Albuquerque HEALTHCARE for the homeless

Albuquerque Health Care for the Homeless, Inc. marks 35 years of continued commitment to serving the health care needs of people experiencing homelessness.

Albuquerque Medical Respite Model

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1. Need

People who experience homelessness are likely to be sicker and have a more difficult time recovering from injury or illness. Access to resources and support to follow a treatment plan, or to have a place to rest and eat regular, healthy meals is out of reach without intervention by medical and social services institutions.

Recent peer-reviewed research showed evidence indicates "**medical respite programs reduced future hospital admissions and hospital days, reduced 90-day hospital readmissions, and reduced hospital length of stay among homeless patients."**[i]

Patients experiencing homelessness stay in the hospital 4.1 days longer per admission than other low-income patients.[ii]

+ 4.1 Days

Currently, the Barrett Foundation and Heading Home's Albuquerque Opportunity Center provide 37 beds in their shelters for recuperative care in a social respite model. The beds are contracted through hospitals and MCOs. **The social model of recuperative care provides a safe place to recover from injury or illness but does not meet the needs of people that require a higher level of medical care.**

A 2017 Albuquerque Medical Respite Community Needs Assessment concluded that there remains an unmet need in our community for medical respite services. The last point in time count reported a

minimum of 1,524 people experiencing homelessness on January 28, 2019. AHCH and community partners estimate at least 16,000 persons – approximately 2.3% of Bernalillo County residents – will experience homelessness during the year. In Albuquerque, homelessness has been increasing at an average annual rate of 7.7% since 2013[iii]. A Columbia University report projects an increase in homelessness by 40-45% this year over January 2019 due to the COVID-19 pandemic.[iv]

2. Objective

To provide patient-centered medical care for people experiencing homelessness to improve clients' health, thereby reducing avoidable emergency department usage, potential hospital readmissions, improving transitions of care from inpatient to outpatient sites, and decreasing lengths of inpatient hospital stays. Medical respite will provide necessary social services and an immediate connection to permanent supportive housing.

This project will be a collaborative effort between University of New Mexico Hospital, homeless shelters, Albuquerque Health Care for the Homeless, partner Federally Qualified Health Centers (FQHCs), and the City of Albuquerque.

What it is: Acute and post-acute medical care for people who are homeless who are too ill 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.

What it is not: skilled nursing facility, nursing home, assisted living, or supportive housing. These are higher levels of care than medical respite. Medical respite can complement these programs.

3. Goals

1. To exit medical respite clients directly into permanent housing.
2. To improve the transition of care from inpatient to ambulatory sites for people without homes.
3. To reduce the hospital readmission rate and length of stay for people without homes.
4. To provide medical care to patients residing at medical respite program.
5. To increase enrollments for Medicaid and access to resources for patients with case management to secure housing, primary care, mental health care, and benefit enrollment

4. Medical Respite Model

1. Onsite case management/care coordination
   - Coordination and transportation to offsite medical appointments
   - Referral or connection to community case management services
   - Completion of case management and supportive services onsite as applicable
2. Connection and transition to primary care provider/health home before discharge
3. Onsite clinical services include:
   - Daily evaluation (or as indicated by plan) by clinical provider
   - Provision of medical clinical services within scope of license and as indicated by discharge instructions and clinical care plan
   - Medication management which may include:
     - Storage of medications by qualified MR clinical staff

    - Dispensing or administration of medication
    - Medication reconciliation
    - Medication monitoring
    - Education and skill development to self-manage and administer medications
    - Identification and implementation of strategies to support independence in medication management
  - Chronic condition management
  - Medical management and treatment
  - Self-management education
  - Monitoring and support to complete intensive outpatient medical treatment, such as:
    - Dialysis
    - Chemotherapy
  - Behavioral health
    - Screening & assessment
    - Ongoing behavioral health care and therapy
    - Connection and transition to long-term community behavioral health
  - Substance use treatment
    - Recovery-focused individual therapy
    - Recovery-focused group education
    - Referral and transition to community-based recovery programs
    - Group education
4. 24-hour program staffing
5. On-call medical support
6. Care coordination with home health and home-based clinical care services
   - Client has space to engage with home-based clinical services not offered onsite (e.g. home health, home nursing care, physical therapy, speech, occupational therapy)

Hospital Support:

1. Data sharing agreement for monitoring and evaluation to measure impact
2. Coordination of specialty services
3. Agreement on admission and exclusion criteria and readmission and coordination/support in negotiating contracts for placements at SNFs
4. 24/7 nurse advice line
5. One dedicated medical respite staff in hospital for care coordination and referrals
6. Agreements on what hospital sends with patient (DME, medications) and planned coordination with specialty care

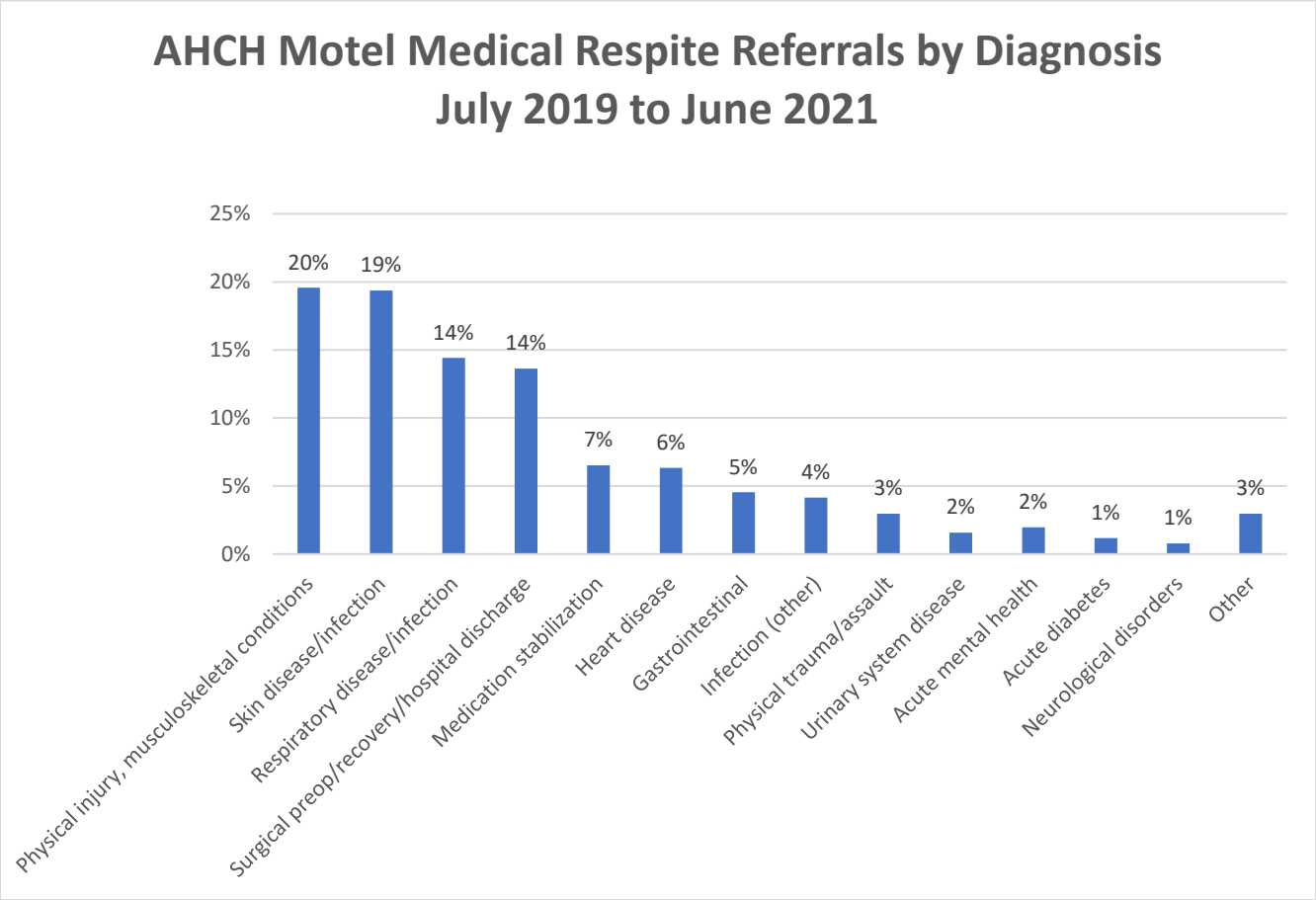
General Medical Respite Facility Operations:

- 24-hour access to a bed
- 3 meals/day
- Transportation to any/all medical appointments
- Access to a phone for telehealth and/or communications related to medical needs
- Safe space to store personal items
- Wellness check at least 1x every 24 hours by medical respite program staff (clinical or non-clinical)

5. Level of Care

5.1 Medical Need and Acuity

The Albuquerque Medical Respite Work Group used proxy data to determine level of medical need in medical respite from Albuquerque Health Care for the Homeless motel respite data.



Of 531 motel medical respite stays:

- median age - 47 years old
- 56% male
- 44% female

Physical injury or trauma such as lacerations, wounds, sprains, contusions, fractures, and burns are leading causes of hospitalization and mortality among people who are experiencing homelessness.[v] [vi] Most medical respite programs nationally treat injuries and trauma with patient care and comfort measures (e.g. wound care and infection control and non-pharmacological pain management).[vii]

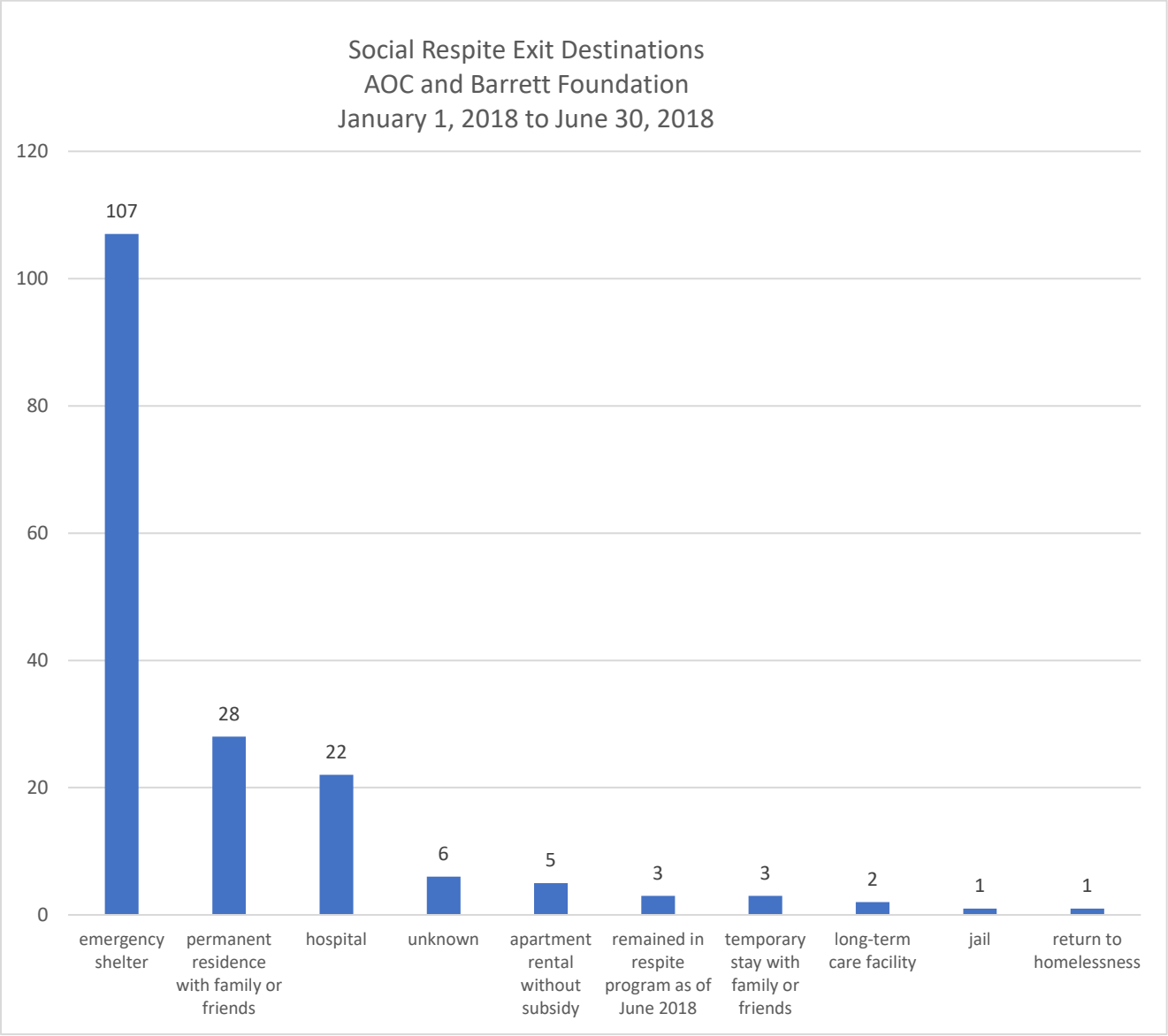
National research indicates that in addition to physical injury or trauma, the following conditions are most commonly seen in the medical respite setting:

- skin diseases including cellulitis, abscess, immersion foot, and skin ulcer including diabetic ulcer;
- respiratory disease including asthma, influenza, pneumonia, upper respiratory infections, tuberculosis, and chronic obstructive pulmonary disease such as bronchitis and emphysema;
- heart disease;
- gastro-intestinal related conditions including hepatocellular carcinoma, cirrhosis, hepatic encephalopathy, colorectal cancer, and hernia of the ventral, inguinal, and abdominal areas, and Hepatitis;
- neurological disorders including epilepsy, peripheral neuropathy, and cerebrovascular accident (CVA); and
- conditions of the Genitourinary System including urinary tract infection and prostatic hypertrophy.[viii]

Nationally, the average length of stay is 42 days and the median length of stay is 30 days.[ix]

Level of Care Gaps Addressed:

- Ability to accommodate infectious diseases (if private rooms are included in design)
- Multi-directional referrals into medical respite beds (homeless shelters, FQHCs, etc.) to decrease ED visits
- Daily onsite medical care to decrease 30-day hospital readmissions
- Focus on exit to housing to improve patient health, decrease ED visits, shorten inpatient hospital stays, and decrease 30-day readmissions (address current exits to shelter)



5.2 Behavioral Health Care

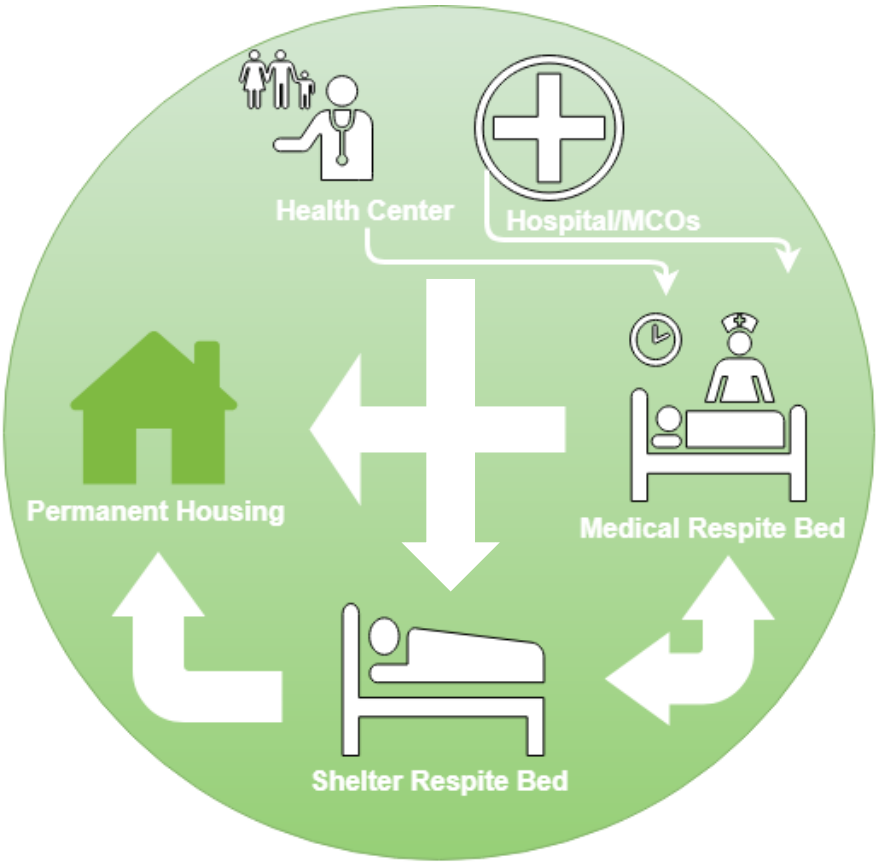
The primary reason for a referral to medical respite will be a medical diagnosis. However, it is not uncommon for medical respite providers to recognize or diagnose behavioral health problems that were missed at the referring hospital or clinic. Co-occurring behavioral health or substance use disorders will complicate medical care and must be treated concurrently to maximize health stability. Medical respite providers are trained to take measures to address behavioral health issues and can detect symptoms of mental illness and substance use disorders and link patients to integrated behavioral health care in their programs. These integrated care models can include providing support groups, interdisciplinary

team meetings with patients, onsite care delivered by licensed clinical social workers, psychologists, psychiatric nurse practitioners, etc., and/or connecting patients to outside behavioral health and substance use disorder treatment agencies.

6. Housing

Medical respite is a high-impact and powerful solution to ending homelessness because, and only as, an exit to housing. Housing and medical respite must be addressed together to achieve the intended impact of medical respite care. Exit to housing is an essential outcome measure for Medial Respite and success will only be achieved if new housing vouchers are available to the Medical Respite program. Based on 25 beds and a median length of stay of 30 days, 300 individuals can be expected to be served in a year. While not all individuals will best be served by a permanent supportive housing voucher, we can estimate that approximately 80% will be, with a need for 240 additional permanent supportive housing vouchers per year. Rapid rehousing, public housing, and 30% housing subsidies and resources will also be utilized.

7. Albuquerque Medical Respite System



Post Hospital	Pre-Admission	Perioperative	Hospice
- Acute medical needs - At risk for clinical deterioration - Possible wound care needs - Possible medication management - Possible medication reconciliation - 30-45 day average length of stay	- Prevent admission to hospital - At risk for clinical deterioration - Possible wound care needs - Possible medication management - Possible medication reconciliation - 30-45 day average length of stay	- Provide better conditions for patients before operation - Preparation for elected procedures such as colonoscopy - Preparation for invasive procedures like heart surgery	- Quality, compassionate care for people facing a life-limiting illness or injury Phase II

Direct Link to Housing through Housing First and Intensive Case Management

Based on Community Needs

Medical Respite services will be developed based on established needs of the community and on data from AHCH Community Needs Assessment, Albuquerque Medical Respite Community Needs Assessment, and hospital utilization data.

Person-Centered and Trauma-Informed

Development of Medical Respite programming, facilitates, and services rooted in evidence-based best practices and built upon person-centered and trauma-informed approaches to health care. The scattered site model may best support these values with more specialized attention, smaller numbers, and a more therapeutic setting. Medical respite program will comply with national *Standards for Medical Respite Programs* from the National Health Care for the Homeless Council.[x]

Housing Pipeline

Medical Respite will be centered around Housing First approaches with immediate connection to permanent housing. Medical respite offers a viable and high impact solution for ending homelessness, with sustainable exits to housing.

8. Policy Opportunities

1. Pursue Statewide Medicaid benefit through 1115 Waiver for medical respite care
2. Examples of Promising Medicaid policy change:
    i. California: Preparing a very large change to their Medicaid plan, called Cal-AIM. In it, they identify medical respite (they call it recuperative care) as an "in lieu of" service. Page 195. This example of a large state moving forward on financing medical respite through Medicaid.
    ii. Washington: Legislative language in the 2021 session required the state to do a study. Budget language/page189: $25,000 of the general fund—state appropriation for fiscal year 2022 and $25,000 of the general fund—federal appropriation are provided solely for the authority to develop an implementation plan to incorporate medical and psychiatric respite care as statewide Medicaid benefits. The plan must include an analysis of the cost effectiveness of providing medical and psychiatric respite care benefits for Medicaid enrollees. In developing the plan, the authority shall consult with interested stakeholders, including Medicaid managed care organizations, community health centers, organizations providing respite care, and hospitals. Amounts provided in this subsection may be used for staff support and one-time contracting. No later than January 15, 2022, the authority shall report its findings to the relevant committees of the legislature, the office of the governor, and the office of financial management.
    iii. Minnesota: Pursuing 1115 Waiver to include medical respite in Medicaid Plan.
    iv. New York: Moving forward with plans to include medical respite in Medicaid Plan.

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[iii] Assessing Shelter Capacity and Dynamics for Accommodating the Homeless Population in Albuquerque NM Report Prepared for the City of Albuquerque, Department of Family and Community Services, November 2019, https://www.cabq.gov/family/documents/assessing-shelter-capacity-final-report.pdf.

[iv] https://community.solutions/analysis-on-unemployment-projects-40-45-increase-in-homelessness-this-year/

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[vii] National Health Care for the Homeless Council. (2011). Clinical Recommendations for the Medical Respite Setting. Nashville, TN: Edgington, S. (Ed.). Available from www.nhchc.org.

[viii] Ibid.

[ix] Ibid.

[x] Respite Care Providers' Network, National Health Care for the Homeless Council, Standards for Medical Respite Programs, https://www.nhchc.org/standards-for-medical-respite-programs, October 2016.