Introduction to Medical Respite Care and Operational Challenges

Coming of Age: Medical Respite Care and HealthCare Reform

Respite Pre-Conference Institute:

National Health Care for the Homeless Conference & Policy Symposium

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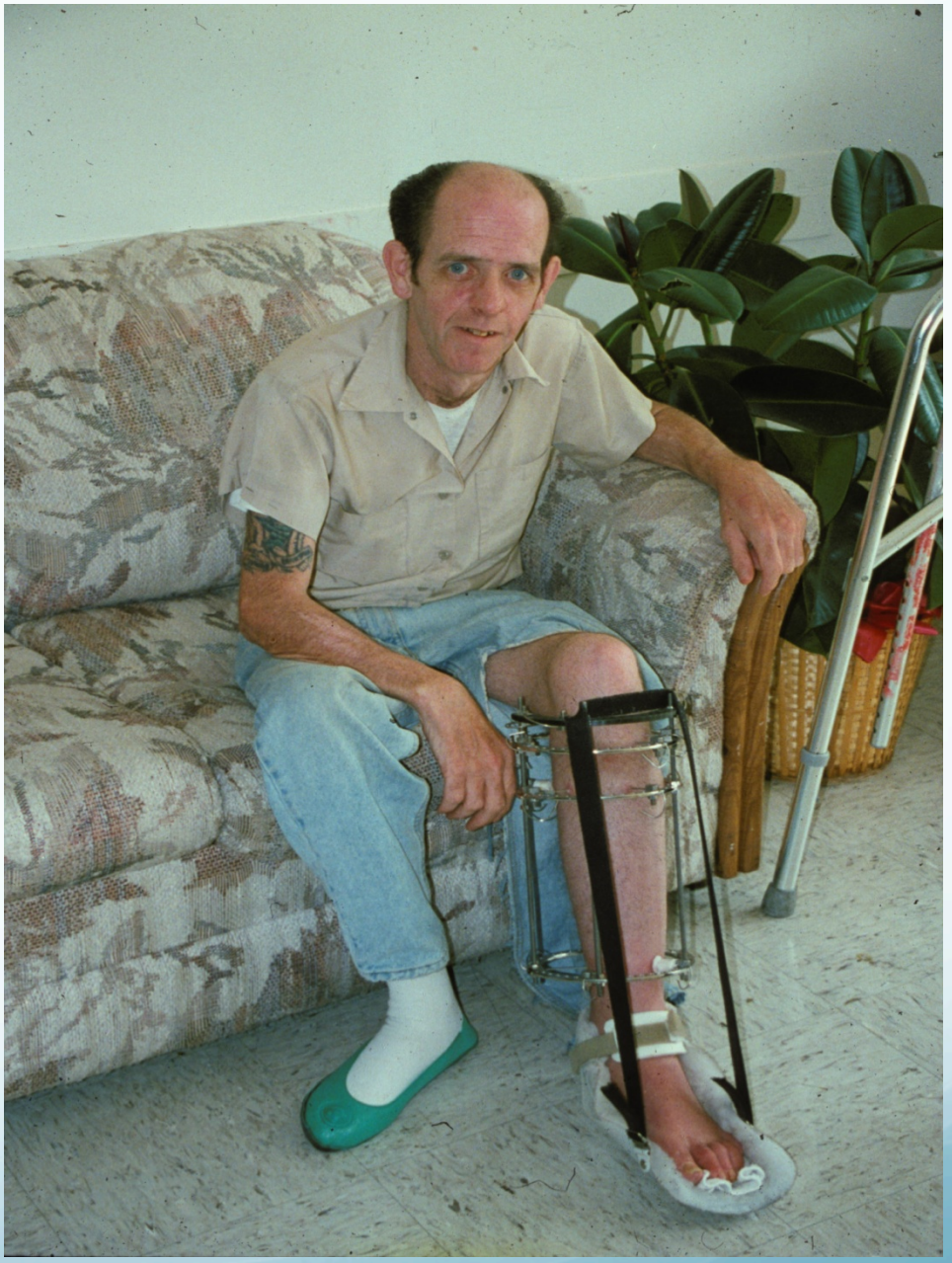
Homelessness and Mortality

- Boston cohort study of 28,023 patients (18,606 m, 9,417 f) *(Baggett et al 2012)*
- Mean age at death: 51
- Ca and heart disease leading causes of death with liver and lung ca the leading types
- Poisoning leading cause in 18-44 year olds and the third leading cause of death overall
- Stereotypical homeless deaths rare (2 hypothermia and 0 TB)

What happens when you are sick and homeless?

- Shelters send all guests to the street in the early morning
- Few have lobby privileges
- Frequent and unnecessary use of emergency rooms
- Exhaustion associated with making it through the day: no easy access to bathroom, bed, food, medication while feeling lousy

How would I walk the streets?



Respite Care for the Homeless

- **Too sick for shelter, not sick enough for hospital**
- **Respite from the rigors of the streets and shelter living:**
- **Respite from substance use**
- **“Home care” for those without a home**
- **Respite for homeless individuals** (Medicare defines the term differently: “respite for the care giver”)

Without a home and ready for discharge from hospital?

- Reliance on home care when discharged from hospital
- Families as care givers
- Care at home includes IV therapy, rehab, peritoneal dialysis, oxygen, transfer to & recovery from chemotherapy and radiation, preparation for endoscopy,
- Nursing Home refuses patient?

Challenges for Hospitals: Sick, Homeless and....

- Needs surgery and/or endoscopy
- Needs place to stay connected to cancer treatment
- Repeatedly uses Emergency Department
- Undocumented
- Sex offender
- Pregnant
- Alcohol dependent
- Mentally ill and not able to cooperate with care
- Alienated from family and supports
- Chronically ill, addicted, mentally ill

Respite Care Fills a Void in Services

- Although pressure on the beds is always high
- Respite staff have benefit of longer relationships with patients thereby facilitating outcomes no longer possible in hospitals where LOS is so short
- Creative, integrated, immersed care in hospitals
- Collaborative with hospitals and community partners
- Demonstrated positive outcomes and cases

Context for Respite Care

- Emergency shelters typically provide night shelter only
- Guests arrive late afternoon
- Line up for meal and shower
- Emergency cot for the night
- Shelters open doors at about 6am and guests are discharged to the street


When sick –how do you climb into a top bunk in Emergency Shelter?

What is Respite Care as it applies to health care for homeless individuals? "Home healthcare for those without a home"

- Medical/nursing ("home care") to a person who has no home
- Short term (LOS <3 weeks) for resolution of illness
- For homeless who are "Too sick for shelter, not sick enough for hospital"
- Resource for hospitals, decreasing admissions and LOS
- Respite Care is an essential part of the continuum of health care services for the homeless post-acute and chronically ill people of our cities and towns and rural communities
- Not housing, but may link folks to housing resources

Benefits of relationship with hospitals: Barbara McInnis House Hospital **2,533** Admissions FY11

- Emergency Department **9%**
- Ambulatory Clinics (day surgeries, endoscopy) **34% of admissions**
- In-patients from all major Boston Hospitals **26% in-patient admissions**
- **70% of admissions come from hospitals**

High Users of Emergency Department of one hospital

- Boston Medical Center
  - 35 people over 8 months (Oct ‘09 – June ‘10)
  - $3,629,907 paid to BMC =
  - $103,712 average per person in 8 months!

Hospital Length of Stay Nationwide

- Average length of stay for those aged
- 65 or older is 5.5 days
- 45-64 years is 5.0 days
- 15-44 years is 3.7 days

- Source: National Health Statistics Report 2008: Hospital Discharge Survey 2006, CDC

The impact of homelessness on length of hospital stay in New York City

- "Because many excess days among the homeless could not be explained by clinical or demographic factors, it appeared that *lack of discharge options was a major reason for longer stays.*"

The impact of homelessness on length of hospital stay in New York City.

Salit SA, Kuhn EM, Hartz AJ, Vu JM, Mosso AL. *AHSR FHSR Annu Meet Abstr Book*. 1995; 12: 111-2. New York City Health and Hospitals Corporation, NY, 10029, USA.

Respite Focus

- Short-term care for medically ill or injured homeless patients
- Goals:
  - ◊ Resolution of acute medical process
  - ◊ Bridge the gap between hospitals and shelters
  - ◊ Window of opportunity to engage into services
  - ◊ Initiate the process of lifestyle stabilization
  - ◊ Decrease hospital utilization and costs

Respite = Opportunity

- Opportunity to reflect and change
- Nutrition and rest and recovery
- Prevention (Pneumovax, PPD, colonoscopy etc)
- Connects individuals to health care
- Housing process may begin
- Benefits (health insurance, SSI/SSDI)
- Mental health assessment and intervention

Potential Roles

- Fill the service gap between hospitals and shelters
- Fill the service gap between hospitals and clinics
- Fill the service gap between SNF and shelters

Common Cases

- Skin and soft tissue infections
- Poorly controlled diabetes
- Respiratory illnesses
- Mandible fractures
- Peri-operative care
- CHF
- Cirrhosis

Acute Care

48 yo male presents to the ED with alcohol intoxication and LLE cellulitis and wound. Being discharged with 10 days of antibiotic treatment. Needs twice daily wound care.

What Can Respite Offer?

- Monitoring for resolution of infection
- Monitor antibiotic compliance
- Daily wound care
- CD counseling and referral
- Mental Health Screening and care/referral
- TB Screening
- Vaccinations
- Housing/Benefit Assistance/Vulnerability Assessment
- Primary Care referral

63 yo female presents to ED with nausea, chills and generally feeling poorly

- Can't recall her medical history
- Chart indicates h/o schizophrenia and sarcoid disease
- Off all meds, disengaged from all care

SH: Staying in various emergency shelters

Exam: 5X5cm irregular breast mass, scabies rash, flat affect with delayed responses to questions

Labs: Unrevealing

What Do You Do?

- Schedule patient for outpatient mammogram/ breast clinic follow-up?
- Admit patient for a inpatient work-up?
- Admit the patient to Medical Respite for a diagnostic work-up and formulation of a treatment plan?

Subacute Care in Respite

- Diagnostic evaluations for disenfranchised patients
- Pre-procedural care for colonoscopy or elective surgery
- Care during intensive treatment regimens (chemo, radiation Rx)
- Hospice care

39 yo female, poorly controlled DM in clinic.

- Erratic BG monitoring
- Erratic BG readings ranging from 50's to 400's
- Respite can offer:
  - Diabetic education
  - Feedback to provider on diet/compliance
  - Titration of meds to avoid complications

Stretching Borders to Fill Service Gaps

- Acutely ill or injured care
- Decompensated chronic medical problems
  - DM, CHF, Cirrhosis, COPD, HTN
- Diagnostic evaluation for disenfranchised
  - CXR nodule, breast mass, 24 hour urine tests
- Pre-procedure admissions
  - Colonoscopy, EGD, ambulatory surgery

Stretching Borders to Fill Service Gaps

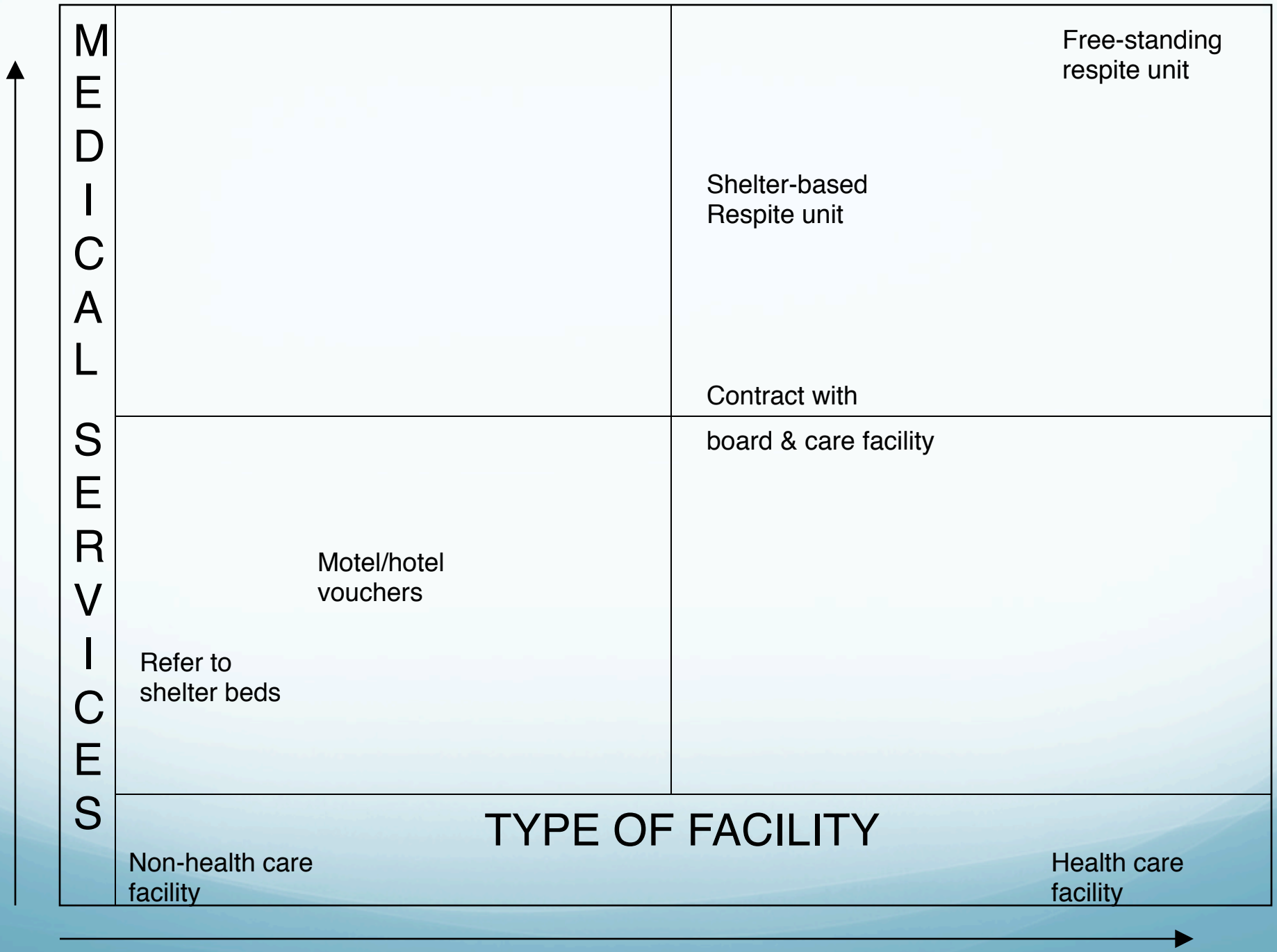
- Care during intensive treatment
  - XRT, Chemotherapy
- Care for clients not eligible for SNF's
- Hospice Care
- Successful care for behaviorally challenging patients
- Offering various levels of care: Utah and Seattle examples

Respite Care History

- NYC Dr. Brickner's Shelter Based Infirmary
- Barbara McInnis House, Christ House and Interfaith House 1993
- In 2000 10 Bureau of Primary Care respite programs
- RCPN Gathering in Chicago, 2001, meets annually
- Now 50+ programs

Models of Respite Programs

- Free standing facility
- Shelter based beds where guest stays in bed to rest
- Nursing component, medical component
- Motel rooms with medical monitoring
- Family Respite (motel, family shelter)
- Contracted service in a board and care facility


MEDICAL SERVICES
Free-standing
respite unit
Shelter-based
Respite unit
Contract with
board & care facility
Motel/hotel
vouchers
Refer to
shelter beds
TYPE OF FACILITY
Non-health care
facility
Health care
facility

Two Primary Models with Numerous Variations Combining….

- Range of intensity and type of services with
- Different facility options
  - Freestanding respite units
  - Shelter-based models

Advantages of a Free Standing Program

Ability to provide more comprehensive services– medical and non-medical with a more intense level of acuity

Respite program controls policies and procedures, and defines scope of care

Respite program controls environment (health and safety issues)

Challenges of a Free Standing Program

Identifying adequate funding to support needed services and operations

Takes time

Finding an appropriate facility

Possible licensing and zoning issues

Possible conflict from neighborhoods (if a new facility)

Advantages of Shelter Based Medical Respite Model

Uses expertise of existing programs (shelters for beds, health program for services)

Reduces facility costs by utilizing existing facility

May eliminate need for special licensing (depending on state law)

Encourages coordination and collaboration between agencies

Helps to demonstrate the argument for the need for respite care

Hospitals and other stakeholders benefit from having a safe place to discharge a patient to, may come to the table for the development of stand alone facility or expanded program

Demonstrates outcomes in making the argument for respite programs

Challenges of a Shelter Based Medical Respite Care Model

Shelters and health programs may have differing philosophies- ongoing tension

Possible conflict over admissions policies and control of the beds

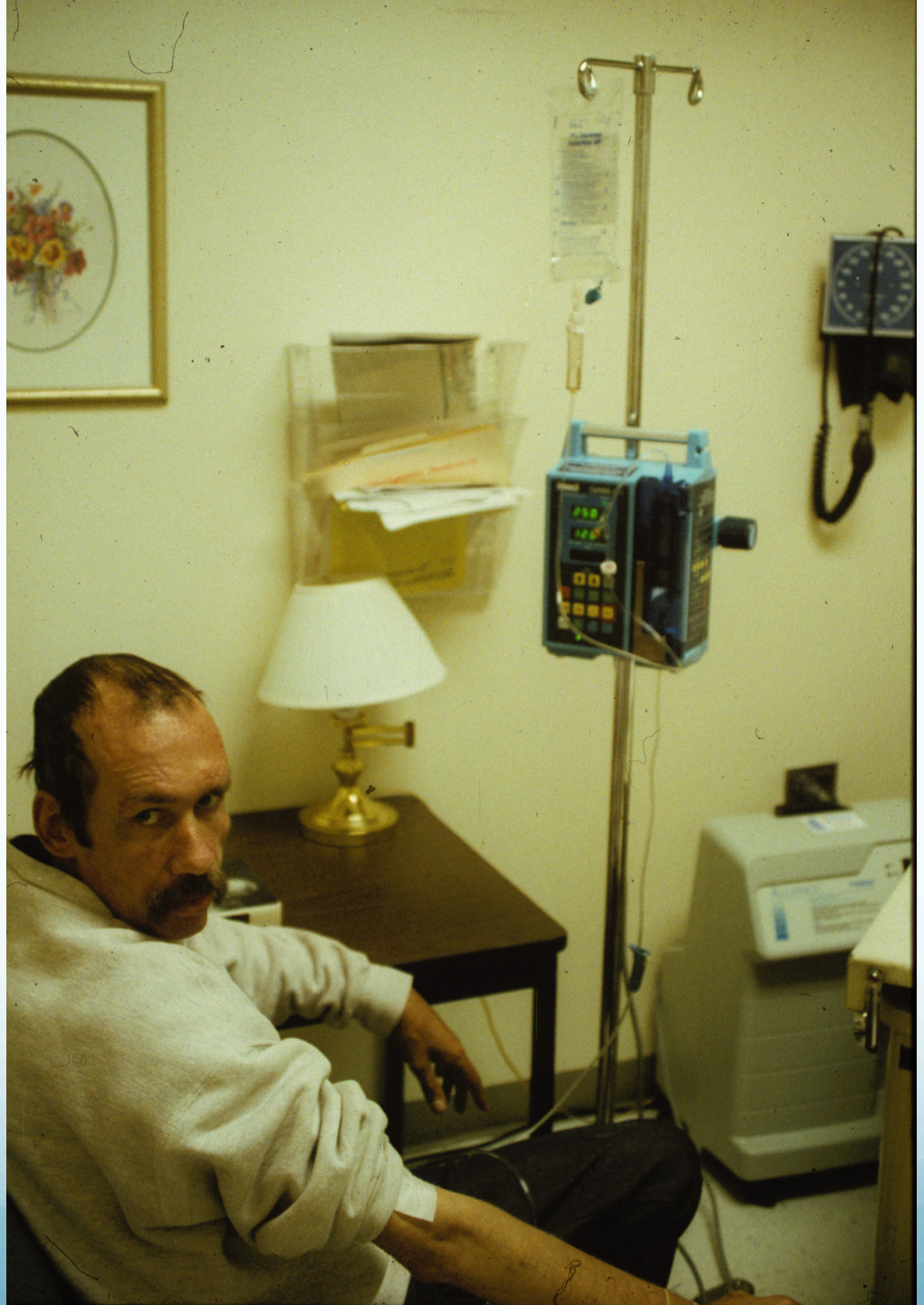
- Health care program has little control over health and safety issues in shelter environment
- Services are more limited, patients have to be quite stable, some patients are too sick to be in this model
- Sobriety is challenged in a shelter where others are misusing substances

Flexibility in the model of respite care

- Flexible model which continually changes and adapts to the needs of our patients
- Expands to include a place for patients to spend the day, transportation provided
- Flex the walls to fill the gap in services, whatever that may be

Defining the Scope of Care and Range of Services

- Ideally dependent on the needs of the patients served, community needs
- Practically dependent on funding, resources, space
- What is reasonable? What defines the basic level of care needed for the medical respite program?
- Who are those that require this care?



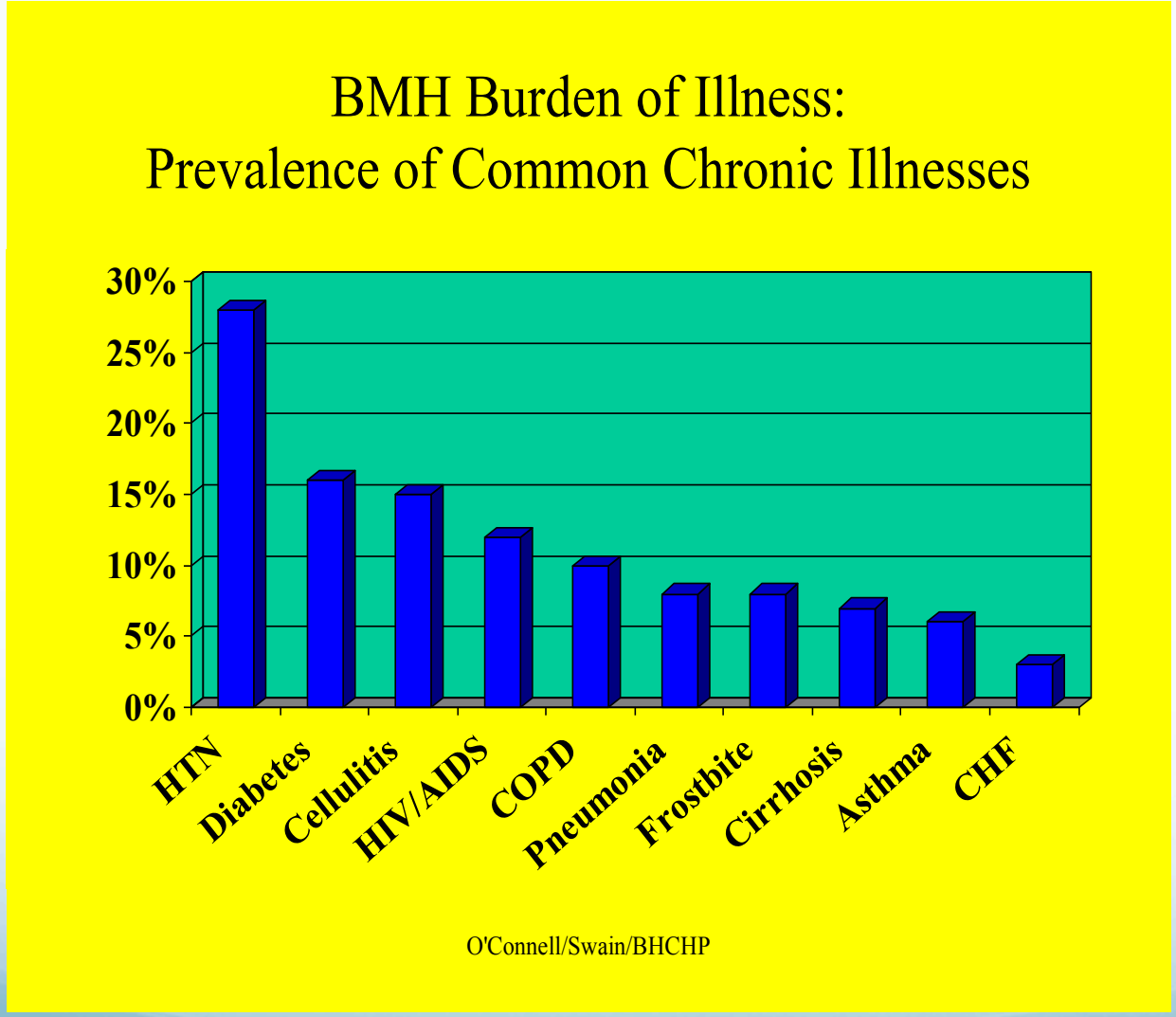
Respite Care does not compete with existing services or programs

- If eligible for other programs or services, patients should go there:
- Skilled Nursing Facilities ("nursing homes")
- State Hospital, DMH Respite
- Respite Care for Homeless patients **fills the gap in services**
- Pressure on beds is high, so if eligible for other program, patient should go there

Core respite services offered

- A safe place to prepare for procedures, recover from illness, trauma and surgery
- Recuperate with medical monitoring
- Nursing care varies from a few hours to 24/7
- Medical care varies from a few hours /week to daily
- Medical Detoxification for some programs
- Support services may include: food, laundry, transportation, mental health support, medications, security, case management, referral to specialty care

Prevalence of Common Chronic Illness



Balancing the need with census

- Filling the beds
- Assuring the mission
- Balancing the needs with available beds
- Pre-booked commitment to day surgeries or endoscopy
- Shelter and hospital partners needs

Respite Program Development

- While essential, medical respite care is rarely funded
- Most new and developing programs are shelter based
- Even with a stand alone facility, there will be the need for shelter based respite care to supplement the needs

Progression of Respite Services

- Set-aside shelter mats/beds for day rest
- Nurse &/or other provider on-site at shelter
- Designated respite space in shelter
- Meals/Laundry/case mgmt on-site
- Non-shelter respite facility with daily medical care
- Gradual enhancement of services/staffing
- Tiered system with various coexisting levels

Respite Funding

- Federal grants
- State Medicaid
- PHD
- Hospitals
- Private Funders
- Ideal: Federal multi-agency funding from HUD, BPHC, CMS, SAMSHA, VA

Billing for Medical Respite

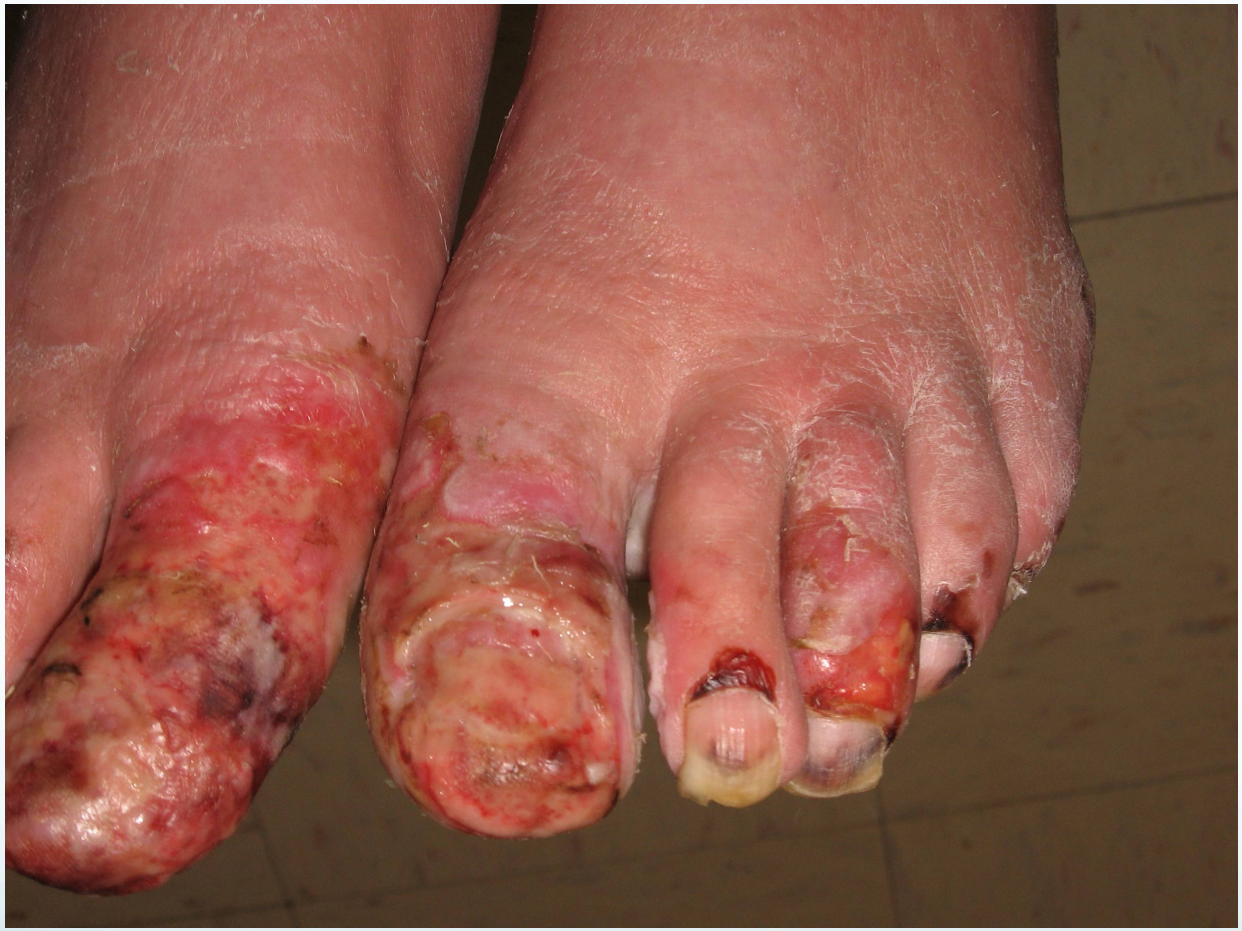
- Medical Respite is not a designated reimbursable service by CMS
- Negotiate with state Medicaid
  - WA state per bed night pilot $
  - State can apply for a CMS waiver
- Bill for ARNP/PA/MD Home visits
- Bill hospitals for each referral or bed night

Hospital Buy-In

- Gather data on homeless utilization in your area (formal or informal)
- Know the hospitals' priorities (this varies)
- Publicize/highlight cases of poor dispositions
- State requirements for safe/appropriate discharges
- Highlight "Million Dollar Murray" cases

2/13/06 New Yorker

- Highlight Success Stories



Health Care & Housing Are Human Rights

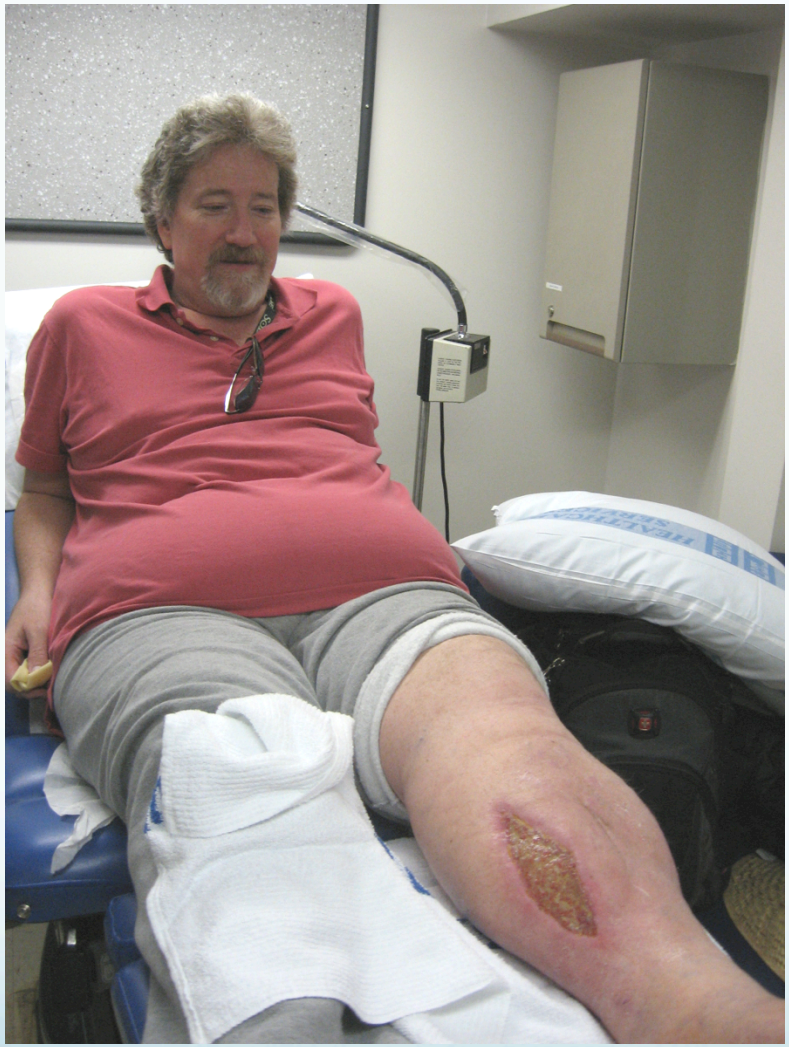
NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

Various Hospital Priorities

- Bed capacity/census
- ED capacity
- Appropriate lengths of stay
- High utilizers
- Ability to place homeless pts in SNFs
- Dispo for pts declined by SNFs
- Lengthy IV antibiotic hospitalizations
- Behavioral management of difficult pts

Respite Benefits

- Avoid emergency room visits
- Decrease length of stay, open up beds
- Offer safe discharge option
- Optimize health outcomes: respite care and f/u
- Offer expertise in behavioral management
- Address patterns of high utilizers by engaging in primary care, CD Rx, mental health services, accessing funding



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Hospital Buy-In

- Offer a central homeless triage staff to facilitate discharges
- Consider respite presence at hospitals
- Shelters return inappropriate discharges
- Regular meetings with affiliated hospitals
- Highlight other cities with programs/map
- Bring an RCPN representative to meet with the hospitals

Growth of Medical Respite

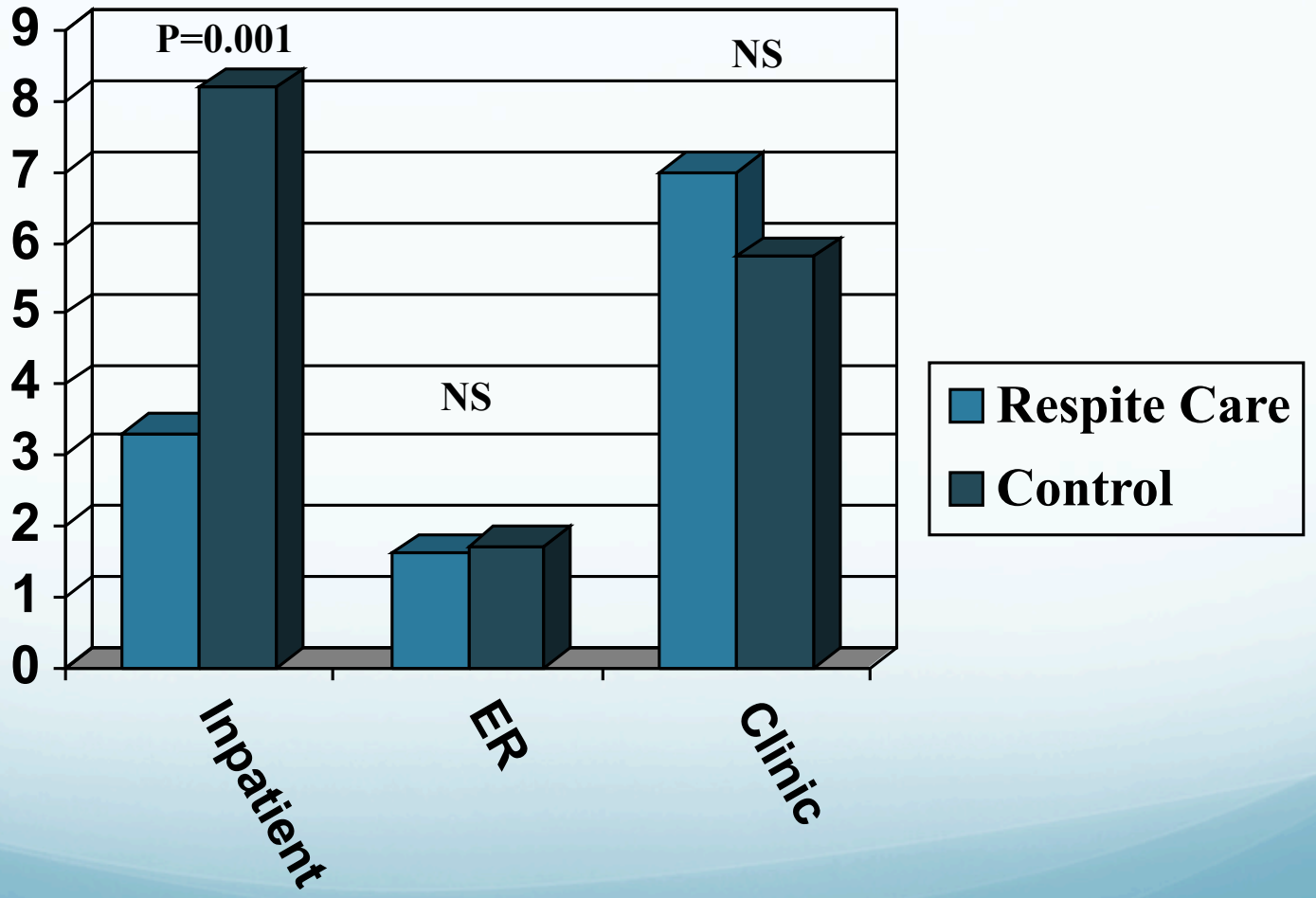
Health Care & Housing Are Human Rights

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Respite decreases utilization and costs

- Interfaith House study, Chicago (Buchanan, Doblin, Garcia, JGIM 2003)
  - 2 year retrospective data review of Cook County Bureau Services for 12 mo following respite care (N=226)
  - Control group respite eligible but no beds
  - Respite clients had 60% fewer hospital days
  - Cost Savings of $5,439-$13,680/client

Results - Controlling for Gender, Race, Diagnosis, Prior use



BPHC Pilot Initiative

- Multicenter qualitative evaluation of impact of Medical Respite
- 10 respite sites participated
- Statistically significant improvements in all measures

BPHC Study Outcomes

- Improved Severity of Illness
- Increased access to primary care
- Improved housing status
- Increase in health insurance coverage
- Increased benefit acquisition: Food Stamps, GAU, Employment, SSI, SSDI
- Statistically Significant Measures

Boston Health Care for the Homeless Program's Barbara McInnis House

- McInnis House is now 19 years old
- Stand alone program 104 beds
- 24/7 nursing care with majority of patients admitted from hospital
- NP/PA visit per day 7 days/week, MD on call
- ALOS <18 days (20 minutes to 109 days)

Boston Admission Criteria

- Must be Homeless
- Have an acute, post acute medical illness
- Be Too ill for shelter
- Be independent in Activities of daily living (bathing, dressing, transferring, ambulating, eating.)
- Not homicidal or suicidal
- Additional screening re TB etc
- Be on **Emergency Room High User List**

Additional Nuances to Admissions Processes

- Accepts sex offenders
- Accepts patients with no discharge options, but with close review
- Negotiates with SNFs in patient management
- Special review of patients who are on Re-admission Criteria List
- Behavioral plans for patients with past difficulties in compliance
- Careful review of medications for frequent admissions (“double dipping”)

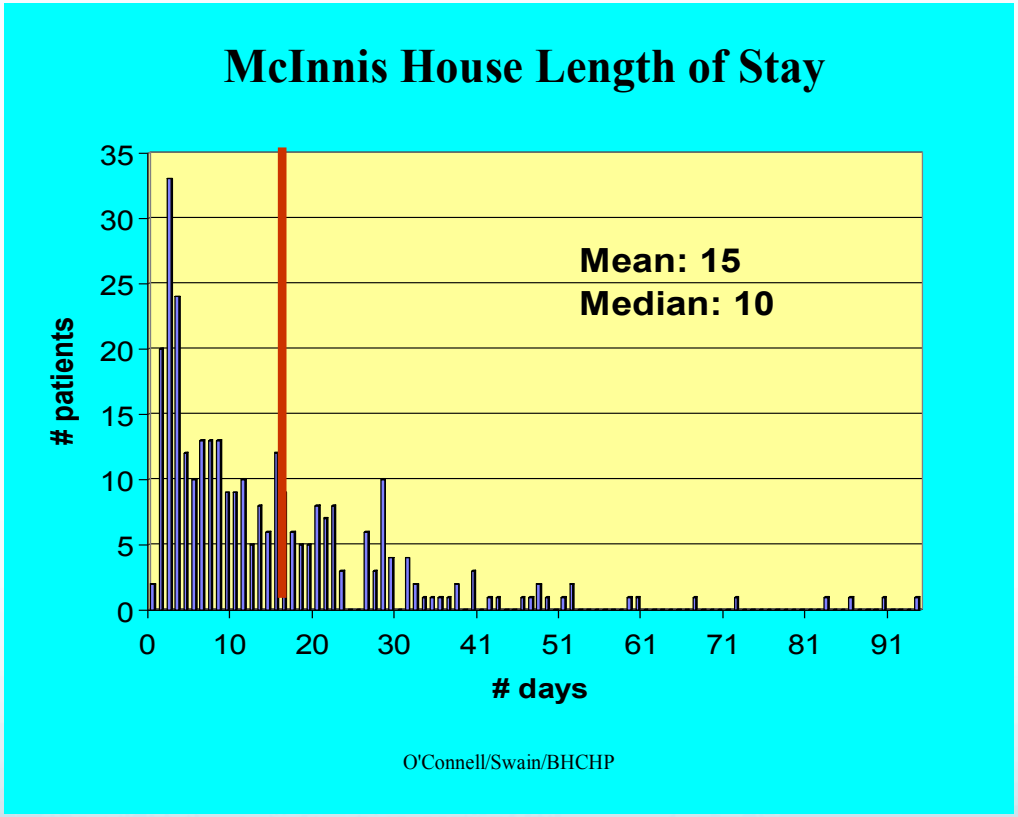
Admission Form and referral process (admit 24/7)

- Priority given to most vulnerable
- Require referral by a RN or medical provider for admission to be accepted
- Hospitals and other programs complete the referral form and fax it over
- Fast track admissions process for *High Users**
- Unusual situations reviewed and cleared by medical director in collaboration with program director, nursing director and psychiatrist
- *High Users of Emergency Services

Re-Admission Criteria

- Past experience at respite provides information about future stays
- Patients with known past difficulties at respite: incorporate this into treatment plan to assure success with next admission
- Treatment agreements, limit visitors, outside appointments, random urine screening, no drop-offs or gifts from others

Length of Stay



McInnis House Length of Stay

	FY08	FY09	FY10	FY11
Adms	1,574	1,701	2,049	2,280
Avg LOS (in days)	19.5	20.2	17.1	15.3

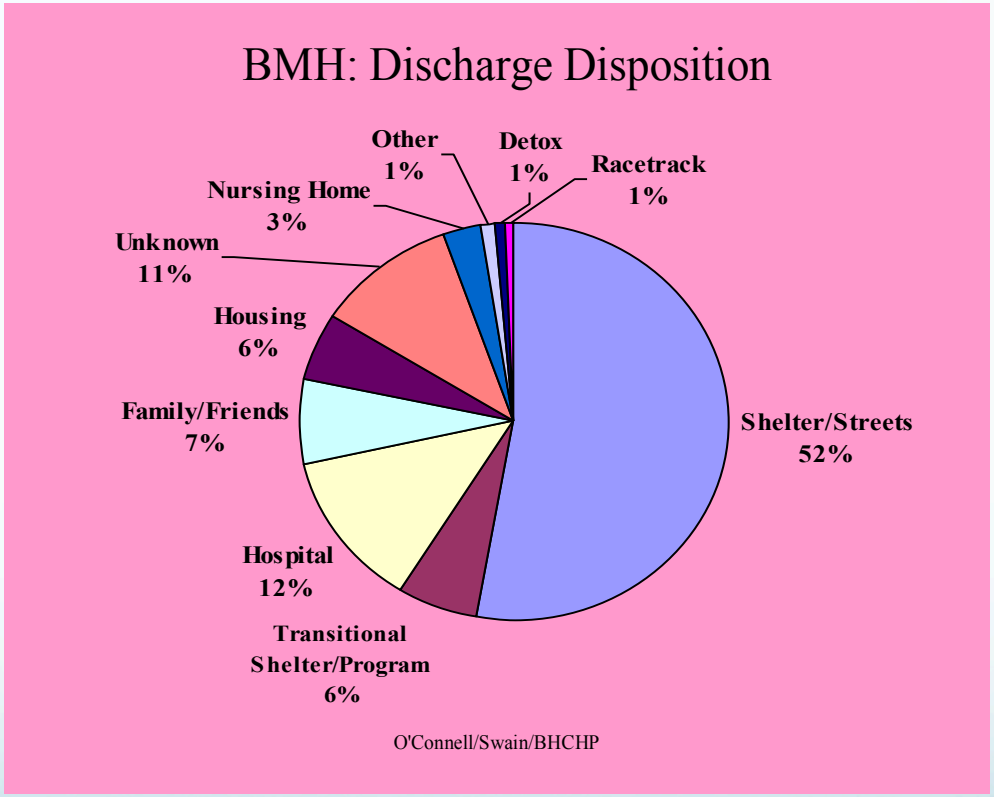
Projected admissions for **FY12** 2,533

Avg LOS 13.8

A place to stabilize when housed

- Former street dwellers now housed
- Former chronically homeless for procedures such as endoscopy, day surgery, short term medical re-stabilization
- XRT and chemotherapy for newly housed without supports
- Housed High Users

Discharge Disposition



Operational challenges

- As each medical respite care program evolves, policies are developed unique to each program's ability to care for patients
- Common practices
- Differences
- Local mandates which affect practice

Operational Considerations

Admissions Processes and Nuances

Ability to care for sex offenders

Medical Necessity and Length of stay

Pain management and end of life care

Methadone Maintenance

Smoking, alcohol, other addictions

Safety

Behavior and clinical indications

Discharge processes

Administrative Discharge processes

End of Life Care

- 82 year old, followed by BHCHP at race track, diagnosed with cancer, mets to spine has reduced mobility, not fully independent in ADL's "but almost"
- Well known to respite, loved by staff
- Asks to come to respite for end-of-life care, does not want nursing home
- Prognosis estimated to be six months

Admission from Prison: Sex Offender

- Patient discharged from 30 year incarceration
- Squamous cell lung cancer diagnosed in prison
- Treated with chemotherapy at state hospital
- Not sick enough to be admitted to hospital and so sent to McInnis House
- Discharged to nursing home for long term care
- Unusual discharge

Transplant: Recipient and Donor

- Pedro 48 end stage renal failure
- Victor, married, father of 3 kidney donor
- Both admitted pre-op for surgery on 5th month
- Surgery 6th
- Victor returns on the 10th
- Pedro on the 11th
- Month long stay for respite and follow-up
- Return to apartment

Street Dweller: Failure to Thrive

- James 77 years old
- Homeless since the 1980's, left home at age 12
- Mentally ill followed by psychiatrist
- Range of chronic medical problems (See next page)

Medical Problems

- ONYCHOMYCOSIS, TOENAILS (ICD-110.1)
- ANGIONEUROTIC EDEMA (ICD-995.1)
- Hx of BENIGN PROSTATIC HYPERTROPHY (ICD-600.0)
- DEPRESSION (ICD-311)
- SHOULDER PAIN, CHRONIC (ICD-719.41)
- PALPITATIONS, OCCASIONAL (ICD-785.1)
- DEGENERATIVE JOINT DISEASE, CERVICAL SPINE (ICD-721.90)
- HIP PAIN, RIGHT (ICD-719.45)
- LEG PAIN, RIGHT (ICD-729.5)
- INGUINAL HERNIA, RIGHT (ICD-550.90)
- CARPAL TUNNEL SYNDROME (ICD-354.0)
- MALAISE AND FATIGUE (ICD-780.79)
- PSYCHOTIC DISORDER NOS (AXIS I) (DS4-298.9)
- LEG EDEMA, BILATERAL (ICD-782.3)
- PAIN IN JOINT, HAND (ICD-719.44)
- COUGH (ICD-786.2)
- BACKACHE NOS (ICD-724.5)
- ? of CELLULITIS/ABSCESS, FACE (ICD-682.0)
- LACK OF HOUSING (ICD-V60.0)
- Hx of COLONIC POLYPS (ICD-211.3)
- ? of HEMATOCHEZIA (ICD-578.1)

McInnis House August10-February 2012

- Not able to follow routines of the McInnis House
- Not keen on personal hygiene or any structure
- Fired multiple urologists
- Team successes in care
- Discharged to nursing home

The Role of Respite with Housing First

- Connection, stabilization
- Identifying steps needed to housing
- Building the relationships to care and housing
- The McInnis House team as housing specialists and partners with Street Team and Housing program


Peanut Butter


Chef BOYARDEE
Mini-Bites
Mini Spaghetti & Meatballs
Cheesy Burger MACARONI
Cheesy Nacho TWISTARONI
Mini Pasta Shells & Meatballs
STOP & SHOP
SPAGHETTI MEATBALLS
In Tomato Sauce
BEEF
Ravioli

Growing Pains: Medical Necessity and LOS

- Pressure on beds from hospitals
- Need to justify length of stay with medical needs of the patient
- Medical Director, Director and Case Management review all patients over 20 days on weekly basis
- Team interventions by Medical Director to challenge readiness for discharge

Seattle Program History

- 1995 Continuum of Care Committee identified need for respite services
- 1996 HUD McKinney Grant funded 12 respite beds, shelter based
- 1997 HUD Expansion Grant: 22 beds
- 2000 BPHC Pilot Grant enhancement $
- 2002 State Medicaid Pilot $ for 1.5 yrs


2030


Respite 2


WILLIAM BOOTH CENTER

Seattle Respite: New Direction

- 2004 enhanced/altered respite services needed
- 2004-2011 planned new respite program
- Sept. 2011 Ed Thomas House opened
  - Free standing, 34 beds
  - Harm Reduction Philosophy
  - Enhanced MH/CD/Medical staffing
  - Higher acuity patients (medical and MH)

Seizing the Opportunity to Affect Long-term Change

52 yo homeless male referred for leg wounds.

PMH: Chronic lymphedema with recurrent wounds, HTN, Schizophrenia

SH: Homeless since the 1970's, slept on a mat at emergency shelter, resistant to engaging

Referral Process

- Refine: Select appropriately/avoid barriers
- Define Admission Criteria
- Formalize admission process to distribute to referral facilities and homeless clients
- Admission orders/standing orders
- Who will screen/accept admissions?

Referral Screening

- Ambassador role!
- Resource for non-respite options
- Accessibility & Timely response
- Efficient, clear process
- Prioritizing referrals
- Ability to accept late admissions
- Outreach education

Referral Screening

- Does patient want to come?
- Is patient appropriate for your level of care?
- Is patient appropriate for your setting?

  Alert: contagion/violence/SA/ortho/dispo needs
- Does the pt have necessary meds/supplies?
- Achievable medical goal?
- Scrutinize pain control/discharge pain meds.
- Provide alternative resources if pt is declined.

42 yo male with heroin dependence referred for Pneumonia.

- Respiratory symptoms for 1 month
- Vital signs are stable and he is on oral antibiotics
- He is independent in his ADL's
- Do you have any questions for hospital team prior to respite admission?

Pneumonia Referrals

- Where is the infiltrate? Clinical course? Does TB need to be ruled out?
- HIV and TB
  - CD4 counts < 200, CXR can be normal or infiltrate could be in any location
  - Consider rule out TB prior to respite admission unless clinical course clearly acute pneumonia

Seattle Admission Criteria

- Pt desires transfer to respite
- Pt is homeless
- Acute medical need
- Indep mobility, transfers, feeding, not a known fall risk
- Not in active EtOH withdrawal
- Behaviorally appropriate for group setting—no known risk SA/assault
- Exclusions: SO, contagious air-borne illness, fecal incontinence

54 yo female with history of BAD with COPD exacerbation

- Off psych meds, unwilling to engage in mental health care
- Not taking Rx prednisone and antibiotics
- Patient is agitated, angry and uncooperative with respite care and unresponsive to behavioral contract
- Patient is discharged by respite due to behavior

The Patient is referred again in 2 months for COPD

- Did you put the patient on a respite “bar” list?
- If barred, how long would bar last?
- Could the patient be put on a “Readmission Criteria” list stipulating that she in stable on psychiatric meds, engaged in mental health care and contracts to cooperate with care?

Case Example F

- 47 yo male in respite for infected wound
- Has crack dependency
- Still using outside of respite facility
- Not receptive to drug treatment
- Reasonably compliant with wound care and meds
- No behavioral problems exhibited
- Infection and wound are improving

What Are Your Options?

- Perform a urine toxicology screen and discharge patient if positive
- Perform a urine toxicology screen and contract patient to maintain sobriety, discharge at next (+) utox
- Continue to engage patient in discussion around use and options for treatment
- Implications of these various options

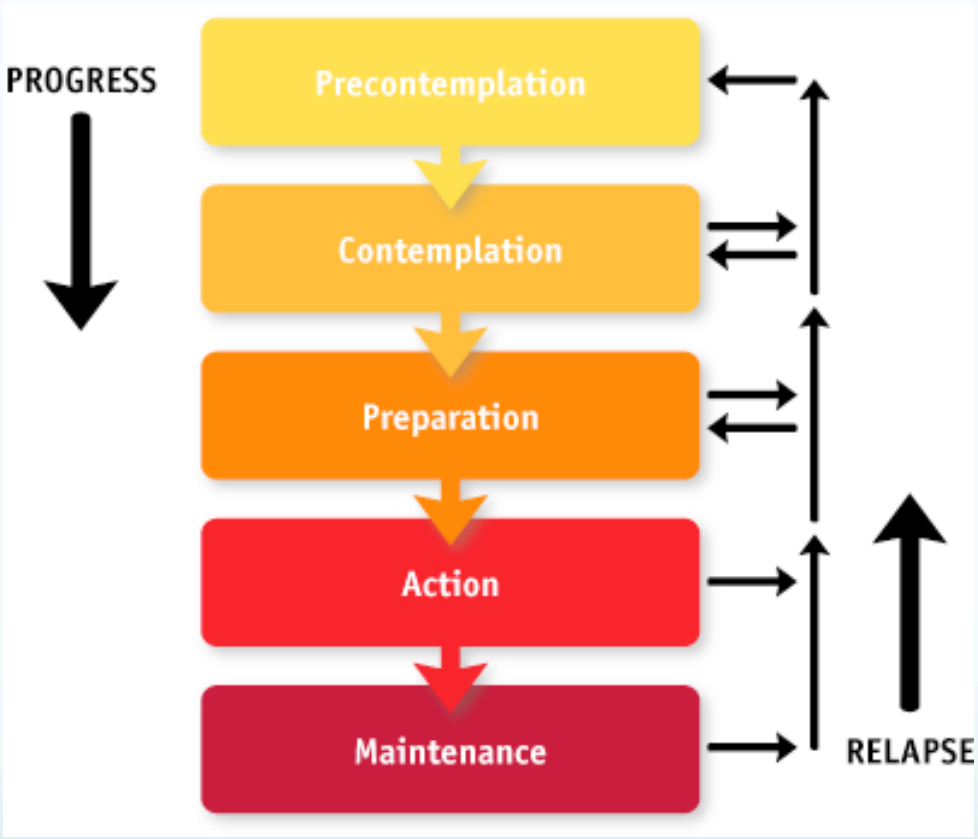
Chemical Dependency Issues: Seattle's Initial Approach

- Shelters were clean and sober facilities
- Intoxicated pts could be admitted
- Substance use in respite was confidential
- Substance use was tolerated for cooperative pts.
- Substance use or paraphernalia on-site resulted in discharge
- Shelter would discharge or contract pts actively using

Consequences of Differing Philosophies

- Tension between shelter philosophy and respite program
- Large numbers of respite pts discharged for SA prior to medical recovery
- Risk complications/readmissions/ED use
- Ultimately not meeting program mission

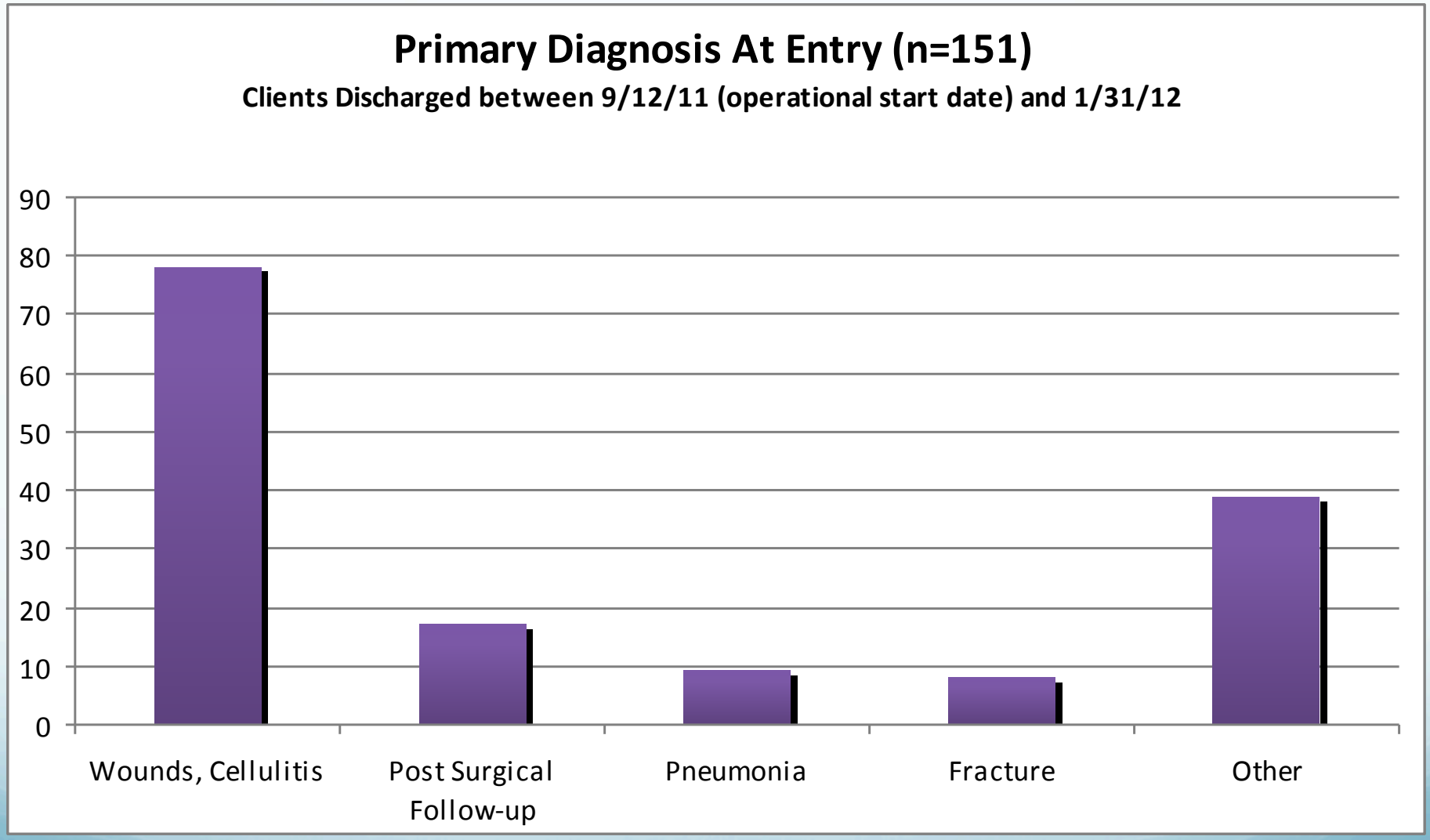
THE STAGES OF CHANGE CONTINUUM

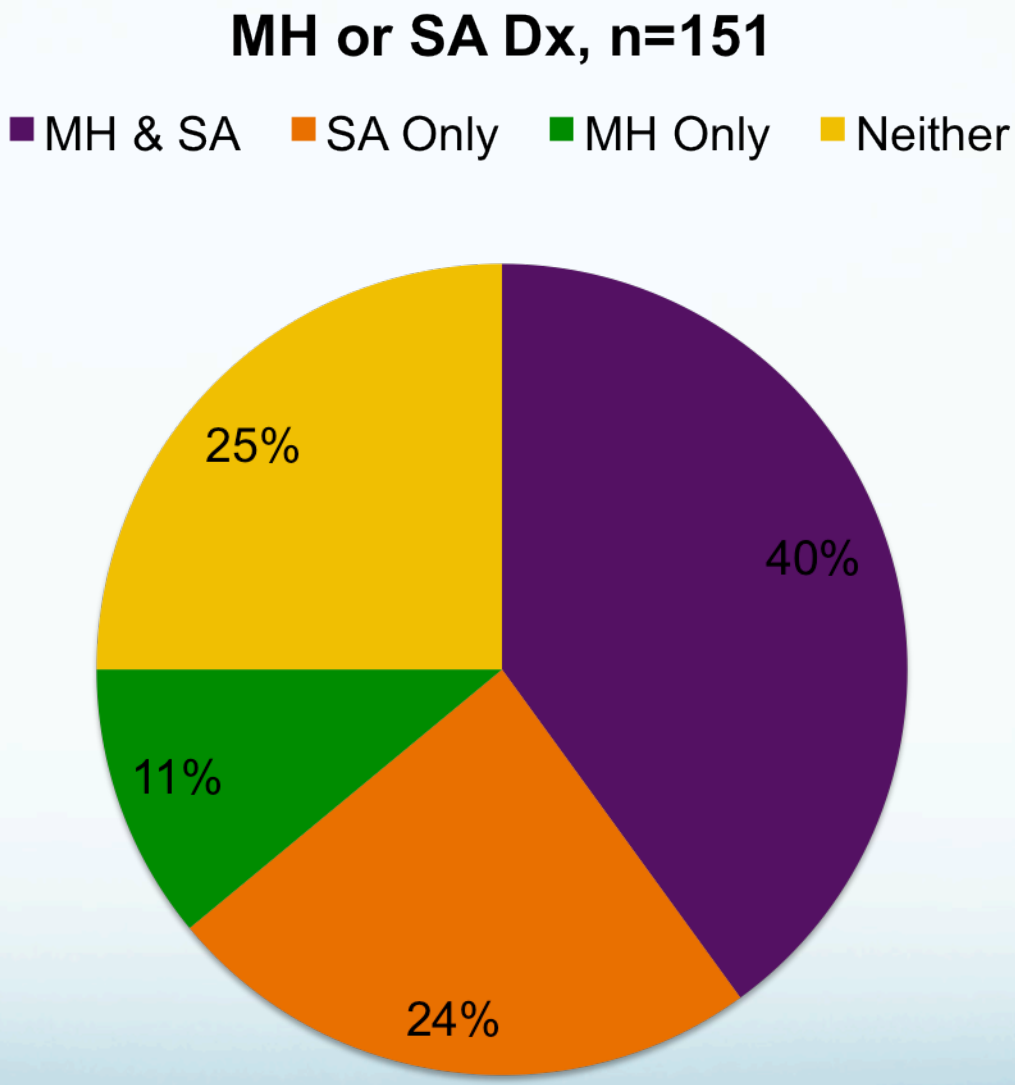


Source: Adapted from DiClemente and Prochaska, 1998

Harm Reduction in Respite

- If program is clean and sober, significant numbers of patients won't be served
- Many not be ready/able to abstain
- Pts still deserving of care when using
- Risks of not offering respite
- Offer spectrum of motivational interviewing, referral
- Retention/completion of treatment improved


Primary Diagnosis At Entry (n=151)
Clients Discharged between 9/12/11 (operational start date) and 1/31/12
90
80
70
60
50
40
30
20
10
0
Wounds, Cellulitis
Post Surgical Follow-up
Pneumonia
Fracture
Other


MH or SA Dx, n=151
MH & SA
SA Only
MH Only
Neither
25%
40%
11%
24%

How to Support a Successful Process?

- Difficult to witness self-destructive behavior
- Clarify case goals with team
- Weigh impacts of various decisions
- Offer venue for venting, discussion, support
- Training on harm reduction

29 yo male in respite for twice daily wound care

- Likes to sleep in, won't get out of bed for nursing visits--takes lengthy cajoling
- Nurse has 10 other patients to see and feels lack of time

What Can You Do?

- Give patient a warning then discharge next time he declines to see the nurse
- Team intervention to review admission agreements, negotiate a behavioral contract
- Impact: Tying up a bed from a patient that might need, and cooperate with, care
- Behavioral difficulties
  - Readmission criteria stipulations
  - Defined behavioral management process
  - Predetermined discharge dates
  - Venue for discussion and support with staff

52 yo heroin dependent pt referred for abscess wound care

- Pt underwent operative drainage of abscess and has a 20 X 10 X 5 cm buttock wound
- Patient was on high dose methadone and prn oxycodone in the hospital
- Hospital prescribes 30 pills of oxycodone at discharge
- Questions? Potential problems?

How will patient's pain be managed?

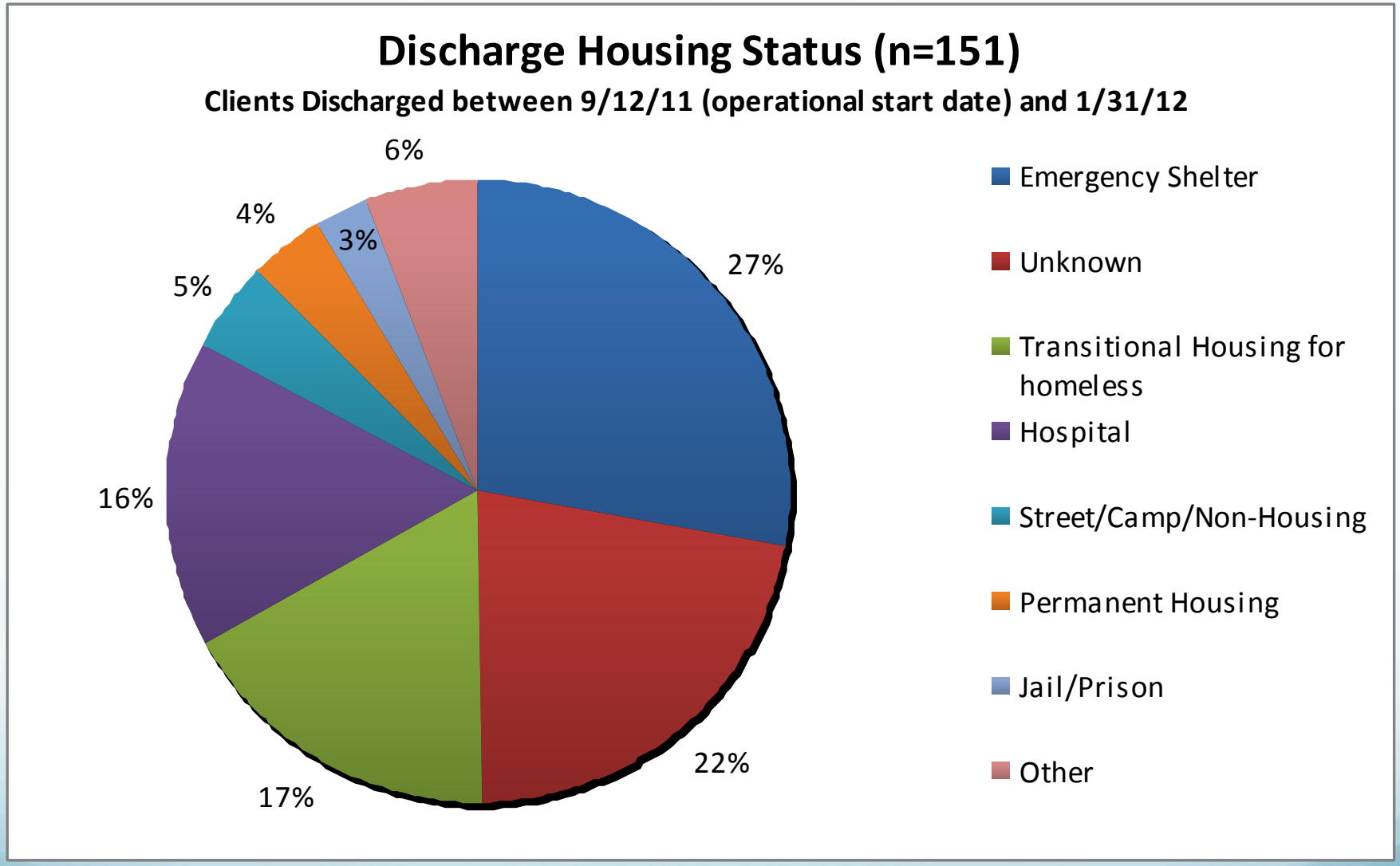
- Do you ask the hospital to Rx higher dose and quantity of narcotics at discharge? (Implications)
- Do you ask hospital team to initiate a pain service consult?
- Do you accept patient and send him to an ED or clinic for pain meds day 2?
- Does respite staff Rx narcotics
- Where will narcotics be kept

Challenges

- Pain management adds to complexity of care
- Difficult for PCP to manage opiate Rx
- Be prepared for potential overdoses
- If lack 24 hr medical supervision, plan protocol for non-medical staff in assessing sedation
- How will patients be monitoring for problems

Discharge Procedures

- Consider weekly team review to clarify medical status, disposition date/place
- Is the acute medical issue resolved?
- May defer discharge for outstanding diagnostic tests/consults
- May defer discharge for anticipated placement in CD treatment or housing
- Housing Challenges


Discharge Housing Status (n=151)
Clients Discharged between 9/12/11 (operational start date) and 1/31/12
27%
22%
17%
16%
5%
4%
3%
6%
Emergency Shelter
Unknown
Transitional Housing for homeless
Hospital
Street/Camp/Non-Housing
Permanent Housing
Jail/Prison
Other

Re-Admission Criteria

- Past experience at respite provides information about future stays
- Patients with known past difficulties at respite: incorporate this into treatment plan to assure success with next admission
- Treatment agreements, limit visitors, outside appointments

Medical Respite Care Resources for new programs

- nhchc.org Medical Respite Care website
- Directory of Medical Respite Programs
- Medical Respite Planning Guide
- Technical Assistance
- Medical Respite Research, Policy
- Sabrina Edgington, NHCHC Respite Support Staff

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