical respite program is precipitated by a health-related event. Whether a client is injured or sick, their referral is connected to a medical condition. The following outcome recommendations focus on the health needs of clients and the clinical care provided by the program. Programs are encouraged to define the specific numerator and denominator for the identified measures and variables based on feasibility of data collection.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Variables</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| **Primary Care**: Connection to primary care is established or strengthened | - Identify primary care provider (PCP)  
- Schedule primary care appointment | Medical respite staff must be familiar with the process in which clients are connected to primary care (e.g., Do they have an assigned PCP? Who is the local Health Care for the Homeless (HCH) provider?) |
| **Assessment**: Assessment and coordination of health | - Assess need for health screenings based on age, | The stability of a medical respite stay provides an |
Tools

Health Outcomes
  Admission Procedure & Checklist – Center for Respite Care (pg. 10)
  CAHPS Health Literacy Survey (Modified) (pg. 11)
  Client Health Summary – Center for Respite Care (pg. 12)
  Client Medication Inventory – Center for Respite Care (pg. 13)
  Medical Intake Form – Center for Respite Care (pg. 14)

Social Outcomes
  Care Transitions Measure (pg. 16)
  Care Transitions Record (pg. 17)
  Client Authorization Form – Center for Respite Care (pg. 18)
  Discharge Planning Form – LCHC/Bridgeway RCC (pg. 19)
  Self-Administered Medication Record – Center for Respite Care (pg. 20)
  Self-Management Tool (pg. 21)

Program Outcomes
  Client Satisfaction Survey – Barbara McInnis House (pg. 22)
  Client Satisfaction Survey – Bridgeway/LCHC RCC (pg. 25)
  Performance Measure Worksheet – Central City Concern (pg. 26)
  Standards for Medical Respite Care – NHCHC
  Standards Organization Self-Assessment – NHCHC

Data Collection & Sharing
  Data Collection Protocol – Bridgeway/LCHC RCC (pg. 27)
  Informed Consent for Treatment Form – Center for Respite Care (pg. 28)
  Universal Informed Consent – Durham Crisis Collaborative (pg. 29)