# Managing Complex Medical and Behavioral Health Needs

NATIONAL HEALTHCARE FOR THE HOMELESS CONFERENCE
PRE-CONFERENCE INSTITUTE: MEDICAL RESPITE
MAY 13, 2024

# Introductions

- **Brittney La Shier, CADC**

    Director of Social Services
    Recuperative Care Program
    Preble Street

- **Susannah King, MSW, LICSW**

    Social Services Manager
    Healthcare for the Homeless
    Hennepin County Public Health

- **Sabina Wong, MD**

    Clinic Coordinator
    Family Medicine Physician
    PCC Clinic at The Boulevard

## Goals & Objectives

- Focused conversation areas of respite care:
  - Defining “medically stable”
  - Substance Use & Mental Health
  - Importance of building trust within the medical system
- Leave with ideas and resources that you can take back to your community and respite programs
- Robust conversation with breakout participants
- Educate and share ideas with each other

# Recuperative Care Program

## An overview of Maine's first Medical Respite Program

Brittney La Shier, Director of Social Services,

Recuperative Care Program

Maine Medical Center
MaineHealth

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

Preble Street
www.PrebleStreet.org

# Partnerships

Maine Medical Center
MaineHealth

- Funders
- Referral source

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

- FQHC
- Provide all medical care

Preble Street

- Social Service Providers
- Manage residential space

# Model

## Program Model

- Comprehensive Clinical Care Model
  - 24-hour clinic, on-call provider
  - Behavioral Health
  - Psychiatric Care opportunities
  - Social Workers & Case Managers
- Stand-alone facility
- Closed door
- 15 beds

## Staffing Model

- Greater Portland Health
  - Providers
  - Registered Nurses
  - CRMA's
  - LMSW
- Preble Street
  - Social Workers
  - Case Managers

# Key Elements

- ➢Opened September 26, 2022
- ➢2-story facility
  - Clinic on first floor, residential are on second floor
- ➢3 meals delivered/day by Preble Street Food Security Hub
- ➢On-site laundry
- ➢Bathroom motion sensor alarms
- ➢Outsides breaks every 3-hours

# Program Stats

- 186 Admissions
- Total bed nights: 6,032 nights
- Average length of stay: 31 days

- Discharge Outcomes
  - 51 Housing
    - Reconnect with family, Housing First, independent apartments
  - 47 to a local shelter
  - 30 outside/encampment
  - 21 Recovery Residence
  - 19 Hospital Re-admissions
  - 09 Other locations (Rehab, hotels, etc.)
- Primary Medical Need
  - Treatment of infection (IV-antibiotics) – 44%
  - Wound care – 30%
  - Mobility/functional recovery – 13%
  - Other – 13%

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# Limitations in client care

- Program limitations:
  - Closed door policy
  - Dietary constraints: diabetic, heart failure
  - Limitations to scope of care: Supplemental oxygen, feeding tubes
  - Medically directed discharge planning
  - Adequate staffing and training in 24-hour program
- Community limitations:
  - Gentrification
  - Maine Coordinated Entry
  - Limited access to housing vouchers

# What "medically stable" looks like

- Medically driven discharge plan
  - Safe to transition to a local shelter? Outside?
  - Assessing vulnerability
    - Weighing location, access to care, community supports, level of independence
  - Setting realistic goals for a return to prior or new environment
  - Overall goal:
    - Is the presenting condition stabilized?

# Meeting clients where *they* are at

- Harm Reduction in our space
  - Client centered approach
  - Easy access to MAT services
    - Methadone- Comprehensive Treatment Centers
    - Buprenorphine- Greater Portland Health
  - Program culture
    - Building strong relationships, leaning in with curiosity
    - Activities calendar- games, art, cooking, journaling/poetry, MH support groups
    - Outside opportunities
    - Embracing the difficult conversations
    - Access to safe use supplies

- Challenges
  - Congregate setting, honoring everyone's journey
  - Closed door policy
  - Realities of discharge
    - Continued access to MAT and current wrap-around supports

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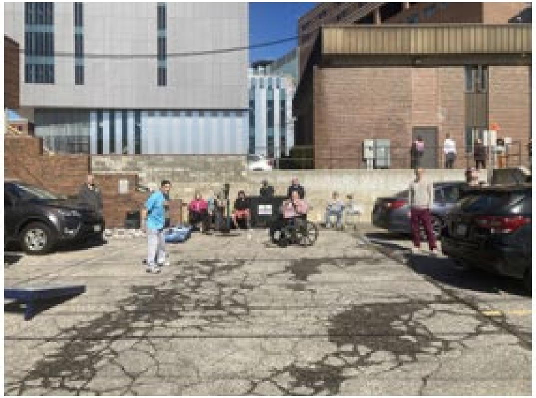
# Building and repairing relationships

*~ Repairing relationships within the medical care system. Every person deserves adequate access to health care. ~*

Celebrating a client's birthday



2024 Solar Eclipse

Animal TLC

Preble Street


# Hennepin County Health Care for the Homeless Endeavors Respite Program

- Partnership between Hennepin County and Catholic Charities
- Opened in July 2022 - 207 admissions
- Average length of stay = 70 days
- Replaced shelter based program that was established in 2007
- 30 emergency shelter beds for respite program (26 private room, 2 shared rooms)
- 3 meals/day, laundry, shared bathrooms
- Community room
- HCH clinic street front clinic

# Medical Respite Overview

**Medical Respite Team consists of:**

- **2 Nurse Practitioners (part time)**
- **Respite RN**
- **Clinical Social Worker**
- **Peer Support Specialist**
- **PharmD Resident (4 hours per week)**
- **Respite Triage RN**

**Respite services are provided during business hours Monday-Friday**

**Eligibility for the respite program is based on acute illness or exacerbation of chronic illness and does not include screening for criminal history, mental health status or substance use, making it low barrier, accessible program**

# Medical Respite Services

- Monitoring, treatment, and care for admitting diagnosis
- Preventative health screenings/maintenance
- Medication setup and education
- Insurance, GA, SNAP
- Appointment scheduling and transportation
- Health education
- Mental health assessment and therapy
- Chemical health assessment and referral
- Peer Support Services

# Collaboration & Partnership- Hennepin Health Care

- Respite Triage Nurse position
  - Able to complete thorough chart review prior to respite admission
  - Can visit people at hospital to assess appropriateness for admission
  - Hospital staff can refer directly through an order in the EHR
  - Was originally funded by HHS as Homeless Consult Nurse position- embedded at the hospital to coordinate referrals from hospital to respite
- Share EPIC - an  electronic medical record
  - Ability to message speciality providers, advocacy
  - Access to telemediq and paging systems
  - Piloting Compass Rose, a case management component of EPIC
- HCH Medical Director - also staff & research doctor at HHS
- Close relationship = patient advocacy and help with health system navigation

# Interdisciplinary Team decision for discharge

Admitting issue to respite  may be resolved but patient could stay while:

- Waiting for pending housing referral to become available -  rather than return back to shelter or streets
- Patient needs more education or teaching around chronic condition (i.e., diabetes, asthma)
- Stabilization for MH-SUD (i.e., waiting treatment or higher level of care)
- Nursing Home admission process to clear

# Substance Use

Supports:

- Harm reduction principles and practices integrated into care
- Narcan and safe use supplies readily available
- Community Room stocked with art supplies, games, TV

Challenges:

- Overdoses have been frequent
- Private rooms can lead to isolation, increase risk of OD (no staff to monitor or do room checks)
- Narcan and safe use supplies not available 24/7

# The Boulevard

- Established in 1994
- One of the original Medical Respite Programs in Illinois


***MISSION:***
***...to help ill and injured homeless adults break the cycle of homelessness, restore their health, and rebuild their lives***

# Medical Respite Care

Community Wellness Center

- 64 beds
- 150 individuals/yr
- Congregate setting: 4-6 individuals per room
- Men on the 1st floor, Women on the 2nd floor
- Average length of stay = 160 days
- Discharge to housing

**PCC Clinic at The Boulevard** (M-F, 9am-5pm)

- 5 family medicine providers (½ day each), 1 peer support
- Full time: 1 LPN, 1 MA, 1 LCSW

# Defining Risk for Complications

- Already outpatient
- Medical complexity still present

- Health status
  - Chronic medical conditions stable?
  - Active issues resolved?
  - Time since last hospitalization?
  - Mental health status, including SUD
- Protective factors
  - Income, support network, PCP, self mgmt skills, transportation

**Medical Stability & Risk Assessment Form** DATE ____________

NAME ______________________ CASE MANAGER ______________________

DOB ____________ TENTATIVE DISCHARGE DATE ____________

| Medical Condition | Low risk | Medium risk | High risk |
|---|---|---|---|
| Hypertension | 100-140/ 60-90 | 140-170/90-95 | >170/95 |
| Diabetes | FBG <130 | FBG 130-180 | FBG >180 |
| | PP <180 | PP 180-250 | PP >250 |
| | A1c < 8 | A1c < 10 | |
| | no hypoglycemic episodes | recent hypoglycemia, addressed | frequent hypoglycemia |
| Asthma/COPD | well controlled: symptoms or albuterol use < 2x/ week | symptoms or albuterol use 3-7 x/ week | symptoms or albuterol use multiple times per day |
| Wound | no active wound | regular would care and healing well | irregular wound care or poor healing |
| Infection | no active infection | recent infection, on appropriate treatment >48hr | active infection, in isolation |
| Pain & Mobility | mobility not limited by pain | occasional pain, responding to treatment | debilitating pain |
| Last hospital admission | >2 weeks ago | >1 week ago | <48 hrs ago |
| Substance Use Disorder | sobriety well established | recent relapse | ongoing substance use |
| Mental Health | stable, no concerns | in process of treatment, connected with BH / psych | volatile mood or behavior, no regular BH / psych |
| **Pending Issues** | | | |
| Labs / tests in process: | | | |
| Referrals in process: | | | |
| Upcoming appointments: | | | |
| Other Issues: | | | |
| **Protective Factors** | | Yes | No |
| Individual health & wellness goals met (see goals form) | | | |
| Employed or stable income | | | |
| Support network | | | |
| Well established with PCP and/or specialist | | | |
| Self management skills | | | |
| | Understanding of diagnosis | | |
| | Self-monitoring routines | | |
| | Medication compliance | | |
| | Transportation access | | |
| **Clinical Assessment** | | | |

Based on today's assessment, patient's risk for medical complications after discharge from The Boulevard is:

LOW MEDIUM HIGH

If HIGH risk, estimated additional time needed to reach LOW or MEDIUM risk: ____________ weeks.

Behavioral Health Assessment recommended prior to discharge: YES NO

______________________________ Provider Signature

____________ Date

# Managing Substance Use

- Never underestimate the impact of SUD
  - Co-occurring, not secondary
  - Congregate setting

LIMITATION

- Harm reduction (individual vs. group)
  - Include SUD recovery in individualized care plan
  - Require resident participation in care plan
  - Emphasize connection to housing success
  - Keep accountable, maintain safety for other residents

# Providing Recovery Support

- Onsite services
  - MAT including oral and long-term injectable
  - Individual, group, CADC, and peer support counselling
  - NADA acudetox therapy
- Outpatient Partnerships
  - Day programs:  Above and Beyond recovery center, Bobby Wright
- Higher level of care
  - Withdrawal unit at West Suburban Medical Center
  - 30-90 day program at Haymarket

# Setting Individual Goals

- Establish why they are here (health/recovery)
    - Space to think
    - Build agency
- Explain why we are here (take care of them)
    - Commit to supporting their goals

**We are on the same side!**

## INDIVIDUAL HEALTH & WELLNESS GOALS

NAME ______________________ CASE MANAGER ______________________

DOB ______________ ADMISSION DATE ______________________

| GOALS AT INTAKE ASSESSMENT | DATE OF REASSESSMENT (check box if goal has been met) | | | |
|---|---|---|---|---|
| 1) | ☐ | ☐ | ☐ | ☐ |
| 2) | ☐ | ☐ | ☐ | ☐ |
| 3) | ☐ | ☐ | ☐ | ☐ |
| 4) | ☐ | ☐ | ☐ | ☐ |
| 5) | ☐ | ☐ | ☐ | ☐ |
| PROVIDER INITIALS | | | | |

| HEALTH EDUCATION (check recommended modules) | DATE COMPLETED | PCC STAFF INITIALS |
|---|---|---|
| ☐ Hypertension Nutrition | | |
| ☐ Diabetes Nutrition | | |
| ☐ Diabetes Self Blood Glucose Monitoring | | |
| ☐ Medication Management | | |
| ☐ Appointments & Referrals | | |
| ☐ Healthy Foods | | |
| ☐ Preventive Care Visit | | |
| ☐ | | |

# Taking the time to Listen

- Secret sauce:
    - Nurse Dorothy!
- Time: Reduced productivity expectations for providers
    - 4-5 patients/ shift
- Availability:
    - Open door policy
- Curiosity:
    - Tell me more about that
- Motivational Interviewing

# Questions

What has worked well for you?

- Defining “medically stable for discharge”
- Managing SUD
- Building trust

## Going a little deeper....

- How does continued substance use change the assessment of whether a patient is medically stable for discharge?
- What are reasonable limits to patient autonomy in a congregate setting?
- What gaps in the system have you observed in caring for complex patients?
- With so much unmet need, how do we guard against burnout and take care of ourselves and our staff?

# Thank you!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