MEDICAL RESPITE CASE STUDY

National Healthcare for the Homeless Pre-conference Institute

March 13, 2013

Case

- ES is a 50 yr old client w/DM, cirrhosis, back-pain, TBI with seizure disorder and depression/PTSD who was released from prison in June 2011 to the street after serving 17 yrs for a sex offense.
- After a month on the streets he presented to the ED with a cough and was given a prescription for antibiotics.
- Five days later he was hospitalized with decompensated liver disease and pneumonia.
- He was discharged to Medical Respite in August with f/u in neurology, medicine, GI, ophthalmology, radiology and a plan for Respite to help manage his ascites, antibiotics, and back pain.

Questions

- First thoughts?
- What do you think about his medical complexity?
- How do you manage multiple f/u appointments w/ different providers?
- How do you deal with clients that have a poor overall prognosis?
- How do you manage clients with a history of Sex offenses? Other legal issues?
- How do you manage opiates in ESLD patient?

Case

- Readmitted 2 weeks later for GI Bleed
- Returned to Medical Respite
- Got progressively worse, despite the care provided at respite.
- Was in & out of the hospital every few weeks.
- We kept accepting him back from the hospital because there were no other shelter/housing options available given sex offender status.

Questions

- Thoughts?
- Are Respite programs equipped to handle this kind of medical complexity?
  - How far do we stretch our limits?
  - How do we deal w/staffing & scope of practice limitations?
  - How do we support staff to provide the best possible care?

Case

- During the next admission, Medical Respite staff pushed the hospital to get a palliative care consult.
- No institution, including our county funded hospice, would take him until he became bed-bound, because of his forensic history

Questions

- How would you handle it?
- Would you take him back?
- Does your program refer to hospice? What do you think of providing palliative care or hospice care in the Respite setting?

Case

- He came back to Medical Respite and was readmitted a few weeks later.
- His next hospital admission lasted 4 months!
- During this time, he got really "tuned up" and the hospital tried everything to get him placed.
- Risk management got involved.
- The county's placement team found an inpatient psych rehab place that agreed to take him, but the parole board wouldn't allow him to go there.

Case

- Sent back to respite in Feb. and actually did OK, with a few brief ED visits & hospital stays.
- He got involved with a church group, began to play music with a few friends, and connected with one of his sisters whom he'd been estranged from.
- He started attending a forensic rehab group
- Despite all this, he became increasingly more hopeless that he would never be able to re-enter society.

Questions

- So now he looks like he might actually have a better prognosis than we thought.
- What do we do now?
- How does a Medical Respite program provide advocacy for a patient like this?
- Which types of agencies would you reach out to?
- How do you manage the increasing despair?

Case

- Efforts shifted from stabilizing his health to working on legal advocacy.
  - Our social worker called the parole board to work on pursuing compassionate exclusion from some of the sex offender regulations
  - I wrote a letter trying to establish cruel & unusual nature of parole restrictions. We asked the PCP and the palliative care team to also write a letter.
  - Our team identified a lawyer to take his case pro bono to petition for writ of habeus corpus
  - The ED Hi User Case Management program was convinced to take him on
- Eventually, his parole restrictions were dropped!

Case

- Our social worker began advocating with the supportive housing folks who fairly quickly approved his application.
- The property managers denied him residence because of his sex offender status.
- There was a lengthy appeals process which he won and was given a move-in date of 2 weeks.

Questions

- How do you prepare a client like this for a move?
- What things need to be in order to safely transition him from Respite to housing?

Case

- A week before his move-in date in April 2012, he became acutely ill and was hospitalized.
- He quickly decompensated and ended up in the ICU with sepsis and liver failure. The decision was made to transition him to comfort care & he passed away soon after.

Admission to Medical Respite August 2011

10 ED visits
4 admissions

4 month inpt stay

4 more admissions

Death April 2012

Questions

- How would you handle this?
- What sort of support would you give your staff?

Highlights of tragic case

- 9 month LOS
- Stretched us to & beyond our clinical limits – appropriate for hospice
- Sex offender status limited services
- He did best in the hospital which tried to do right by him but could not hold him endlessly
- MR staff had to provide tremendous amount of advocacy with parole board and local attorneys
- Care required much collaboration w/multiple providers including PCP and hospital's palliative care service
- Despite all this work, he decompensated quickly and died before he could reap the fruits of all of our work.