

Strengthening Care Coordination & Transitions in Medical Respite Care Panel Discussion

Medical Respite Care: Positioning your Program for Success

National Health Care for the Homeless Conference & Policy Symposium

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Hilton Portland

Grand Ballroom II

Speakers

Moderator: Julia Dobbins, MSSW

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Assistant Professor, *Duke University School of Nursing*
- Honora Englander, MD, FACP
Medical Director – Community & Clinical Integration, *Oregon Health & Science University*
- Caitlin Synovec, MS, OTR/L, CPRP
Occupational Therapist, *Health Care for the Homeless - Baltimore*

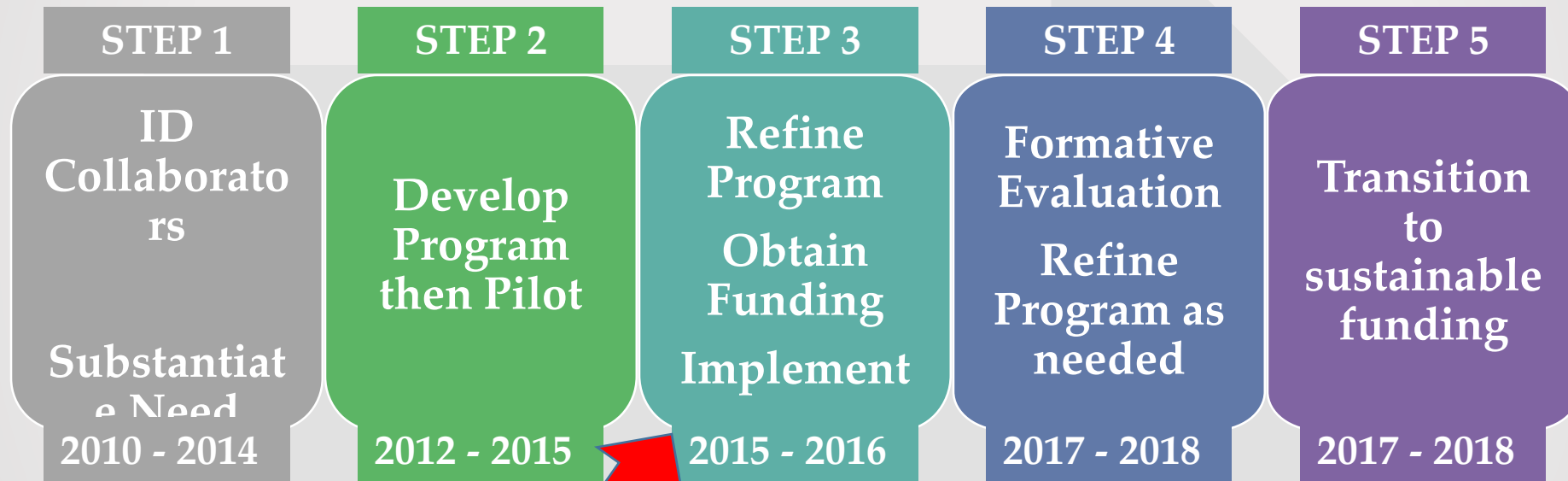
Implementing a Homeless Transitional Care Program

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Julia Gamble, NP, MPH

Sally Wilson, M.Div

Overview



You are HERE!

Step 2 - Initial Program

- Primarily supported by in-kind contributions
- Focus on nurse care management for medical respite
- Strict criteria including that person would be discharged to home if one were available
- Patients to be housed in one of two facilities where home health, PT/OT, and other in home services could occur

Screening

- Screening/clinical assessment to be completed by hospital discharge planner (if being discharged from hospital) or primary care provider (if outpatient) using pilot project referral form
- Intake Coordinator (from Project Access of Durham County or CAARE if veteran) will review referral form with a transitional nurse care manager to make an eligibility determination
- Intake Coordinator will respond to referral request within 4 hours (Monday - Friday , if received before 2 pm)

Intake

- **If accepted into the program the Intake Coordinator will:**
- Confirm proposed respite length of stay with discharge planner or primary care provider
- Determine the respite site and make financial arrangements
- Fax acceptance form to team
- Confirm transportation and arrival plan
- Schedule the medical respite transitional nurse care manager to meet the patient when he/she arrives at the medical respite setting (Monday - Friday, 8 - 5 pm)

Transfer to Respite

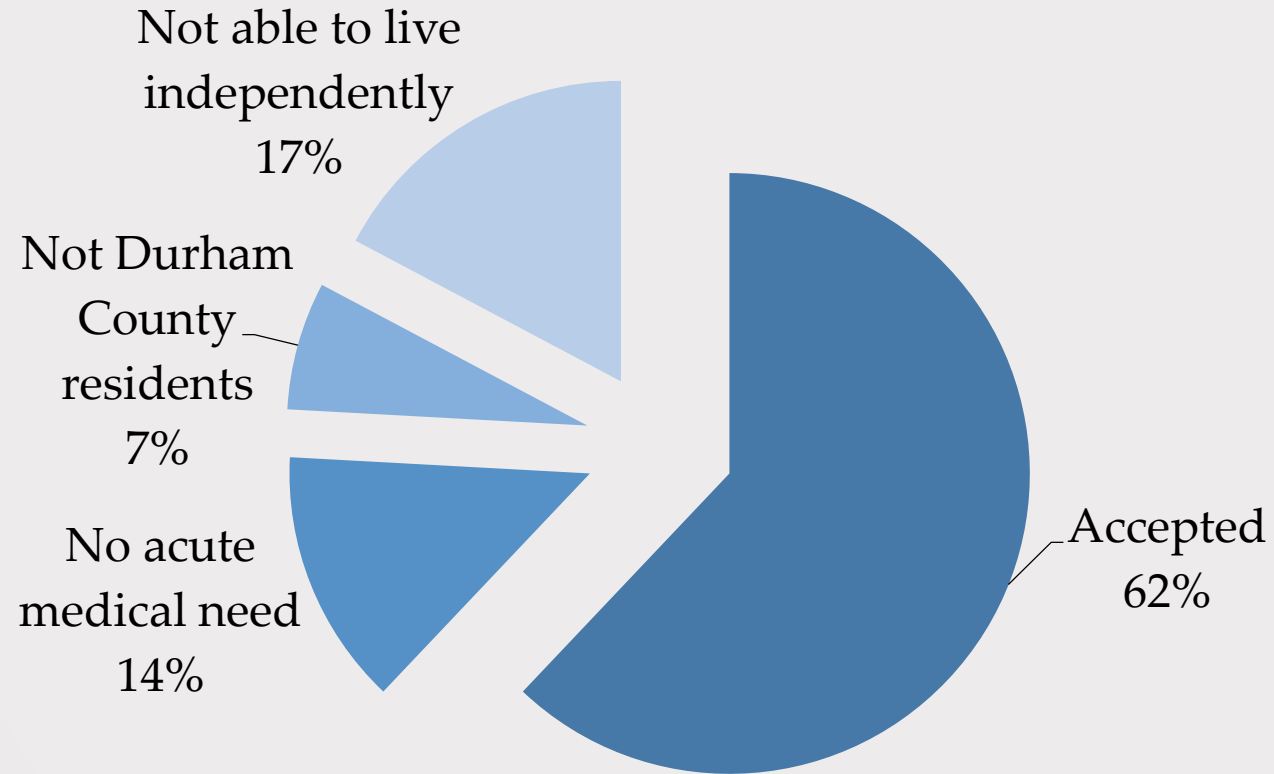
- **If accepted into the program the referring entity will:**
- Provide information on care plan including discharge notes, medication list, and pending appointments
- Arrange transport to the respite setting

Preliminary Pilot Results



Step 2

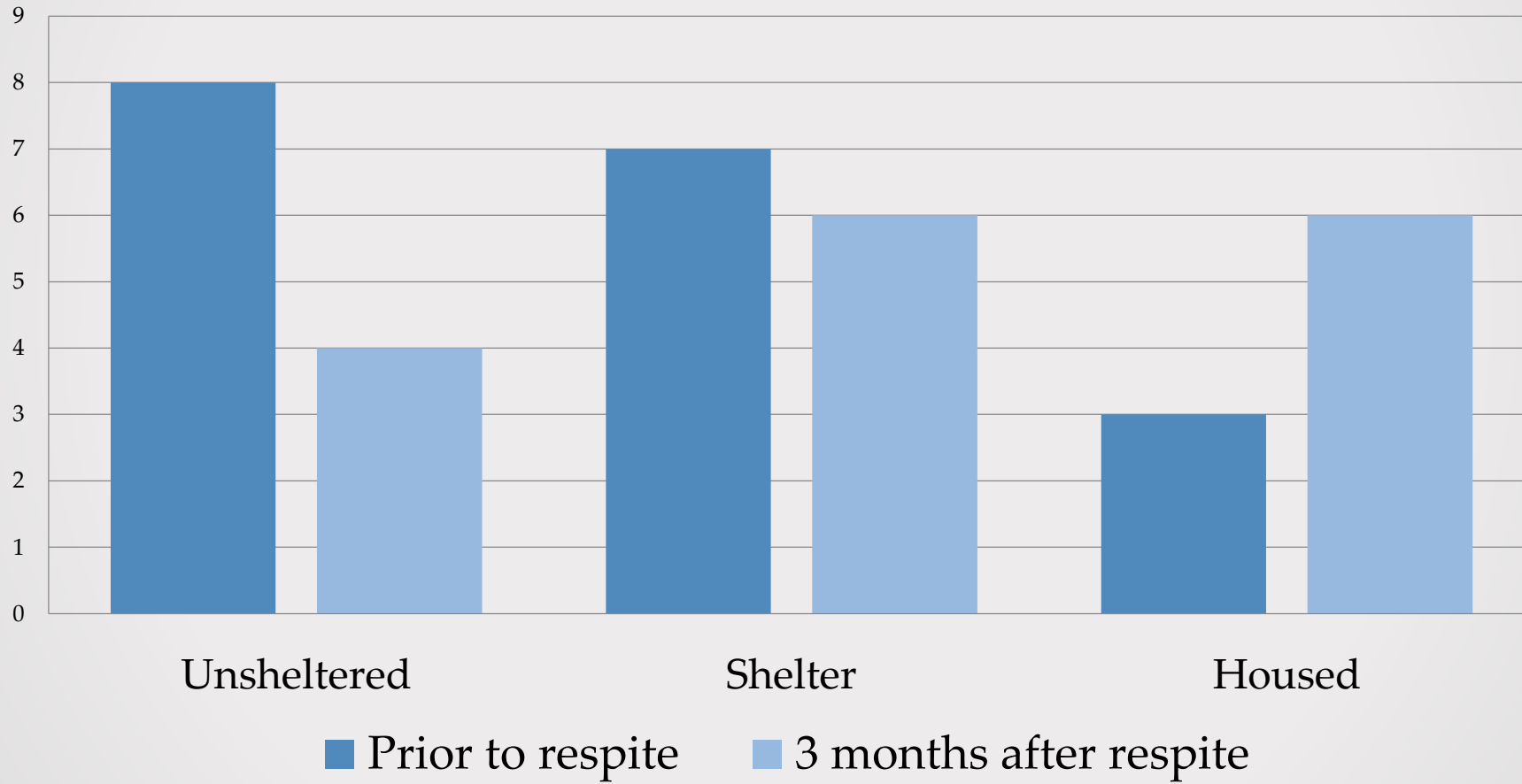
Respite Referrals (n=29)



Referral source (n=18)

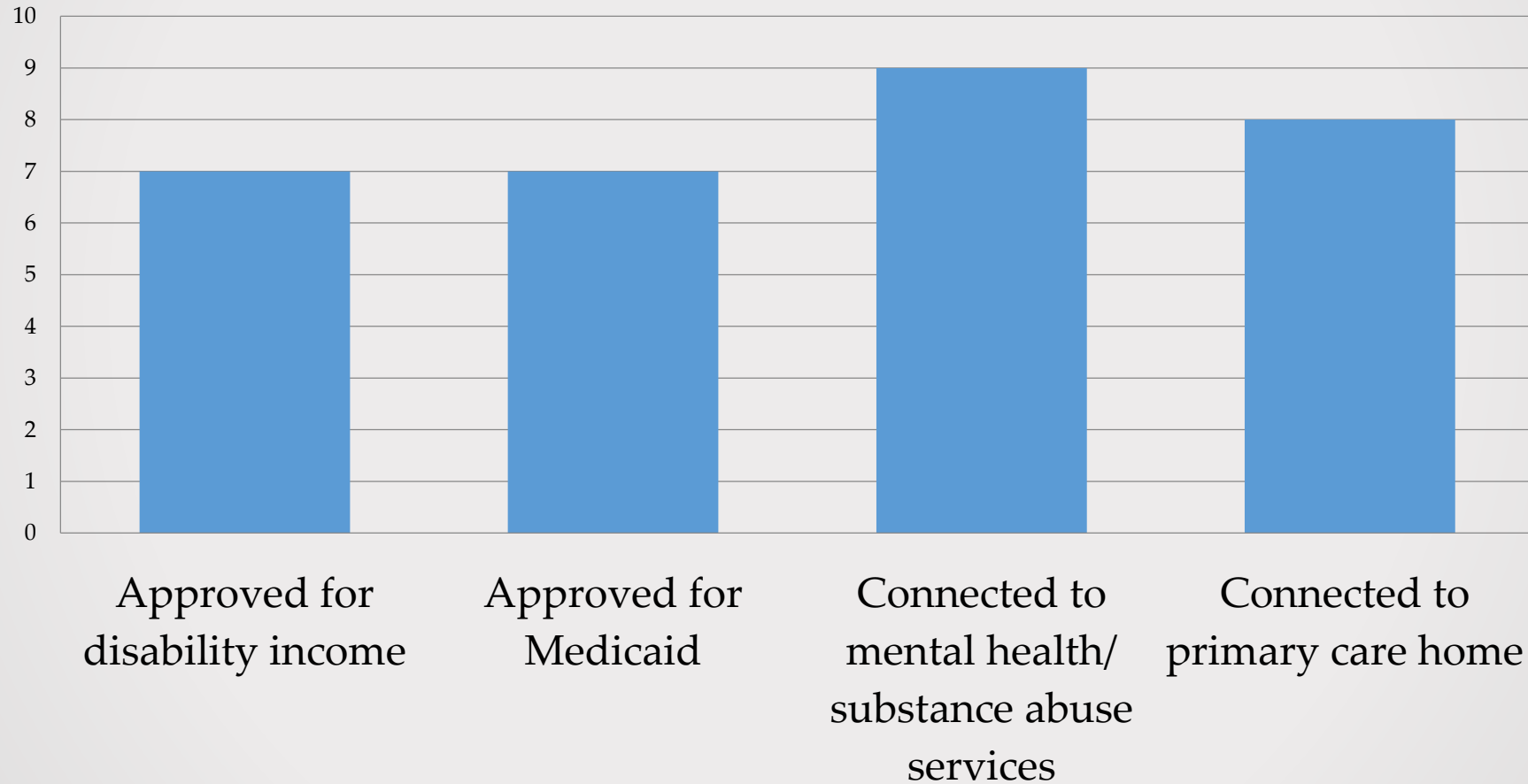


Housing Status



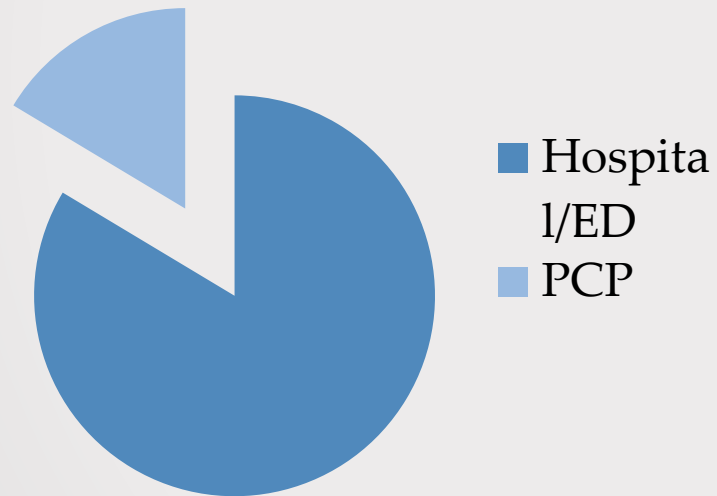
*Prior N=18; Post N=16 ~ 2 people are not yet 3 months out

Benefits & services obtained through respite program (n=18)

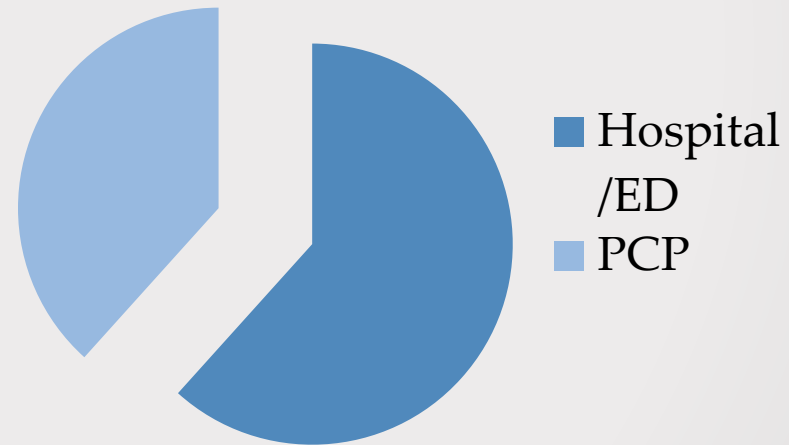


Health system use

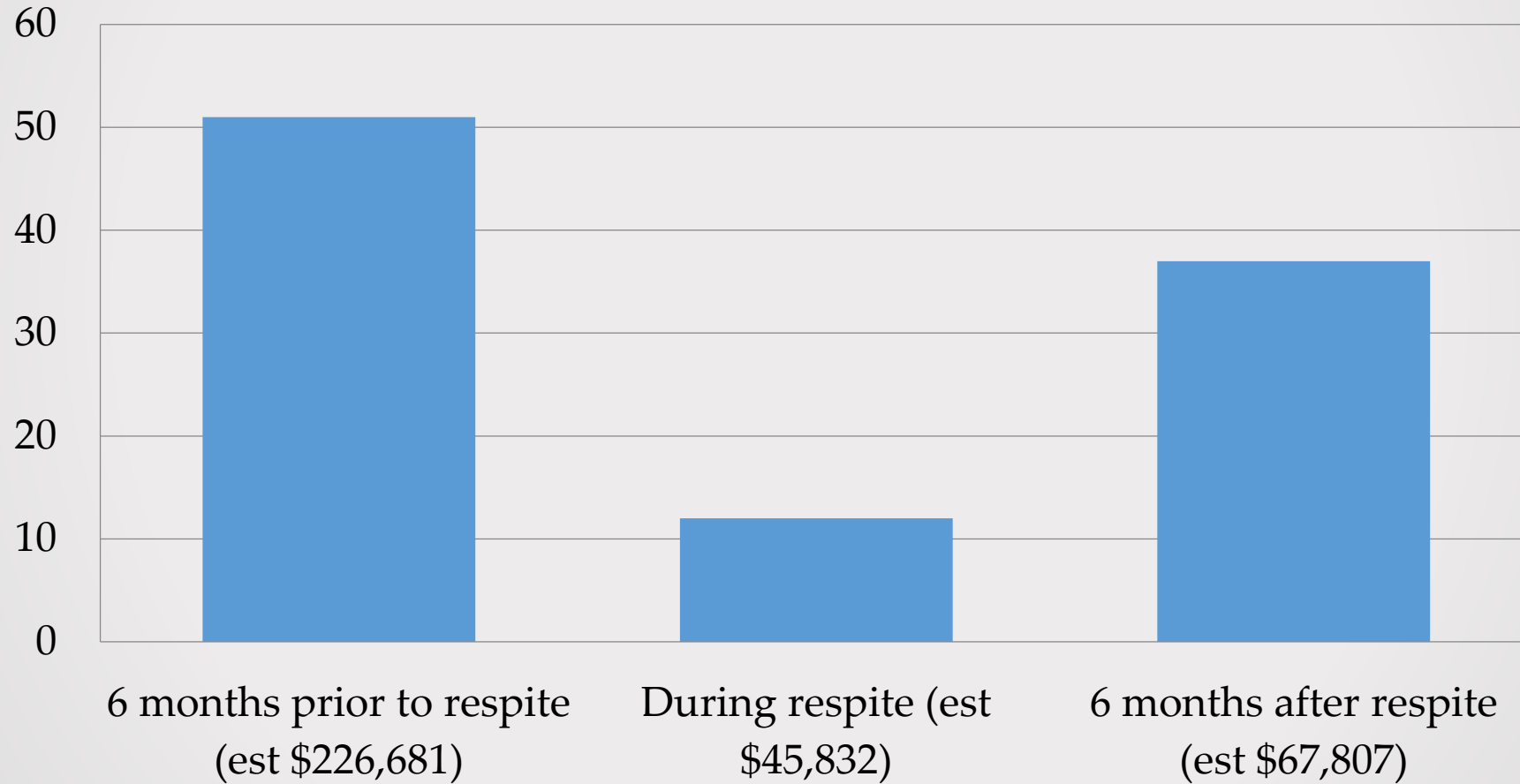
6 months prior to respite



6 months after respite



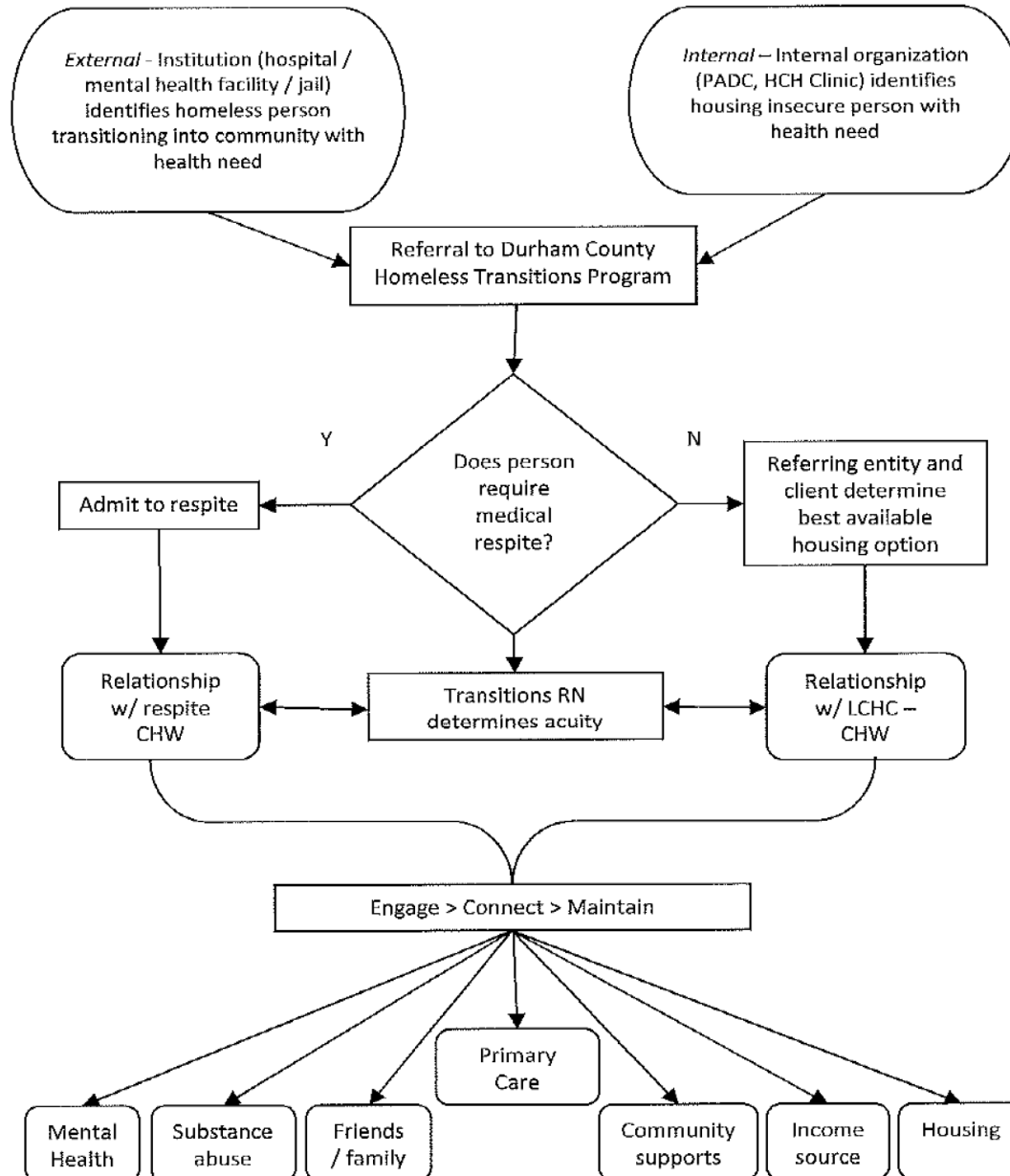
Hospital / ED Visits (n=11)



Refine program, obtain funding,
implement

...

Step 3



Hillman Innovations in Care Award

- Implement transitional care model that includes linkage to services with or without medical respite
 - Funding for Nurse Care Coordinator and 2 Community Health Workers
- Broaden scope to receive referrals from Duke Clinics as well as behavioral health providers and ultimately the county jail
- Provide educational opportunities for health care team members regarding the program, caring for homeless persons, ICD-10 code usage, other yet to be determined educational needs.

Implementation - Successes

- Making lots of contacts within our health system – educational opportunities abound!
- [Online referral system](#) that feeds directly into database
- Great new staff
- Had plenty of time to refine our protocols and documentation forms; saved some money

Implementation - Challenges

- Key staff turnover: HCH clinic provider, complex care manager, case manager
- Delay in subcontracts
- Delay in hiring key personnel
- One CHW did not show up

Lessons Learned

- Fully understand hierarchy within your health system and make sure contracts are funneled through right mechanism
- Allow at least 3 months, maybe more, for start-up
- Ensure job descriptions reflect program needs and will result in qualified applicants
- Be prepared for challenges; reframe them into successes!

Hospital to home transitions for adults with substance use disorders (SUD)

Honora Englander, MD
Associate Professor of Medicine
Oregon Health & Science University

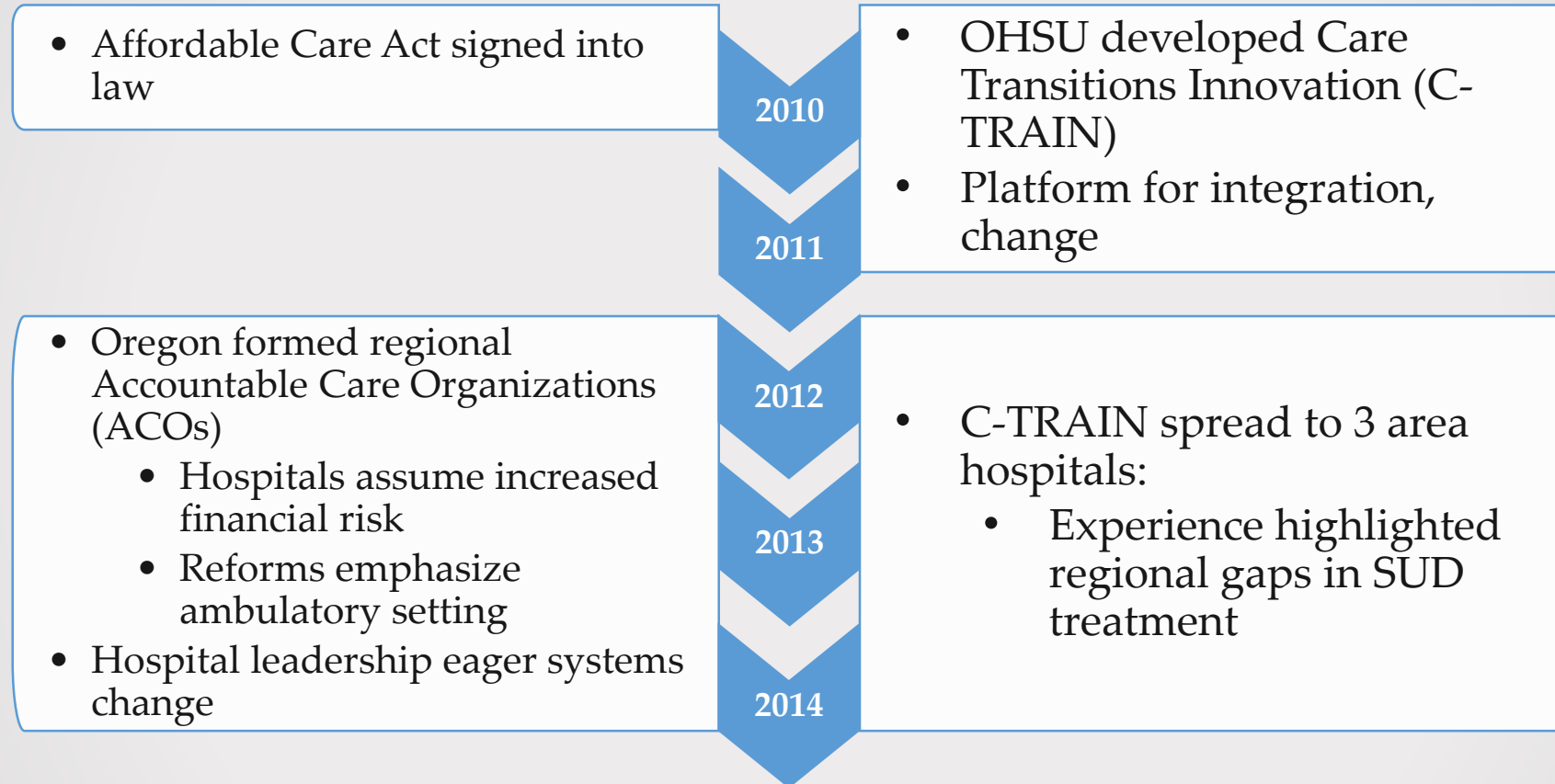
Email: englandh@ohsu.edu

 [@honoraenglander](https://twitter.com/honoraenglander)

Background

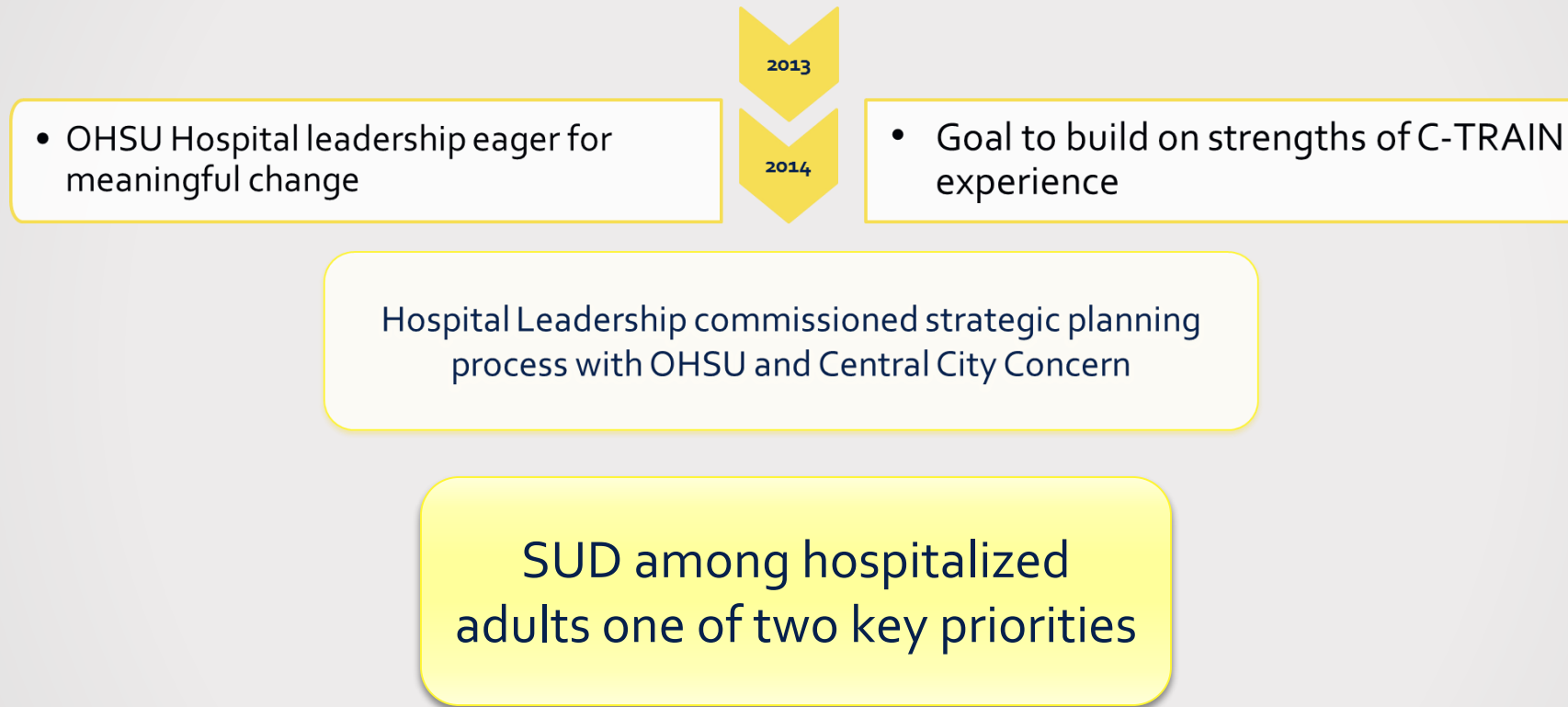
- 1 in 4 hospitalized adults has a substance use disorder (SUD)
 - SUD drives high rates of hospitalizations, readmission, long LOS
 - Skyrocketing costs: \$15 billion in inpatient hospital charges related to opioid use disorder in 2012
 - Many people not engaged in SUD treatment
- Hospitalization often addresses the acute medical illness but not the underlying cause, the SUD
 - Leads to significant waste and poor outcomes
- Effective treatments exist but are under-utilized
 - Physical health and addiction care systems are siloed
 - Substance use integration efforts limited almost entirely to outpatient setting, missing many high risk adults who do not access primary care
 - Need for new care models

Context for reform



Englander, JHM 2012
Englander, JGIM 2014
Davis, JGIM 2012

Context for reform



Patient Needs Assessment

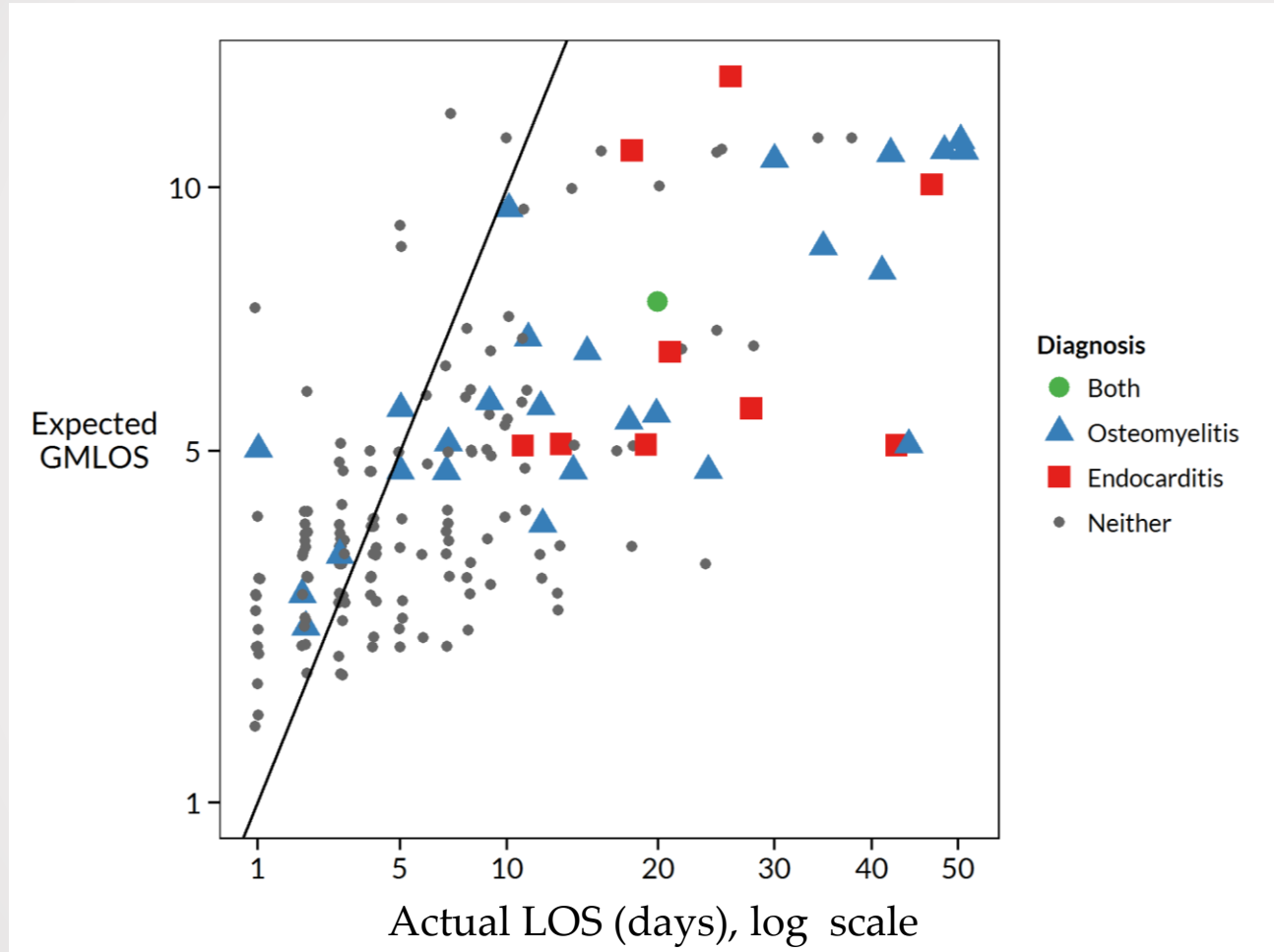
- Mixed-methods survey of 185 hospitalized adults (09/14-04/15)
- Hospitalization as reachable moment
 - 57% of high risk alcohol users; 68% of high risk drug users reported wanting to cut back or quit
 - Many wanted medication assisted treatment (MAT) to start in hospital
- Patients valued treatment choice, providers that understand SUD
- Gap-time to community SUD treatment

Costly readmissions

Used interim data to meet demands of hospital budget cycle:

- Among 165 patients, 137 readmissions over mean observation period of 4.5 months
- Mean charge per readmission \$31,157
 - \$55,493 for endocarditis readmissions
 - \$68,774 for osteomyelitis readmissions

Prolonged Inpatient LOS

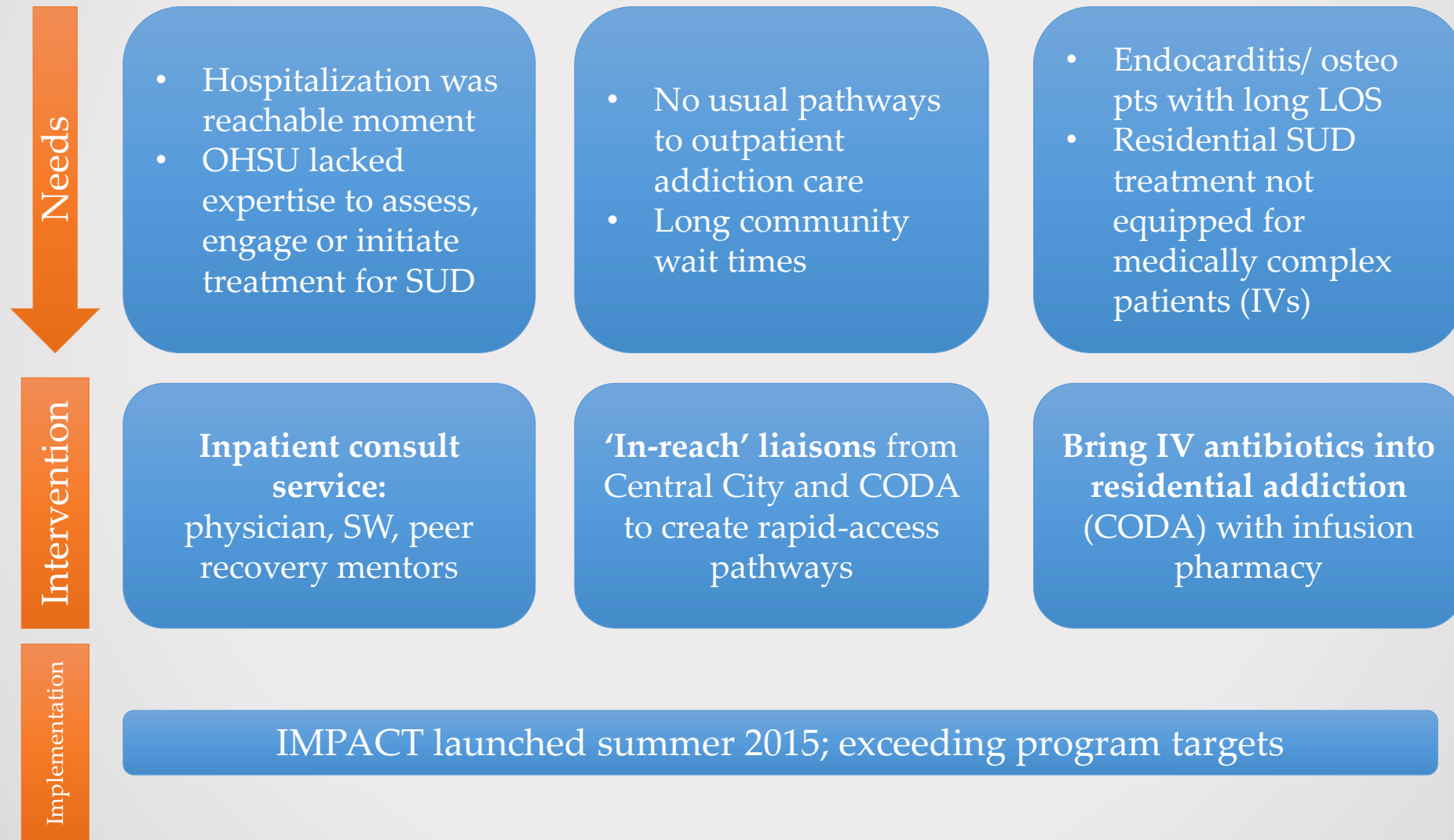


Needs assessment: Engaging community stakeholders



- Convened leaders over 3 large group meetings, numerous small meetings
- Mapped patient and system needs to intervention components
- Developed business case

IMPACT: Improving Addiction Care Team



Case example (1)

- 55 yr old man with homelessness, opioid and methamphetamine use disorders admitted with large intramuscular abscess
 - Started on methadone on admission
 - CODA in-reach linked to community methadone, intensive outpatient treatment
 - Connected to primary care and transitional housing (RCP) at Central City Concern
 - Now has an ID, stable housing, engaged in SUD treatment and primary care, and plans to start working

Case Example (2)

- 35 yr-old man with severe opioid use disorder with MRSA native valve endocarditis with septic emboli to lungs and spine
 - Hospital course:
 - Extensive spine surgery, started methadone, changed insurance (WA to OR Medicaid)
 - Reported high interest in treatment
 - Withdrawal treated with methadone
 - In custody for drug possession after arrest by local police and US Marshall
 - IMPACT worked with US Marshall to allow treatment instead of jail
 - Discharged to MERT to continue treatment doses of methadone and complete 30+ days IV ABX
 - Getting primary care at Old Town Clinic (part of Central City Concern)

IMPACT patients

IMPACT Volume	9/21/2015 – 2/29/2016
Total number of referrals	128
Unique patients served by IMPACT	106
Number enrolled in study	79

Demographics	N = 79
Male gender	48 (61%)
Mean age (years)	40 (SD = 10.94)
Homelessness	38 (48%)
Primary substance use disorder by DSM-V	
Opioids	43 (53%)
Alcohol	10 (13%)
Meth	12 (15%)
Cocaine	2 (3%)
Benzodiazepines	1 (1%)
Multiple	9 (11%)

Intervention Experience

Intervention experience		n=79
Provider encounters	MD encounters/ patient (average)	2.7 (range: 0-20)
	SW encounters/ patient (average)	4.8 (range: 0-23)
MAT	New MAT started in-hospital	63 (80%)
	Methadone	44
	Buprenorphine/naloxone	10
	ER Naltrexone	6
	Oral Naltrexone	2
	Acamprosate	1
	Plan to continue MAT post-discharge among those started in hospital	45/63 (71%)
	*difference accounted for by methadone for withdrawal only	

Lessons learned

- Treatment changes culture
 - IMPACT has “elevated the consciousness... that substance use disorders are brain disorders and not bad behavior.” *Hospitalist*
 - “Hospital attitude is changing... I see jaw-dropping a-ha moments happening.... you watch the residents and staff realize that there's actually a whole team of people who are there [to treat substance use disorders]. It makes people more open to treating people if they don't feel isolated and out of their depth.” *infectious disease attending*

Lessons learned

- Value of interprofessional team and hospital- community partnerships
 - Addresses an array of needs including mental health, family, criminal justice, housing needs
 - Improves patient experience and trust
- Partnerships that support rapid access to community SUD care are key to leveraging the reachable moment:
 - Before IMPACT “we almost never got anyone – I think maybe once or twice in my whole inpatient years – was I ever able to facilitate a direct transfer to a residential treatment program... it was really difficult.” *Social worker*

Lessons Learned

- Housing is key to recovery
 - Next frontier in this work

Acknowledgments

- Funding:
OHSU,
CareOregon
- Partners:
 - CODA
 - Central City
Concern
 - Coram
Infusion
 - OHSU



Occupational Therapy in Convalescent/Respite Care Programs

Caitlin Synovec, MS, OTR/L, CPRP

- **Caitlin Synovec, MS, OTR/L**
 - **Occupational Therapist at Health Care for the Homeless, Baltimore, MD**
 - **Previously worked at Johns Hopkins Hospital in inpatient psychiatry and outpatient addictions clinic**
 - **Developed role of OT within the Baltimore HCH setting**
 - **Currently serves clients engaged in all levels of care at HCH**

Role of Occupational Therapy

- Occupational therapy (OT) addresses barriers perceived by clients in their community, and seeks to improve skills and provide supports for successful engagement in meaningful and productive community activities (AOTA, 2013).
- OT increases clients' ability to live independently within the community through assessment, task analysis, and development of skills and adaptations through practice.
- Focuses primarily on the impacts of a client's symptoms or diagnoses on their ability to function within the community of their choice.

Role of Occupational Therapy

- Within the Baltimore HCH Convalescent Care Program
 - Provides functional or skill based assessments of:
 - Cognition/functional cognition
 - Memory & attention, executive function
 - Physical/motor skills
 - Medication management
 - Money management
 - ADL and self-care
 - TBI Screening

Role of Occupational Therapy

Following assessment, OT provides:

- Feedback on performance and recommendations for transition of care and ways in which CCP providers can develop skills
- Individual interventions for clients
 - Focuses on developing skills that were identified as barriers/deficit areas in evaluation to support successful community transition
- Identification of undiagnosed or unreported medical or cognitive issues

OT and Care Transitions

- OT Evaluation...
 - Identifies client's current level of self-care and functional performance as well as capabilities
 - Identifies optimal environment following discharge from program
 - Provides opportunity to focus on specific skill building prior to client's discharge from program, to minimize errors or issues with medical management

OT and Care Transitions

- Possible Recommendations
 - Transition to weekly medication adherence program with HCH nursing staff
 - Most appropriate level of support and/or housing following discharge
 - HCH Supportive Housing Services
 - Transitional housing, independent living, structured program
 - In-home ADL/health care assistance
 - Identification of community programs
 - PRP, supported employment

OT and Care Coordination

- Care coordination:
 - Identifies client's current living of self-care and functional performance as well as capabilities
 - **Provides recommendations for other providers to implement**
 - Identifies optimal environment following discharge from program
 - **Assists in identifying additional programs or services that may be beneficial and process can be started while on unit**
 - Provides opportunity to focus on specific skill building prior to client's discharge from program, to minimize errors or issues with medical management
 - **Can be developed and supported by all staff within the unit**

OT and Care Coordination

- Recommendations for Care Coordination
 - How to effectively structure routines or program to support client engagement
 - How to develop skills for medication management
 - How to develop skills for attending appointments and managing other health care
 - How to develop communication skills
 - Develop understanding of cognitive performance:
 - Rule out low motivation vs. lack of understanding
 - Identify need to develop skills for frustration tolerance
 - Identify skills to express when information is not understood OR to assess if client does understand
 - Identify problems with memory and/or attention that may impact learning
 - Allows for clients to have more active engagement in care and increase independence while on CCP

OT and Care Coordination

“ Based on Mr. R’s below average score on the ManageMed, it is anticipated the client may demonstrate difficulty in the following functional performance areas:

- Difficulty with learning and applying new instructions, information and concepts. Will benefit from visual or structured cues to establish new routines (e.g. alarms/timers to remind to take medications).
- Difficulty understanding abstract, non-specific directions. Will benefit from specific, step by step instructions with clear outcomes, to support motivation and understanding of information.
- Will benefit from easy open tops on medications to increase ability to independently open and organize information.
- Will require cuing to recall taking medications - visual (e.g. place medications in commonly viewed area) or auditory (alarm set on phone).
- Will benefit from supervision to organize weekly pillbox to assess for errors and problem solve errors made.
- Have client repeat back any important information regarding instructions to ensure understanding and recall
- Will benefit from use of calendar or planner, to organize information to support recall and follow through.
- Will work most effectively with consistent routines.
- Highlight or mark important information on written instructions. “

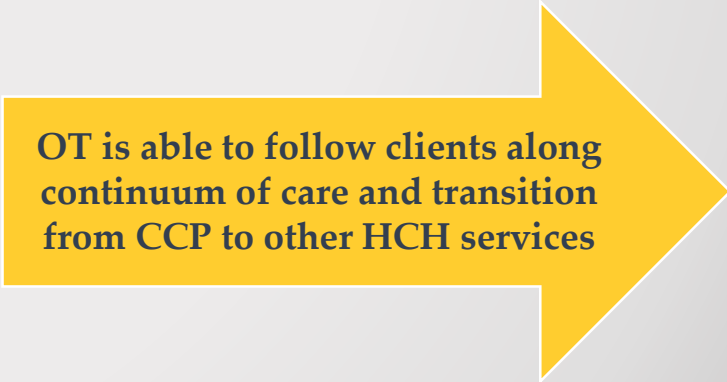
OT and Ongoing Intervention

Possible individual interventions :

- Medication/health management
 - Strategies for improved follow through on medications
 - Strategies to manage ongoing health problems
 - Ex: Meal planning for dietary guidelines
- Development of daily living skills for independent living
- Self Organization:
 - Development of habits/routines
 - Use of planners/checklists for time awareness and orientation, attending scheduled activities, develop ability to follow through on tasks planned

ADL – adaptive devices,
skill development

Budgeting/bill payment
Household management



OT is able to follow clients along
continuum of care and transition
from CCP to other HCH services

Stories from the Field

One Time Assessment

Client Ralph, was admitted to CCP for resolution of edema, after multiple CCP admissions for similar medical issues. Client demonstrated difficulty self-managing medications, although reports ability to do it and appeared unwilling to receive assistance or recommendations.

The client often demanded a lot of support, but then compensated for his deficits by angrily insisting on his independence.

Stories from the Field

Ralph was assessed by the occupational therapist using ManageMed Screening tool.

- His score was within normal limits for his age group, however, the following problem areas were identified:
 - Decreased prospective memory: Client required cuing to recall verbal information given, client able to recall information that was read and/or applied.
 - Decreased attention to detail: Client required cuing to attend to detailed information located on labels.
 - Decreased problem solving: Client required assistance to problem solve more detailed information. Client may have lower reading/comprehension level, as he was better able to problem solve and apply information when questions and statements were re-phrased with simpler language.
 - The client demonstrated good awareness and insight into performance on assessment.

Stories from the Field

The OTR provided the following recommendations regarding his health management:

- Information presented in multiple formats regarding medication or health instructions. Use of simple, basic language for instructions will be beneficial to ensure understanding.
- Have client repeat back any important information, or demonstrate application of information, regarding instructions to ensure understanding and recall.
- Highlight or mark important information (e.g. “to be taken with food.”)

Education provided to client within assessment:

- Client was educated on use of notebook to record medical information and prescription information.
- Client was encouraged to review notes with providers at end of appointments to ensure accuracy and understanding.
- Client was encouraged to use notebook to write questions and organize information amongst various providers.
- Client was receptive to strategy, but will benefit from assistance to initiate use of strategy to improve self-management of health care.

Stories from the Field

Summary of assessment:

“He presents with fair understanding of his medical issues, but demonstrates decreased self-efficacy and insight into ways he can control and manage medical conditions. He identifies ‘The doctor’s need to do something different,’ as he can not identify any tangible steps for self-improvement in regards to medical care.”

Recommendations were utilized with the following perspective of CCP providers:

- “ We were able to better understand the client’s mixture of cognitive and personality concerns. The OT explanation for his behavior made it easier to understand where he was coming from when he was unhappy with us and our program (often). “
- Assisted in developing a more effective approach for engaging the client, and to minimize conflict
- Staff focused on developing client’s self-efficacy and sense of control over his health

Stories from the Field

Ongoing Intervention

Client Andrew was admitted to CCP following a stay at a nursing home and having hospitalization for aspiration. The client had a history of difficulty living in ALFs or nursing care. Client also had a significant history of traumatic brain injury. He became easily frustrated, demonstrated difficulty with self-expression and communication, and had an unclear level of self care and IADL skills.

He was approved for a housing voucher through the city, and was referred for occupational therapy to determine level of independence and/or supports needed.

Stories from the Field

Andrew was assessed by the OTR using the Assessment of Motor and Process skills and the Montreal Cognitive Assessment (MoCA)

He presented with the following results:

- He was greater than 3 standard deviations below the mean in processing skills (cognitive), and two standard deviations below the mean in motor (physical) skills.
- He scored 20/30 on the MoCA – a score of 26 or greater is considered typical

Assessment Summary

“Overall, Andrew presents with physical and cognitive limitations. He also demonstrates difficulty with effectively planning and implementing tasks, which impacts his efficiency and physical ability.

Despite these limitations, Andrew was able to complete functional tasks, benefiting from increased time and allowing for him to self-correct errors.”

Stories from the Field

The OTR provided the following recommendations:

- Increased time to complete basic functional tasks. Client will increase safety and effectiveness when allowed additional time to self-complete tasks.
- Visual cues to improve recall and ability to follow multiple step instructions
- Development of adaptive strategies for physical limitations, with practice to increase skill
- Instructions given clearly and concretely. Client may not be able to draw abstract conclusions (e.g. may need specific instructions for diet)
- Use of calendar/planner to organize information and tasks.
- Development of strategies for safe meal preparation

The client received a housing voucher and was subsequently referred for the Supportive Housing program.

Stories from the Field

Additionally, the client was followed for ongoing intervention with the occupational therapist.

The client identified the following goal areas for OT intervention:

- Managing medications
- Using public transportation
- Cleaning
- Grocery shopping
- Time management

Stories from the Field

Initial interventions focused on developing skills for medication/health management, where the client was able to develop skills to organize and use his pillbox independently to take medications daily.

The client also began using tools to record and organize appointments, to increase knowledge, awareness of and independence in health care appointments.

Needs areas were communicated to and supported by supportive housing staff as client transitioned into housing.

Questions?

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