The Role of Specialized Medical Respite Care in Treating HIV Positive Homeless Adults

Lisa Silvestro, NP-C

Jennifer K. Brody, MD, MPH

Objectives

- Description of BHCHP's specialized medical respite care for HIV positive homeless adults
  - Key components
  - Case presentations of improved care
- Explore the clinical and public health benefits
- Replicability for other respite programs

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Homeless Medical Respite

- *Too sick for the streets or shelters, not sick enough for the hospital*
- Offers:
  - Acute and post-acute medical and nursing care
  - Safe shelter
  - After care planning assistance
- 57 respite programs across the US (and growing!)

National Healthcare for the Homeless Council, Medical Respite Program Directory, 2011

Benefits of Medical Respite

- Safe and humane option to institutions seeking to discharge homeless patients
- Stabilization of uncontrolled chronic illnesses
- Connection with primary care
- Cost effective
- Reduces hospital readmissions
- Social support and service-networking

Buchanan, et al JGIM, 2003; Podymow, et al CJPH, 2006; Buchanan et al. AJPH 2006

Barbara McInnis House (BMH)

- Clinical services
- Team based care (1 MD, 2-3 NPs, 1 case manager, 1 RN)
- 24-hour nursing care and medication dispensing
- Substance abuse referral/treatment
- Behavioral health
- On-site dental, optometry, podiatry, dermatology, neurology, and physical therapy
- On-site full service pharmacy

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Medical Respite at the Barbara McInnis House (BMH)

- Support Services:
- 3 meals per day
- Transportation and accompaniment to medical appointments
- Intensive case management
- Housing referrals
- Benefits enrollment
- Other: laundry, security, pastoral care, volunteers provide variety of recreational support services

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Barbara McInnis House (BMH)

- Funding Sources
  - Hospital
  - HRSA 330(h) funds
  - HUD
  - Medicaid
  - Medicare
  - Private donations
  - Foundations

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HIV+ Respite Patients

- Some of the most psychosocially and medically complicated in our practice
- Large number of HIV team patients in respite at any one time
- Prior to specialized respite team:
  - Low medication compliance
  - Fragmented care between in-patient and out-patient settings
  - Frequent hospital and respite admissions
- Believed that HIV specialized respite care would ***improve outcomes*** for our HIV positive patients

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Benefits of HIV+ Respite Team

- Continuity of care:
  - Between in- and out-patient settings
  - Between respite visits
- Improved medication adherence and retention in care after discharge
- Improved access to community resources
- Build rapport with providers
- Increase provider willingness to consider starting (or restarting) ARVs
- Improved ability to treat opportunistic infections more effectively

Ultimately hope to reduce AIDS related morbidity and mortality

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HIV Respite at BMH

- Team Based HIV Respite Care:
  - HIV-certified physicians and nurse practitioners
  - Case managers trained in HIV-based social services and housing
  - Access to HIV trained pharmacologist, behavioral health providers, and onsite infectious disease specialist
- Weekly case conferences between in-respite providers and case managers and outpatient team
  - Respite team MDs also on outpatient team

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HIV Respite at BMH

- Over last 2 years:
  - **104** unique patients seen in HIV specialized respite
  - Average of **2.48** visits
  - Average length of stay was **13.8 days**

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The cases…

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Case 1: Patient FC

49 y.o. woman with advanced AIDS (CD4 16) dx 1993, PSA, and hx of unintentional drug overdoses, infections including PCP pneumonia, endocarditis, and severe c.difficile colitis requiring colectomy, hx of PTSD, anxiety, and bipolar depression

- Not on HAART due to non-compliance/refusal
- Discharged from suboxone program due to ongoing substance abuse
- Frequent utilizer of ER and hospital services
- Intermittently housed

Case 1. Patient FC

- 9 admissions to BMH in the last 2 years primarily for:
  - Medical stabilization following acute hospitalizations
  - Stabilization of her substance abuse
  - Bridging to substance abuse programs after housing loss

Case 1: Timeline of Respite Admissions

Admission Date	Reason for Admission
November 2010	Parotitis
February 2011	Found down
March 2011	Drug relapse/ nausea/vomiting
March 2011	Colostomy reversal
April 2011	Post-op pneumonia
July 2011	Skin abscess
December 2011	Crack cocaine relapse/ candidiasis
February 2012	C.diff/UTI
March 2012	PCP PNA, start ARVs

Case 1: Achievements

- Connected her with substance abuse treatment programs
- Restarted her on suboxone once in residential substance abuse program
- Tapered her benzodiazepines in monitored setting
- Provided safe place for recovery from ileal anastamosis, so that she would no longer need to have colostomy bag
- Provided safe place following hospitalization from PCP pneumonia and other acute illnesses
- **Fostered trust, rapport building with HIV team that ultimately led to her to accept ARVs, started in February of this year**

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Case 2: Patient JS

53 y.o. woman with AIDS, pulmonary embolus, disabling systemic sarcoidosis requiring steroids which led to multiple complications and to her becoming wheelchair bound

- Thought to be infected with HIV by her ex-husband, difficulty accepting her HIV diagnosis, struggled with depression and isolation
- Came to Boston from out of state to be closer to family, but had a falling out and became homeless for the first time in her life
- First referred to respite following a hospitalization for DVT and a new HIV diagnosis

Case 2: Timeline of Respite Admissions

Admission Date	Reason for Admission
August 2009	s/p hospitalization for DVT/ new HIV diagnosis
November 2009	s/p hospitalization for PNA
March 2010	Coordination of care for sarcoidosis work up, mgt of complications of tx
November 2011	Stabilization of sarcoidosis flare
December 2011	s/p hosp for urosepsis

Case 2: Achievements

- **Built rapport and trust in a patient newly diagnosed with HIV, was very private about her diagnosis**
- Provided support post-hospitalization to prevent re-hospitalization for frail shelter dwelling individual
- Provided medical stabilization during periods of de-compensation, avoiding hospitalization
- Enabled expedited medical work ups, and coordination of specialty care, avoiding hospitalizations
- Disability benefits application process expedited
- Housing process was expedited while at BMH, patient became housed in Oct 2010
- **Patient has been on ARVs for the past 2.5 yrs and has had an undetectable viral load since then**

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Case 3: Patient TC

33 y.o. woman from Central America with advanced AIDS (CD4 count 64), infected through a sexual assault as a teenager, long history of ARV adherence challenges who, as a result, developed multidrug resistant HIV

- Currently housed has 2 young daughters
- Had not disclosed HIV status to family
- Referred for respite after failing outpatient treatment for toxoplasmosis and continued non-adherence to ARVs

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Case 3: Achievements

- **Patient was offered directly observed therapy in respite for both ARVs and toxoplasmosis therapy with close monitoring of side effects and supportive care for 2 weeks**
- Brain scans showed improvement in her infection at 2 weeks
- Intensive adherence counseling provided
- Home based nursing services re-established for ongoing assistance with medication adherence
- **With assistance from PCP, recently disclosed HIV status to partner**
- **Patient achieved undetectable viral load for over 8 months following discharge from respite, CD4 count rose from 66 to 432, toxoplasmosis infection remained quiescent**

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Case 4: Patient MA

52 y.o. MTF Spanish speaking transgender with advanced AIDS with multiple OIs including CMV retinitis, Kaposi's Sarcoma, PML, hepatitis C with cirrhosis, and major depression

- Initially presented to care from out of state, came to live with a friend, became homeless after an argument
- Off all ARVs
- Initially admitted to respite for expedited work up of rectal mass and rectal bleeding

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Case 4: Timeline of Respite Admissions

Admission Date	Reason for Admission
December 2009	Coordinate colorectal biopsy
April 2010	Supportive care during chemotherapy and radiation
June 2010	Supportive care/fecal incontinence
July 2010	s/p hospitalization for rectal bleeding and rectal pain

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Case 4: Achievements

- **Built rapport and trust**
- Expedited malignancy work up and connection with oncology and surgical care
- Provided medical stabilization and supportive care s/p hospitalizations
- Time/space provided for advanced care planning, goals of care, and end of life discussions with HIV providers from outpatient team
- Provided palliative care and pastoral care
- Offered place for pt to meet with estranged sister
- Offered bridge to hospice where patient ultimately passed away

Case 5: TJ

45 y.o. male with advanced AIDS (CD4 count 53), never on ARVs due to adherence challenges, HCV, traumatic brain injury due to gun shot wound, active IV heroin abuse.

- Pt presented as a new patient to the BHCHP clinic with profound depression and a recent suicide attempt, AIDS wasting, scabies, lower extremity edema, and dizziness
- Initially admitted to respite for expedited work up, and to reinitiate ARVs and anti-depressants in a monitored setting

Case 5: Timeline of Respite Admissions

Admission Date	Reason for Admission
August 2009	Expedited medical work up/start ARVs/connect with behavioral health
July 2010	Shingles/heroin relapse/ worsening depression
October 2010	Influenza like illness/PNA
February 2012	s/p ER visit for Syncope/recent suicide attempt

Case 5: Achievements

- **Established rapport/trust**
- Provided medical stabilization and expedited work up in medically complicated AIDS patient, that avoided need for hospitalization
- **Started ARVs in monitored setting (patient remains with undetectable viral load 2 years later, with CD4 count of >600)**
- Established care with behavioral health specialist and stabilize psychiatric illness
- Connected with residential substance abuse treatment to stabilize substance abuse disorder

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Summary of Achievements

- Respite provided :
  - **Medical stabilization** following hospitalization, or to prevent hospitalization
  - **Intensive outpatient medical work ups** and diagnostic procedures
  - **Coordination of complex specialty care**
  - **Adherence support**
    - Start or restart ARVs in supportive environment with adherence counseling, side effect management, and monitoring
  - Short term **DOT** for OI treatment
  - **Psychiatric stabilization** and reconnection to behavioral health care
  - **Stabilization of substance abuse disorders**, with bridge to residential substance abuse programs
  - **Palliative care**, advance care planning, bridge to hospice
- We believe that addressing the above needs increase the likelihood that our patients will be successful managing HIV

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Benefits of HIV+ Respite Team

- Build rapport and trust with HIV providers (all cases)
- Continuity of care (all cases)
- Improved medication adherence and retention in care after discharge (cases 2, 3, & 5)
- Improved access to community resources (all cases)
- Increase provider willingness to consider starting (or restarting) ARVs (case 1&5)
- Improved ability to treat opportunistic infections more effectively (case 1&2)

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Further Benefits

- Prevented the need for hospitalizations for expedited medical work ups or medical stabilization
- Expedited connection to social services such as applying for benefits, substance abuse programs and HIV housing

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Buchanan Study

- Buchanan, et al. AJPH 2006
- Cohort study:
  - 255 hospitalized patients consecutively referred for general medical respite from a public hospital
  - Study group: accepted to respite
  - Control group: denied from respite due to lack of beds
- Looked at change in # of hospital days, ER visits, outpatient clinic follow up and 1 year mortality
- Reduced inpatient days by 58%, hospital admission by 49%, NO differences in ER visits, no differences in mortality (no deaths in 12mo follow up)
- Pt's with HIV diagnosis showed greatest decrease in hospital days

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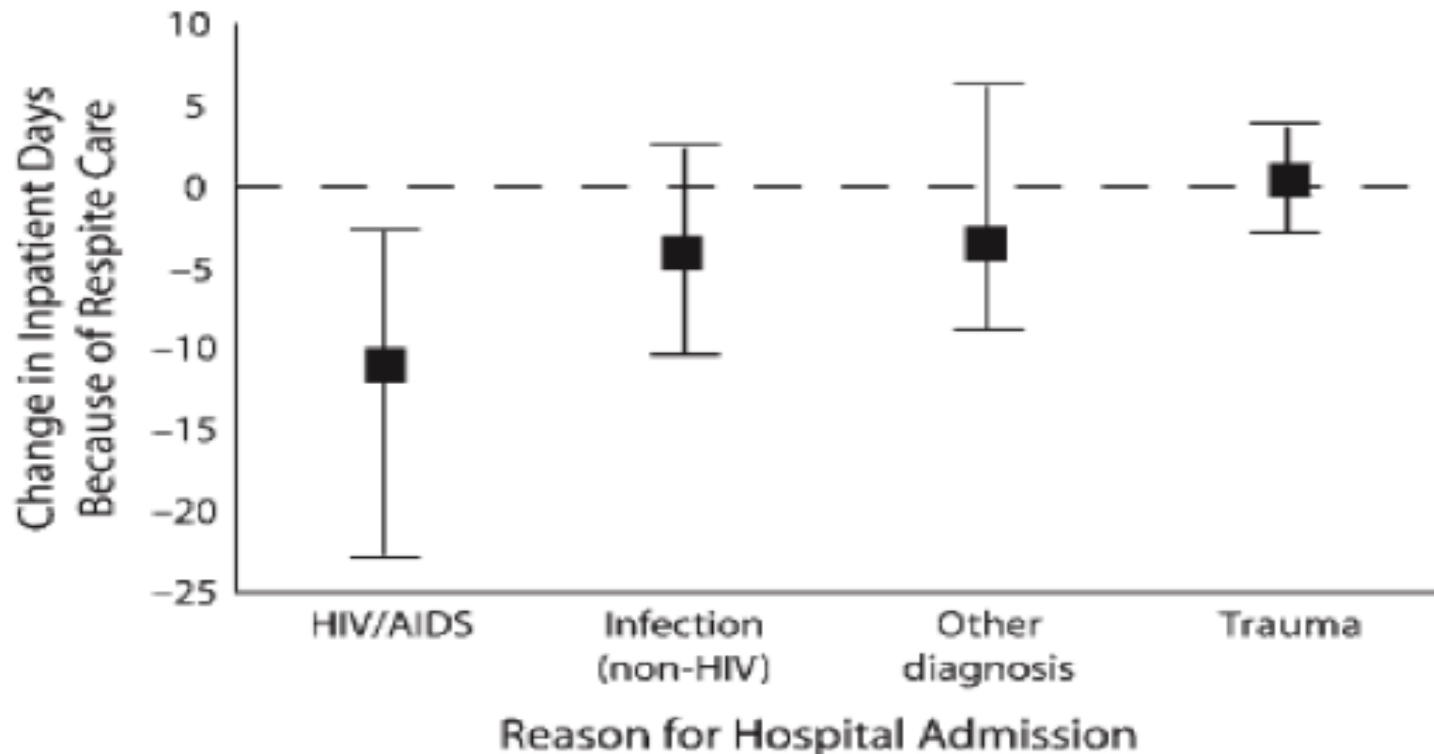
Buchanan Study Results



Buchanan et al. AJPH 2006

Potential Benefits

- Improves retention in care
- Improves ARV adherence and clinical indicators such viral load and CD4 count
- Lowers community viral load

Quantitative data is necessary to prove the above benefits

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Next Steps

Program evaluation

- Improved clinical outcomes
- Decrease in hospitalizations
- Decrease in ER utilizations
- Cost effectiveness
- Improved retention in care

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Essential Components of HIV Respite

- HIV trained clinician, NP, MD, or RN
- HIV-services trained case manager
- Commitment to close communication and collaboration with outpatient providers

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Discussion

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