Medical Respite Programs for Homeless Persons: Survey on Relationships with Hospitals

Respite Research Task Force

2008

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INTRODUCTION AND METHODS

In Spring 2008, the Research Task Force of the Respite Care Providers' Network developed and then conducted a survey of known medical respite programs for homeless persons across the United States to develop a profile of if/how those programs were relating with hospitals in their communities. Of the 32 surveys sent (via post and e-mail), four of the programs were no longer in existence of were unable to be contacted. Twenty-four (24) of the remaining 28 programs submitted surveys (86% response rate). This report briefly summarizes the findings from that national survey.

Survey Respondents

T-1

Location of Survey Respondents Alphabetical by City Name	
Bakersfield CA	1
Bangor ME	1
Boston MA	1
Chicago IL	1
Cincinnati OH	1
Dayton OH	1
Denver CO	1
Ft Lauderdale FL	1
Houston TX	1
Indianapolis IN	1
Miami FL	1
Minneapolis MN	1
Missoula MT	1
New York, NY	1
Portland ME	1
Portland OR	1
Raleigh NC	1
Salt Lake City, UT	1
San Francisco CA	1
Savannah GA	1
Seattle WA	1
St. Paul MN	1
St. Louis MO	1
Washington DC	1
Total	**24**

HOSPITAL REFERRALS

Volume and Source of Hospital Referrals (T-2, T-3)

Half of these medical respite programs receive referrals from 1-5 hospitals in their area; nearly half (46%) receive referrals from six or more hospitals.

Two-thirds (66%) of the medical respite programs receive more than half of their referrals from area hospitals. The referrals typically come from a mix of public and private hospitals. For example, about half (54%) of the programs receive half or fewer of their referrals from public hospitals, while about two-thirds (67%) receive half or fewer of their referrals from private hospitals. It is relatively rare for programs to receive no referrals from public hospitals (8%) or from private hospitals (4%).

T-2

# Hospitals Directly Refer Clients to the Respite Program		
	Number	Percentage
1-5	12	50%
6-10	6	25%
>10	5	21%
Missing	1	4%
Total	**24**	**100%**

T-3

Percentage of Medical Respite Program Referrals That Come From… (N=24)		
Area Hospitals		
	Number	Percentage
<25%	2	8%
25-50%	5	21%
51-75%	8	33%
>75%	8	33%
Missing	1	4%
Public Hospitals		
None	2	8%
<25%	5	21%
25-50%	8	33%
51-75%	2	8%
>75%	5	21%
Missing	2	8%
Private Hospitals		
None	1	4%
<25%	11	46%
25-50%	5	21%
51-75%	3	13%
>75%	2	8%
Missing	2	8%

RELATIONSHIPS WITH HOSPITALS

Agreements (T-4, T-5, T-6)

Nearly half (46%) of these respite programs either have a written agreement with referring hospital(s) (38%) or are in the process of developing such an agreement (8%).

T-4

Does your Respite Program Have any Written Agreements with Referring Hospitals?		
	Number	**Percentage**
No	13	54%
No, but in process of developing	2	8%
Yes	9	38%
Total	**24**	**100%**

The elements most frequently included in these nine written agreements are: medications and patient information (n=7 each), followed by supplies/equipment (n=5). Physician or nursing care, access to labs and radiology, and daily reimbursement are included in fewer than half of the agreements.

T-5

Does your Agreement Cover the Following? **(N=9 – Only Those with an Agreement)** *Multiple responses accepted*	
	Number
Medications	7
Patient Information	7
Supplies/Equipment	5
On-going physician care	4
Nursing Care	4
Access to labs and radiology	3
Daily Reimbursement	1
Other*	5

* *Other* includes: financial support in annual grant; RCP staff contracted as onsite patient review; reimbursement of $2500/individual referred from ED or inpatient; TB clearance, meth maintenance referrals; they set up home health and meds for 14 days; doctor-to-doctor consultation; ability to refer back with no problem if needed

Example of A Respite Program/Hospital Agreement: Denver CO

Our respite program currently has a contracted with five hospitals to fund a total of six beds. The funding is provided on a yearly basis- so we receive that money even if the bed is not in use for a period of time. Prior to discharge, the patient has to come with a minimum supply of medication, all assistive devices needed. If they are in need of wound vacs, IV antibiotics, or oxygen therapy all of those arrangements must be made prior to discharge and the contracted agencies (home health, O2 supplier) must maintain service while the patient is in the respite program. Additionally, for those on IV antibiotics, the infectious disease group who followed the patient in the hospital must maintain oversight of labs, continuation of therapy, etc.

Hospital administrators were included in the establishment of seven of the nine written agreements.

T-6

Who was Involved at the Hospital in Establishing the Agreement? (N=9 – Only Those with an Agreement) Multiple Responses Accepted	
	Number
Hospital Administrator(s)	7
ED Staff – SW/Case Mgmt	4
Physicians	3
ED Staff – Nurse Managers	3
ED Staff – Discharge Planner	2
ED Staff – Physicians responsible for discharge	2
Hospital Board	0

How did you access individuals within the hospital who made a difference in developing this agreement?

- *Personal contact (3)*
- *Discussion with established contact regarding mutual patients and the barriers to discharge, burden of repeat ER visits*
- *It's a hospital-based program*
- *Multidisciplinary stakeholder meeting met for a year – follow-up meetings with Hospital Council*
- *Via MD who works in hospital and case management departments*

> *In my experience, on-going contact with case managers at various hospitals help to set the tone in terms of respite offering a safe alternative for hospital discharge planning. Those individuals helped to provide a collective voice which enabled the respite program to meet with the formal leadership to discuss utilization, cost saving, and liability\risk reduction for the hospital. – Respite Coordinator*

Subsidized Care (T-7, T-8)

Half of these medical respite programs reported that they receive some subsidized care from hospitals. This most commonly includes patient information (n=8/12), medications (n=7) or some other financial support (n=7).

T-7

Does your Respite Program Receive any Subsidized Care from Hospitals?		
	Number	**Percentage**
No	12	50%
Yes	12	50%
Total	24	100%
What Does This Include? **(N=12 – Only Those Receiving Subsidized Care)** ***Multiple responses accepted***		
		Number
Patient Information		8
Medications		7
Other financial support		7
Access to Labs and Radiology		6
Supplies/Equipment		4
Ongoing Physician Care		3
Staffing		2
Daily Reimbursement		2

One-third (34%) of these programs receive half or less of their annual budget from a hospital source, and two-fifths (38%) receive no funding from hospitals whatsoever. One-quarter of respondents did not know what percentage of their program's annual budget comes from hospitals.

T-8

Percentage of Annual Budget from Hospitals?		
	Number	**Percentage**
None	9	38%
<25%	4	17%
25-50%	4	17%
51-75%	0	0%
>75%	1	4%
Missing/Don't Know	6	25%
Total	**4**	**101%**

Communications (T-9, T-10)

Survey respondents were asked to identify whether their respite program staff have any of the communication arrangements with referring hospitals that are listed in Table 9, below. All said respite staff communicate with referring hospitals by telephone to discuss referrals and to complete patient assessments. More than half provide information sessions to hospital staff on respite program and its admission criteria (79%); meet in-person to discuss specific referrals (58%), and share general information about community resources for homeless persons (54%). One-quarter of the respondents indicate that their respite program staff also work within the referring hospital to screen or assess homeless patients.

T-9

Communication Arrangements with Staff from Referring Hospitals (N=24) ***Multiple responses accepted***		
	Number	**Percentage**
Communicate Via Telephone to Discuss Referrals/Compete Patient Assessments	24	100%
Informational Sessions on Respite Program/Criteria	19	79%
Meet In-Person to Discuss Specific Referrals and/or Do an On-Site Assessment Prior to Accepting Referred patient	14	58%
General Information about Community Resources for Homeless Persons	13	54%
In-Service Training on Homelessness and/or Homeless Health Issues	10	42%
Meet Regularly With Hospital Staff to Discuss Specific Patients/Cases	7	29%
Work as Staff in the Hospital to Screen or Assess Homeless Patients	6	25%
Other*	5	21%

*Other includes: annual matching of respite client data to hospital data to look at re-hospitalization rates; in-service on respite program; invite hospital to participate in Advisory Board; notify hospital via e-mail about respite

The most frequent barriers to developing even more or better relationships with hospital staff are lack of time (33%) and lack of staffing (25%).

T-10

Have Any of the Following Prevented You from Developing More/Better/Different Relationships with Hospital Staff? (N=24) *Multiple responses accepted*		
	Number	Percentage
Lack of time	8	33%
Lack of staffing	6	25%
Lack of specific contact person	5	21%
Specific rules of facility where respite beds are located	3	13%
Lack of formal agreement	3	13%
Hospital staff unsupportive of respite care	1	4%
Facility staff unsupportive of respite care	0	0%
Other*	3	13%

**Other* includes: hospitals are difficult to approach for funding; lack of ALFs that want to contract with us.

Discharge Guidelines (T-11)

Just one-quarter of these survey respondents said that their local hospital has standard discharge guidelines or practices specifically for homeless persons, though many (29%) are not sure whether these are in place.

T-11

Does your Local Hospital Have Standard Discharge Guidelines or Practices for Homeless Persons?		
	Number	Percentage
Yes	6	25%
No	11	46%
Don't Know	7	29%
Total	**24**	**100%**

Descriptions of Standard Discharge Guidelines or Practices (N=6)

Describe standard discharge guidelines

- Homeless patients assigned to social worker once identified as homeless
- Hospital-specific
- JCAHO

Guidelines appropriate for homeless people?

- More education on needs of homeless people would be beneficial
- Yes (2)

How consistently are guidelines enforced?

- Depends on the hospital – that's why it's important to train case managers at all hospitals
- Since former nurse manager is there – 100%

Respite Providers' Comments on Ideal Working Relationships with Hospitals

These respite program coordinators were asked to describe what the ideal working relationship between their respite program and a referring hospital would look like. The most frequently mentioned elements were: a formal agreement; funding; and quality communication. Below are their responses.

What would be an ideal working relationship between your respite program and a referring hospital?

Formal Agreement and/or Funding

- Formal agreement
- Formal long-term funding agreement for all medical related costs of the facility (i.e. medical staff, medical program costs, related administrative costs)
- 1) Formal agreement. 2) Funding
- Formal agreement and funding. The formal agreement, ideally, would include a hospital discharge plan for homeless patients co-created with the respite program staff.
- Funding with formal agreement.
- A formal agreement would be beneficial only if the hospital would help fund the program to ensure adequate staffing to handle the referrals. Proper funding would be ideal so that we would not have to worry about getting funds from somewhere else. Also, it would be great if all physicians, nurses, etc. would be helpful in understanding the needs of the homeless individual.
- Formal agreement (being signed next week!) and specific procedures for discharges into homelessness.
- A formal agreement with hospital funding and strong communication as well as an onsite relationship between hospital and respite staff.
- More respite beds.
- Formal agreement with mutually agreed-upon guidelines plus match funding.
- A formal agreement with several public and private hospitals to providing funding (along with other misc. funding) would be ideal. The hospital funding would be based on a number of beds, services and staffing (including 24 hour coverage). This would allow the program to services most of the patients referred by the hospitals and remove many of the limitations of the current program.
- Being funded for 24 hour a day staffing.
- If the hospital would recognize the vast amount of savings that our program provides as a respite center, and begin funding a portion of these dollars.
- Formal agreement, funding, medical support

Communication

- Early frequent verbal communication. Our doctors work in hospitals, the operational relationship is more important than the written agreement.
- We are the hospital – to have our own ALF/Nursing Home
- The relationship we have works for us right now. We accept referrals from the 3 area hospitals and foster a positive relationship. Since we have only 4 rooms, we appreciate the flexibility ownership provides.
- HCH staff liaison on staff at hospital – discharge planning, accept/deny referrals, coordinate transferring care and readmission.
- Any kind of communication.
- Referred patients meet our admissions criteria of homeless patients with an acute medical need. Hospital would agree to provide follow-up outpatient care for patients they refer including a mechanism to readmit the patient to the referring hospital if patients' condition becomes unstable and beyond the scope of care we are able to provide.
- We have an online referral process with our large public hospital that we can't replicate with the other community and university hospitals; the fax and follow-up referral process is cumbersome. In addition,

each of the hospitals has a different EMR and they don't communicate with one another. This makes follow-up and continuity challenging. Ideally, all hospitals would use the same referral mechanism and all of our EMRs would communicate so that we could track our patients more efficiently and effectively.
- The contracts in place are relatively new. Initially, one hospital funded two beds. This was a successful pilot project which enabled us to expand to other hospitals. Currently, the process seems to be working well. Because of the contracts in place, it has allowed respite staff to meet the case managers at area hospitals to discuss respite and build collaborative relationships.

Respite Providers' Advice on Developing Relationships with Hospitals

What advice would you give to a new/developing respite program about relating well with hospitals?

- Communicating effectively with all supportive staff at the hospital
- Begin with a true spirit of collaboration.
- Enlist the support of a key advocate (person or organization) with influence among hospital executives (e.g. HMO conversion foundation; collaborative health care membership organization; sympathetic public official; health commissioner).
- If possible, get a challenge matching grant from the HMO conversion foundation or other key local foundation sympathetic to homeless health issues. The challenge is to the hospitals to provide funding.
- Enlist the help of a sympathetic health educator, preferably a physician who teaches at a medical school or teaching hospital.
- Enlist the help of a data analyst or financial analyst.
- Enlist the help of someone who speaks "hospital" and/or speaks "business".
- Conduct an Internal Review Board (IRB) approved study at the hospital that treats the majority of homeless people. Captures information on the rate of hospitalizations and ER visits from people who are homeless. The work may be done with the help of students. It can be involved (manually pull a sample of patient records), but a quicker, easier approach is to request a computerized data file (have analyst help design the data request).
- Get free American Hospital Association data on hospital costs by region (med school library). For a subscription fee you can get hospital specific data through online services.
- Analyze the approximate financial impact of unreimbursed hospital costs for homeless people.
- Key advocate invites all hospitals (and some key government officials) to a joint meeting to discuss the results.
- Present the data is a professional business-style manner (e.g. PowerPoint) including financial impact. A knowledgeable physician should present the medical need. Financial analyst presents the data and financial impact. Business / hospital professional closes the presentation with the ask. Present the need from the perspective of the audience (i.e. brief focus on the patients' unmet needs, but a greater focus on the hospital's need to discharge sooner or prevent repeat visits to the hospital due to lack of healing – sounds cold and heartless but is necessary for success).
- Close with a folder including the slides from the presentation and a concise (one page) written bullet-point summary that ends with a call to action (hand this out at the end and discuss). The people sent from the hospitals to attend the meeting will probably not be the decision-makers. They will take this back to their executives.
- Be sure to suggest that the funding might come from the hospitals' "Community Benefit" budget. The IRS and state/city governments have been challenging the tax-exempt status of hospitals around the country. Tax-exempt hospitals look too much like for-profit hospitals (high executive salaries and some charity care. They must demonstrate that they provide community benefit significant enough to justify

continuing the status (tax-exempt status means no property taxes as well as no income taxes). Hospitals have set up new budget line items and even whole departments, called "community benefit". Homeless respite care should be highly consistent with the mission of most hospitals (and it saves them money). Even if a hospital has a separate foundation they will not want to pay you from the foundation. The money has to come from the hospital budget to count for this purpose.

- Don't forget public officials and the business community. The community benefits from homeless respite care in many ways, including financial. When a homeless person is treated at a hospital and cannot pay, the unreimbursed costs are ultimately spread across all customers. Everyone pays more for health care when some cannot pay. So unnecessary hospitalizations of people with no pay source drive up costs for everyone.
- Follow through with the collaboration. Allow all funders to have seats on your board or on an advisory committee.
- Include HIPAA-compliant agreements to share patient data from the hospitals. Have patients sign HIPAA releases upon admission to allow data sharing. Gather data periodically (annually) to demonstrate that respite patients are not being readmitted to the hospital (or shorter stays). This is important to get continued funding.
- Publicly thank hospital funders for being heroes.
- Continue throughout with a true spirit of collaboration.
- With hospital funding and board members, it's sometimes difficult to walk that line between the needs of the clients and the hospitals' need to "save money". It feels slimy to talk about saving hospitals money when there are people dying on the streets, but it's necessary to get the attention and support of the hospitals. Never compromise your mission to help people who are homeless. This must always be the first priority. But at times you will have to continue to demonstrate the financial benefit to the community and to the hospitals to receive ongoing support. Work to bring the right people from the hospitals onto your board (i.e. ones who believe in the mission, not just look out for their money).
- Make connections with case managers and MDs, keep detailed notes of case studies and cases which went well, hold frequent meetings with hospitals and constantly work on relationship building and education of hospital staff re. homelessness and issues related to homelessness
- Be flexible, be clear, have good boundaries. Because of staff turnover in social services at referring agencies, periodic in-services need to be done.
- Make contact with the social workers. Most meet monthly as a group and you can attend a meeting to introduce your staff and services.

1) Set up regular meetings/in-services at the hospital with discharge planners, social workers, case managers, ER physicians
2) Try to get hospital administrators present at these meetings or separately.
3) Be a general resource re. homeless issues/requests for services, etc. for hospital staff
4) Make sure they are able to contact you – case managers, physicians, social workers – via phone and/or e-mail, particularly ER physicians
5) Provide your clinic's hours of operations, scope of services and liaisons with other homeless service providers
6) Let them know that you are trying to prevent unnecessary ER visits by homeless patients and instead, get them into your primary care
7) Discuss cost savings for hospital
8) Discuss efficacy of treatment outcomes with addition of respite care for homeless in your community

- Go and explain your program to the hospital social worker.

- Frequent contact with social work, ER staff is helpful to ensure the understanding of homeless patients and the program options to support patients at discharge.
- Do not get discouraged and keep soliciting them for funding. Continue to communicate with the appropriate staff and build good working relationships. Make sure to be clear on referral guidelines and stay consistent. It is important that they know your face and that you advocate for the client at all times.
- Get in there early. Sell respite program as a means to alleviate their problem.
- Get to know the discharge staff.
- Find out who does the placement and speak directly to them.
- Come visit the Recuperation Care Program in Portland to shadow us and experience how we interact with our hospitals or bring us with you to talk with your hospital partner regarding how they can benefit as well as ours have. Hospital funders are mostly concerned with shortened hospital stays and reduction in repeat ER visits but hospital staff see our biggest assets as ease of accessibility to the program, making their day and job easier.
- Stick with it, hospital attorneys will make this as difficult as possible, get sympathetic physician-champion.
- Highest priority is to meet the needs of the patients. Though a referral may be made which is outside the scope of what should be accepted, do what is right and best for the patient.
- Convene a committee of stakeholders that include folks involved in homeless healthcare (medical, substance use, psych, etc.) AND folks from institutions or agencies that haven't yet developed expertise in issues around homelessness. Encourage people to bring their concerns & questions to the table early. Ask each of the stakeholders what they need and what they're willing to give. Start meeting early & meet often. Develop clear MOU's before accepting patients; it's much easier to create a culture than to change a culture. Do not back down around things that are important. For example, for us several issues were deal breakers. Any hospital that could not commit to adhering to our referral process (including involving clinicians in the referral), to sending patients with a week's supply of meds, in hand, and to sending patients with a discharge summary, would not have access to respite. Many of the hospitals complained that they would never be able to convince their inpatient pharmacies to comply with the medications, but when push came to shove, they did.
  Once the respite facility is up and running, reconvene the meetings semi-regularly to update your stakeholders on your successes and your challenges. Start collecting data from the moment you open your doors – demographics, length of stay, discharge venues, etc.
- Initially meeting with hospital staff most directly responsible for discharge planning is key. Through presentations on the nuts and bolts of respite, who is and who is not appropriate, and the expectations of patients leaving the hospital can set a tone for clear and on-going communication.
  Maintaining consistency with the admission requirements and educating hospital staff on what cannot be safely managed in the respite program is a critical**.** I have found that discussing our limitations is as important as reviewing our available services.
  If someone is inappropriately or prematurely discharged, it is important to contact the facility and case manager (if available) to discuss the reason a patient is being returned to the emergency department. A small percentage of the time, this is a difficult conversation but I have found that a majority of the time it was a lack of understanding as to what the respite team is able to safely provide.
  Giving those directly responsible for discharging a tour of the respite facility also helps because they are able to see first hand the staffing, the living quarters, and the degree a patient is responsible for providing self care.
- Be sure you have hospital support before beginning project unless you have adequate money to care for very sick patients. Set up a community or interagency advisory committee before you do anything else.
- First establish the limitations of the program with the hospitals with explanations for the limitations. Attend staff meetings periodically to go over the program with the discharge planners and social workers. This provides you with an opportunity to refresh experienced staff and introduce the program to new employees while putting a face and name with the program. When accepting or declining a referral,

always speak with the discharge planner. Provide explanations for declining a referral and alternative solutions. Many discharge planners are not aware of the conditions of the shelter systems, both good and bad. Helping them be more aware would allow them to better serve the patient and understand the needs, limitations, and gaps in the homeless care system. Be flexible and accommodating without compromising the program. Remember that making an exception may mislead the discharge planners to believe the exception has become the rule.

- They should have written agreements regarding medications, primary care and follow-up specialty care.
- To consistently keep the dialogue open on the Administrative level: Having a consistent person that you are in contact with who will follow-up on issues of concern and work within the program guidelines would be great.
- Team up with an agency that is successfully working with the hospitals as it relates to respite.