# MEDICAL RESPITE
# COMMUNITY NEEDS ASSESSMENT

## Albuquerque, NM, JULY 2017
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Barrett Foundation
City of Albuquerque, Department of Family & Community Services
Heading Home

# Executive Summary

**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 for them without intervention by our medical and social services institutions. Medical respite programs have developed around the country and in Albuquerque to try to address the needs of persons experiencing homelessness and who have medical needs. The Respite Care Providers' Network (RCPN) defines medical respite care as "acute and post-acute medical care for patients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in shelter or on the streets, but who are not sick enough to be in a hospital".

Medical respite often implies that some combination of medical treatment services, transportation, behavioral health and social services case management, including connection to housing, is also available to the person for a short-term period. In spite of decades of federal funding to support services for persons experiencing homelessness and to address the challenges in providing access to appropriate health care services for indigent people, however, there remains no dedicated funding stream for medical respite services. This means that the models and arrangements to provide an appropriate care setting for this population are as diverse and varied as the communities and cities across the country where they have been developed.

Homeless services organizations in Albuquerque formed a work group in March 2017 to organize a community needs assessment to understand perspectives and potential for advancing our medical respite service system. Some questions the group sought to answer were, for example, "How well does the current system support the medical respite needs of the homeless community?", "where do opportunities exist to engage others in planning and financing medical respite services?', and "how do we move toward meeting national voluntary medical respite standards?".

The City of Albuquerque Family & Community Services Department, led by Doug Chaplin, provided funding to Albuquerque Health Care for the Homeless to contract for the coordination of the initial meetings of the Medical Respite Work Group and to conduct the community needs assessment.

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The work group recognizes that the need for appropriate care settings in our community extends beyond that of our community members that are experiencing homelessness. Appropriate respite services for persons that are experiencing acute psychiatric issues is also a need in our community, for example, and planning is underway in Albuquerque and Bernalillo County to try to meet this need.


*Examples of communities needing respite services*

Others that are older but don't meet age eligibility for Medicare, and are poor, but not poor enough to meet Medicaid eligibility can't afford an appropriate care setting when they are too ill to be at home. Discharge planners face challenges in finding a safe placement for many patients and public funding falls far short in closing gaps to meet needs.

For the purposes of this report, however, the population of focus is on persons experiencing homelessness and that need medical care.

The Medical Respite Community Needs Assessment was conducted from March to June 2017 and included an online survey, key informant interviews, and literature research, most of which is provided by the National Health Care for the Homeless Council and their Respite Providers Resource Network. Four core themes emerged from the community needs assessment.

## Core Theme #1: Engage a broader group of stakeholders

Response to the survey and interview requests were positive and came from diverse representatives of our health care system, in addition to hospital representatives. Hospitals have been partnering for several years with homeless services organizations to create solutions to providing appropriate care for this population, but there are numerous other stakeholders that care for and encounter homeless people in need of medical care in their roles, and that struggle to serve them. Broadening stakeholder participation and involvement will lead to a stronger medical respite service system.

## Core Theme #2: Promote comprehensive care transitions

"Care transitions" refers to how patients move into medical respite services, the decision-making process that gets them from one care setting to another, and what is involved in moving patients out of medical respite services. Better care transitions ensure that the patient's interest is at the center and that health improvement, and connection to housing, are intended outcomes.

A greater focus on care transitions would address concerns that were expressed in the assessment by stakeholders.

## Core Theme #3: Improve data collection, tracking and shared reporting

Data collection that is standardized and shared among key medical respite stakeholders could improve our collective understanding of the system dynamics, including demand for services, utilization, care transition processes and outcomes, and health and housing outcomes. Sharing reports and setting collective indicators and goals based on standardized information would lead to a more effective and efficient system. Currently, differing documentation and coding taxonomies, and/or lack of tracking of housing status, create an inaccurate picture of the needs.

## Core Theme #5: Medical Respite must center on Linkages to Permanent Housing.

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.

## Core Theme #4: Diversify financial support for system improvement and growth.

Who pays and how much funding is available for medical respite care is important to participants in the assessment. The current system in Albuquerque is solely dependent on Heading Home and Barrett Foundation contracts with four major hospitals and one managed care organization, and a small annual grant supports medical respite needs for patients at Albuquerque Health Care for the Homeless.

Models in other parts of the country have been able to acquire funding support from diverse partners and entities, which has benefited overall commitment to system improvements and collaborative problem solving.

# Medical Respite Landscape in Albuquerque

The primary location for medical respite services in Albuquerque is Albuquerque Opportunity Center (AOC), which is part of the non-profit organization called Heading Home. AOC is a large shelter for male individuals that are experiencing homelessness. The shelter is closed during daytime hours and clients must be away from the shelter until it opens again in the evening. A distinct section of the shelter is dedicated to medical respite patients and consists of 30 beds, shower and bathroom facility, common area, computer labs, library, laundry facilities, food services, and an outdoor courtyard. Individuals assigned to the medical respite beds stay in during daytime hours. AOC also provides contract administration services for Barrett Foundation's program, Barrett House, a shelter for female individuals experiencing homelessness, where 6 beds are set aside for medical respite services. Individuals who need medical respite care access the beds at AOC or Barrett House from one of four hospitals: UNM Hospital, Presbyterian Hospital, Lovelace Hospital or the Veteran's Administration Hospital, and from the managed care organization, United Healthcare. The contracts with AOC are for a specific number of beds, and pay $150 per day per bed, at 80% occupancy for their number of contracted beds. Medicaid and Medicare do not allow billing for medical respite services.

Patients in medical respite at AOC and Barrett House receive three meals per day, a place to keep medicines, and transportation to medical appointments. They are required to be ambulatory and able to perform Activities of Daily Living (ADLs), and must administer their own medications. Some case management is provided to patients by the respite coordinators at each location, but resources for case management services are limited. UNM students from the School of Medicine, College of Nursing, and College of Pharmacy visit AOC on a weekly basis and evaluate patients as part of a collaborative community-based and integrated professional education initiative. At Barrett House, Albuquerque Health Care for the Homeless medical providers make weekly visits to shelter residents and medical respite patients. In both cases, however, these medical services are not considered as formal service provision to the medical respite patients.

The hospitals work closely with the shelter coordinators at AOC and Barrett House to manage transfers into the beds and exits from the beds to the regular shelter services at these organizations. Because the referrals to the medical respite beds must exclusively come from contracting agencies, patients usually are coming from inpatient hospitalizations, and occasionally from the emergency department or an outpatient clinic within that hospital's system. Information about, for example, patients that needed a bed but could not get one due to level of need for medical services or availability, or occupancy peaks and valleys, stays within each of the hospital systems. Sharing plans and providing regular progress updates on individual health, housing and case management goals for medical respite patients does not appear to be a formalized aspect of communication between respite care coordinators and hospital discharge planners.

Another component of the medical respite service system is that of motel vouchers that are issued by Albuquerque Health Care for the Homeless (AHCH) medical providers to their patients, and to some extent by several larger health systems and MCOs. The providers assign motel vouchers, obtained through a grant from the City of Albuquerque HUD funds, when patients need shelter for recuperating and to have some temporary stability in order to go back and forth to the clinic for treatment or appointments. The voucher for a motel stay is part of an array of medical and case management services that identified medical respite patients receive through the FQHC that serves exclusively people without homes. In 2016 AHCH assigned 107 vouchers and stays averaged just over 2 weeks per individual or family receiving a voucher.

Skilled Nursing Facilities (SNFs) receive patients from hospitals that qualify for medical respite, insofar as their housing status, but that require a high level of medical care and so cannot go to the hospitals' contracted beds at AOC. Medicaid covers SNF placement for these patients, a result of the implementation of ACA and Medicaid expansion.

According to a SNF social worker, their facility is willing to admit a patient from one of the three hospitals that have contracts with AOC, because the eventual placement for a medical respite bed can be a condition of admission to the SNF. In other words, the SNF will not have to then find a safe discharge for the patient when they no longer are eligible for SNF services (Medicaid requires that they are making adequate progress in their treatment plan). Since the SNFs don't have contracts with AOC, they are not able to refer directly. Still, SNFs should be considered a critical player in the dynamics of our medical respite service system because, in addition to patients that they admit from hospitals with pre-arranged medical respite beds, they also admit patients that either lose their housing arrangements over the period of hospitalization and SNF placement, or that were already homeless but the patient's housing situation was not apparent.

**Because the referrals to the medical respite beds must exclusively come from the three hospitals, patients usually are coming from inpatient hospitalizations, and occasionally from the emergency department or an outpatient clinic.**

How does our system compare to national standards and other models? The chart below provides insights.

| Comparison Chart of Albuquerque's Medical Respite Service System | | | | |
|---|---|---|---|---|
| | | National Standards | ABQ | Other Models |
| 1 | **Accommodations and environment** | Standard 1: Safe and quality accommodations |  | Free-standing units (Phoenix, Boston, others) are clinical settings that must meet licensing regulations. |
| | | Standard 2: Quality environmental services Ex: Written policies for infection control, reporting communicable diseases, managing biohazards |  | |
| 2 | **Care Transitions** | Standard 3: Timely and safe care transitions to MR<br><br>Ex: reconcile medications, contact primary care provider, advance directives |  | Oakland: Tracking and reporting with primary care important in care transitions<br>Phoenix, Boston: Referrals originate from multiple sources |
| | | Standard 6: Safe and appropriate care transitions from MR<br><br>Ex: Patient knows placement options and has discharge summary & instructions, primary provider notified of discharge plans | | Phoenix: 75% of patients connected to housing at discharge. |
| 3 | **High quality clinical care** | Standard 4: High quality post-acute clinical care<br><br>Ex: Patient assessment includes physical and mental health, fall risk, pain status; an individualized care plan, and interdisciplinary, collaborative care provided. |  | Phoenix: 24/7 nursing and caregivers<br>Seattle: 12 hr/7 days medical, nursing and mental health services.<br>Coordinates clinical care provided by multiple, off- site providers. |
| | **Health care coordination Wrap around support services** | Standard 5: Health care coordination & wrap-around support services<br><br>Ex: self-management goal setting, navigate referrals and connect to primary care, counsel for housing connection |  | Oakland: Track and report readmissions and primary care connections<br>Phoenix, Boston: High rate of connection to housing for patients |
| 4 | **Data, tracking & reporting** | Standard 7: Care driven by quality improvement<br><br>Ex: Annual QI plan, safety training plan, patient experience of care survey |  | Unknown |

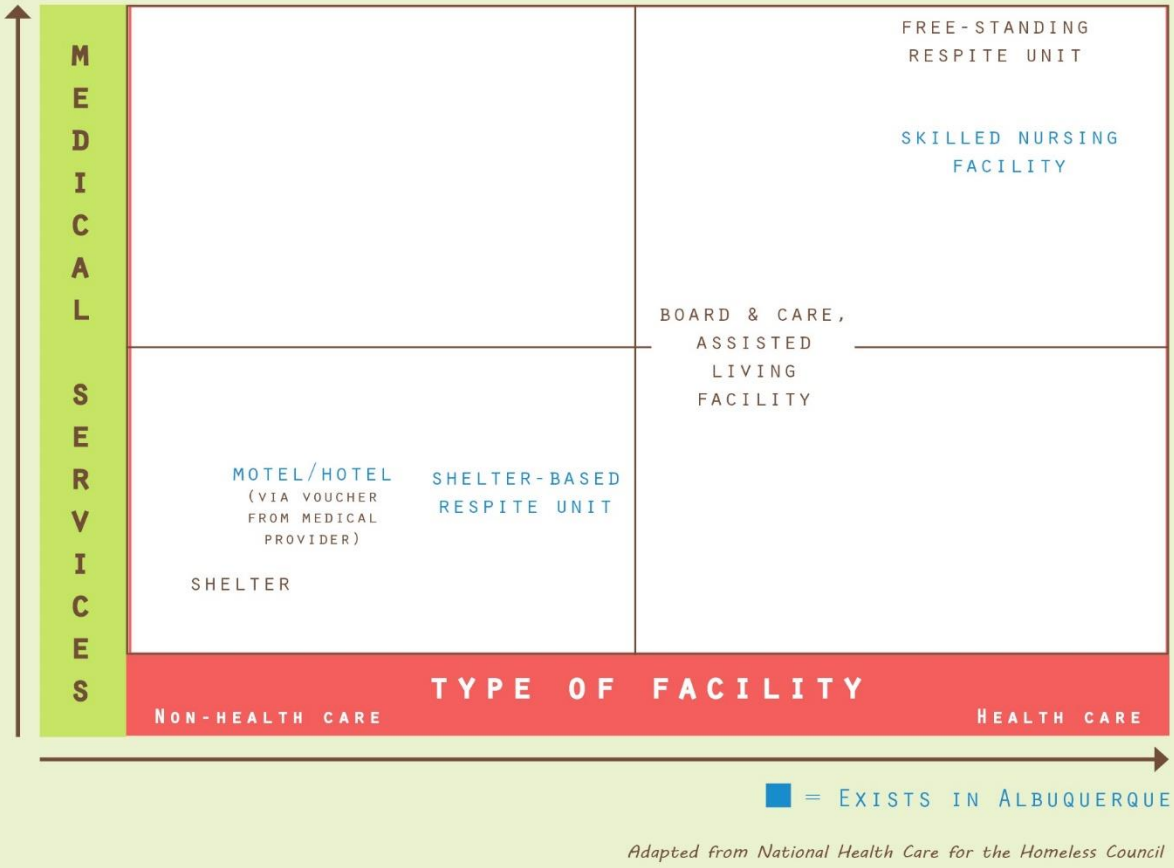
# Models to Consider

According to the National Health Care for the Homeless Council/Respite Care Provider's Network's (RCPN's) Practical Planning Guide there is a continuum of models that fall under the umbrella of Medical Respite services, and include two overlapping ideas: medical services provided along with the type of facility the services reside in, as seen in the diagram below. The most basic component of this continuum would be a discharge from the hospital to a general shelter bed, which would be considered by this paradigm a non-health care facility that provides little or no medical services.

On the other end of the continuum is the free-standing medical respite unit. This is a health care facility and individuals that are discharged from the hospital, or referred from the community, go to an environment that would meet the daily needs of shelter and nutrition, offer daily medical care, even complex care such as IV infusion therapy, and provide wrap around services to address the issues of homelessness.

Albuquerque's current medical respite services fall on different levels of the continuum of care, yet the organizations providing these services

## Types of Services Provided




*Adapted from National Health Care for the Homeless Council*

acknowledge, through their desire to delve deeper into the issue with a community needs assessment, that there is potential for more comprehensive services in our city.

The models of Medical Respite across the U.S. are as variable as the cities where they reside. The details of each program can be found in the 2016 RCPN's Medical Respite Program Directory and include a brief description of the philosophy of the program, a profile of the bed capacity and hours of medical services provided as well as the admission criteria. During this community needs assessment, the Assessment Team spoke with executive leaders for medical respite programs in Phoenix, AZ, and Seattle, WA. Circle the City is a 50-bed free-standing medical respite facility in Phoenix and the Edward Thomas House is a 35-bed medical respite unit located within a public housing complex across the street from the safety-net hospital in downtown Seattle. Circle the City is a relatively new program, opening their doors in 2012. Prior to this free-standing facility, the program operated 8 stay-in beds in a general shelter. Their growth from a lower level on the continuum of care to the most developed and comprehensive level was of particular interest to our assessment process.

### Circle the City
### Phoenix, AZ

- 50-bed free standing facility
- 24/7 nursing care and caregivers
- Referrals from hospitals (50%) and other entities (50%)
- Most patients are discharged to housing and not the street (75%)

Both transitions into and out of the medical respite program are important standards to consider when looking at how comprehensive a medical respite program is. In many cities, including Albuquerque, the transition to medical respite only happens in a single direction: the hospital refers individuals to respite program which follows the flow of funding or a single agency offers their clients access to an emergency service like motel vouchers. Hospitals pay for the medical respite beds and therefore use them for their own patients. According the Brandon Clark, CEO of Circle the City, the referrals for their facility come from hospital discharge planners (50%) as well as from out-patient clinics, MCOs and other social service agencies (50%). Individuals and families can self-refer via the web site and all referrals are screened by a case manager. This referral system allows different systems to use the beds in a more flexible manner; not only to provide extended care after a hospitalization to prevent readmission, but also to prevent an initial admission to the hospital. This model looks more like the spokes of a wheel with individuals able to access the hub (medical respite) from multiple access points.

Circle the City also focuses on the transition from medical respite to discharge back into the community. An impressive 75% of their clientele are discharged somewhere other than the street or an emergency shelter: 1/3 move to permanent supportive housing, 1/3 are discharged to temporary housing while the last 1/3 are reunited with family and friends.

Care transitions are optimized in other models, as well. The Barbara McGuiness House in Boston, MA which is a 104-bed free standing facility that uses street outreach, a very low-barrier access point, as a way to reach individuals who would benefit from medical respite. The Lifelong Medical Care program in Oakland, CA, while not a stand-alone facility, emphasizes tracking and reporting, including readmissions, primary care links, and housing status for patients using medical respite services.

# Conclusions and Phase II Data Collection

The assessment demonstrates that there is unmet need in our community for medical respite services, and provides some understanding of characteristics of the need, such as level of medical care that is available in our current settings, and the limitations on where referrals can originate, as examples. But the narrow data flow in our current social model of respite makes it very difficult to understand what the demand for services is, both in volume and in types of services, and what utilization and transitions are in terms that would be relevant at a broader level beyond hospital bed counts. Because of the direction of referrals to the established programs from the hospital, neither AOC nor Barret Foundation can speak to the absolute need for respite beds in our community. Contracted hospitals stay in close communication with those organizations and only request transfers for the space they know is available.

Understanding the need for medical respite services in our community is hampered because the entry point into respite is from a high-level, tertiary point of care: the hospital. A strong connection to primary care and allowing other service providers to identify possible candidates for respite care would mold a more person-centered, patient-centered system.

Albuquerque currently has a social model of respite care administered primarily by Barrett Foundation and AOC. Data collected in Phase II of this assessment indicates an unmet need for a higher-level of medical care in a respite setting. The information presented in Phase II provides a deeper understanding of the level of medical care needed for the purposes of developing a medical respite system in Albuquerque.

# Phase II Data Collection

Medical providers at Albuquerque Health Care for the Homeless (AHCH) utilize motel vouchers as a form of respite for clients. Data collected on motel voucher referrals from the AHCH Medical Clinic are as follows:

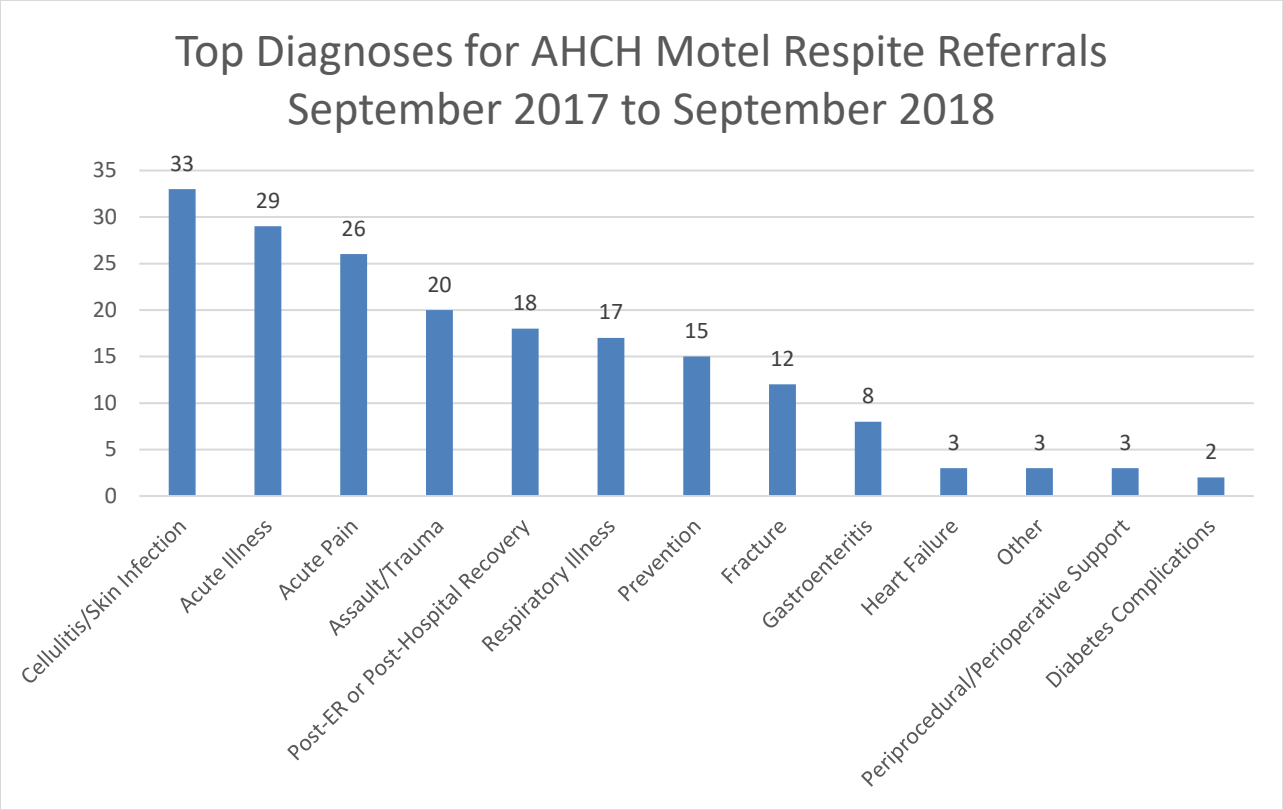
**Motel Voucher Referrals by AHCH Medical Providers September 2017 to September 2018**

| Gender | Average Length of Stay | Count of Gender | Average Age |
|---|---|---|---|
| Female | 7 | 87 | 45 |
| Male | 8 | 101 | 47 |
| Transgender | 7 | 1 | 23 |
| **Aggregate** | **8** | **189** | **46** |

Of AHCH clients receiving motel vouchers from September 2017 to September 2018, demographics were as follows: 53% male; 46% female; and 1% transgender. In AHCH's overall client demographics for 2017, 63% were male and 37% were female. There is a slight increase in the percentage of female clients that are provided with referrals for motel respite. The average age of clients receiving motel vouchers for respite is comparable to the average age of AHCH's overall client demographics.

The length of stay for clients receiving motel vouchers from AHCH medical providers are largely dictated by funding streams. Each voucher is typically issued for a time period of 7 days with recurring vouchers provided when additional days are determined medically necessary by medical providers. The average length of stay for the 2017 to 2018 time period was eight days.

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



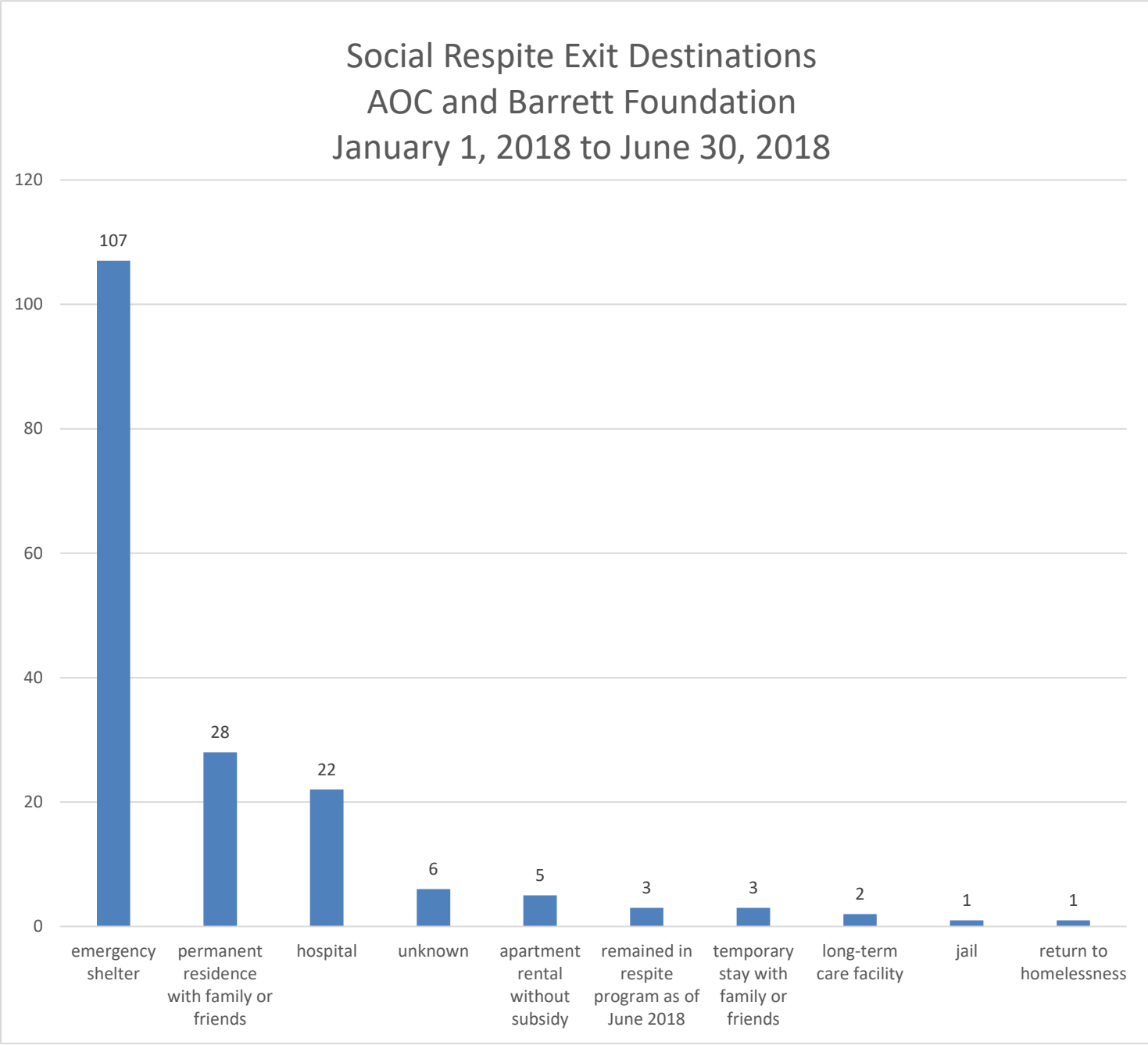

The top reason for referral to motel respite from AHCH medical providers during the period of September 2017 to September 2018 was for cellulitis/skin infections accounting for 17% of all referrals. Acute illness accounted for 15% of referrals, followed closely by acute pain and assault or trauma. The "prevention" category includes diagnoses that put individuals at high risk for severe morbidity/mortality on the streets. The "other" category includes diagnoses that do not fit into the other 12 identified categories such as hypothyroidism.

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.[ii] [iii] 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).[iv]

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);
- conditions of the Genitourinary System including urinary tract infection and prostatic

hypertrophy.[v]




The above data from Barrett Foundation and AOC points to a need for permanent supportive housing vouchers and additional case management in our community. Additionally, the relatively high percentage of exits back to the hospital indicates a need for higher level medical care. A medical respite program must include permanent housing resources and dedicated case management to successfully transition clients into housing.

The National Health Care for the Homeless Council echoes this importance "case management activities are integral to helping medical respite program patients access needed services and transition from the medical respite program into housing. …Nearly every medical respite program in the United States links patients to a primary care provider and assists patients in understanding the patient-provider relationship. Linkages are also made to appropriate behavioral health and specialty care."[vi]

There is also an identified need for family respite. No solution currently exists for someone in a family unit who needs a respite bed. For example, if a mother needs a respite bed, and has two children, the hospital or managed care organization (MCO) would have to pay for three respite beds, which hospitals and MCOs are not willing to do. Additionally, if a family unit includes males and females, and one of them needs respite care, they will have to be split up between respite programs.

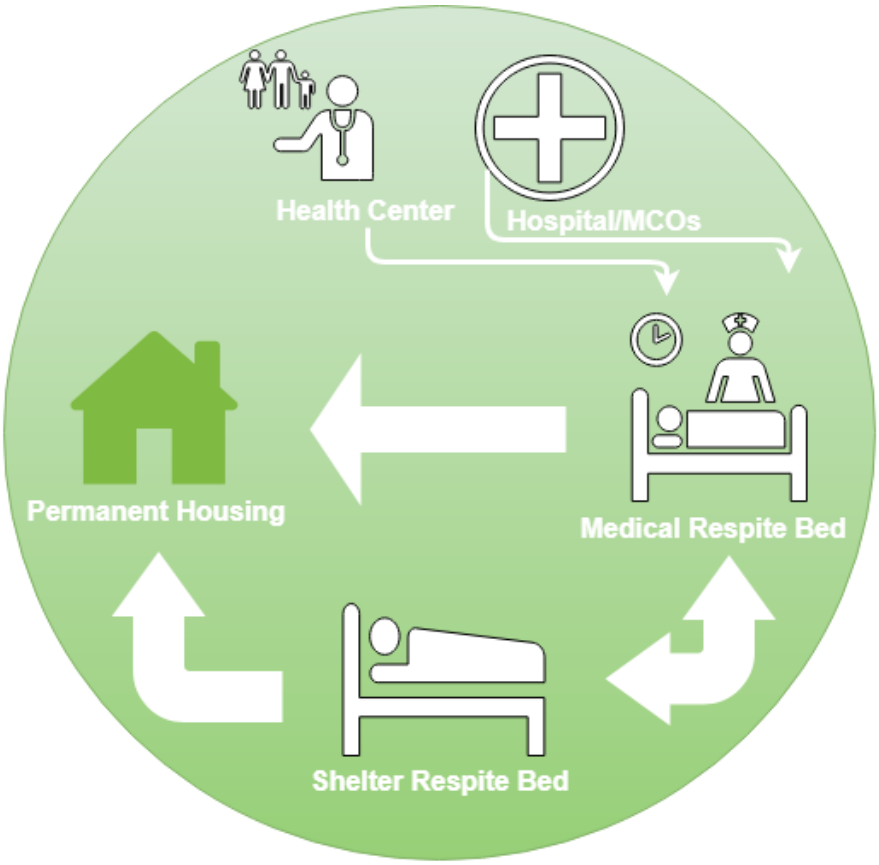
# Recommended Medical Respite Model

Based on the above data from Albuquerque's main respite programs, a medical respite model that follows the following values is proposed:

1. **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.

2. **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.

3. **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. Medical Respite programs will neve discharge clients back to the street.




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

**Direct Link to Housing through Housing First and Intensive Case Management**

## References

[i] National Health Care for the Homeless Council. (2016). 2016 Medical Respite Program Directory: Descriptions of Medical Respite Programs in the United States. Retrieved from http://www.nhchc.org/resources/clinical/medical-respite/tool-kit/medical-respite-programs-united-states/

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[iv] 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.

[v] Ibid.

[vi] Ibid.