



Expanding Medical Respite Services

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Objectives

- Describe the expansion of the San Francisco Medical Respite program services to Shelter Health/Street Medicine
 - Describe the original San Francisco Medical Respite program
 - Describe the Shelter Health program prior to expansion
- Discuss events leading up to expanding to shelter as an additional referral source
- Discussion programmatic planning for expansion
- Discuss challenges working with expansion clients
- Discuss lessons learned



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SFDPH Medical Respite Program

- Program of SF DPH in partnership with CBO (CATS - Community Awareness and Treatment Services)
- Opened in 2007
- Original program capacity: 45 beds
- Post-acute recuperative care for homeless people who are too sick or frail to be on the streets or in the shelter

The mission of the Medical Respite and Sobering Center is to provide medical and social services to promote stabilization, hope and healing to adults experiencing homelessness in San Francisco.



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What Respite Offers

Medical Services

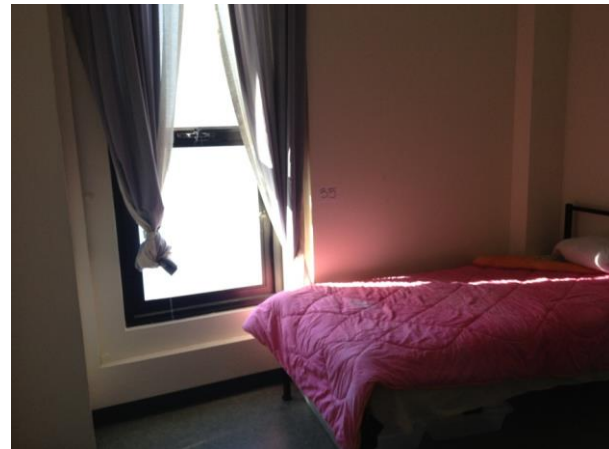
- Safe, clean place to stay while recuperating from an acute medical or surgical condition
- Successful resolution of acute conditions and stabilization of chronic conditions
- Linkage and bridging to primary care
- Linkage to specialty medical care
- Provide urgent care services as needed
- Care coordination for development of treatment plans focused on positive long-term change

Hospitality and Social Services

- Linkages to social services and entitlements:
 - General Assistance
 - Housing applications
 - Medi-Cal/Medicare enrollment
 - Substance use treatment programs
 - Mental health
- 3 meals/day
 - Some specialized diets can be accommodated
- Transportation to medical and social service appointments
- Recuperation from the emotional distress and isolation associated with homelessness and illness



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SF SHELTER SYSTEM

- Over 21 emergency shelters
- 1300 city-funded beds for single adults and families
- 4 Navigation Centers total 290 beds plus stabilization rooms
- Department of Homelessness and Supportive Housing (HSH) contracts eight different agencies to provide shelter services, including:

Government (SF DPH)

Non-profit

Faith-based organizations



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Shelter Criteria

- Clients must be independent
- Shelter staff are not trained to assist clients with ADL's
- Shelters are understaffed serving a large number of clients
- Shelter staff have no medical training except CPR and health and safety concerns



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Shelter Criteria: Functional Status

- Independent ambulation with or without assistive device
- Independent with dressing, bathing and daily self care
- Can get in and out of bathroom/ toilet without assistance
- Can get in and out of shelter bed/mat without assistance
- Able to manage elimination of bowel and bladder without assistance.
- Able to get out of shelter to obtain food
- Able to follow discharge instructions without assistance
- Able to get to follow-up medical appointment
- Able to self manage medical equipment (i.e. oxygen) or other medical supplies without assistance
- Able to take medications without assistance
- Able to manage wound care needs,
or able to go to clinic for wound care



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Shelter Criteria

Medical Status

- Does not require acute hospitalization
- Does not have infectious disease that requires isolation (example – active TB)

Mental Status

- Alert and oriented to person, place and time
- Has decision capacity
- Able to meet behavioral guidelines of shelter and program, including agreement to leave shelter when bed stay is over



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Shelter Health and Wellness up until 2015

- One 0.5 PHN and one Registered Dietician consultant
- Consultation on individual clients and health and safety issues
- Policy recommendations
- Staff Trainings and Teaching materials for environmental health and medical topics
- Critical Incident and Death Reviews
- Quarterly health screenings at select shelters Flu and Tdap vaccine campaigns each year in all city funded shelters



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911 calls Next Door

| | | | | | | | | | | | | | | | | |
|-----|-----------|----------|----------|----------|----------|----------|------|----|-----------|---|-------|----------------|------|----|-----|--------|
| 178 | 140620244 | 14020996 | 03/03/14 | 15:33:00 | 15:34.41 | 15:39.24 | | 77 | 1001 POLK | 3 | 31D3 | FAINTED N TH3 | | 77 | SFG | 69.28 |
| 179 | 140620287 | 14021041 | 03/03/14 | 17:27:11 | 17:43.05 | 17:56.22 | KM06 | | 1001 POLK | 2 | 26A7 | SICK-EVAL TH2 | KM06 | | STF | 61.77 |
| 180 | 140640155 | 14021616 | 03/05/14 | 12:21:41 | 12:22.14 | 12:29.06 | | 53 | 1001 POLK | 3 | 12D2 | SEIZURE N TH2 | | 53 | SFG | 84.18 |
| 181 | 140640374 | 14021814 | 03/05/14 | 22:58:19 | 23:03.21 | 23:11.32 | | 89 | 1001 POLK | 3 | 28C4U | CVA WEAK PDT | | | | 29.58 |
| 182 | 140660244 | 14022352 | 03/07/14 | 14:22:48 | 14:25.12 | 14:36.03 | KM09 | | 1001 POLK | 3 | 6D2 | SOB DIF S TH2 | KM09 | | CPP | 92.37 |
| 183 | 140670048 | 14022577 | 03/08/14 | 04:23:39 | 04:27.02 | 04:33.02 | KM03 | | 1001 POLK | 2 | 26O8 | SICK EXT I TH2 | KM03 | | STF | 62.52 |
| 184 | 140680244 | 14023066 | 03/09/14 | 18:40:44 | 18:42.26 | | | 79 | 1001 POLK | 3 | 6D2 | SOB DIF S TH2 | | 79 | | 0.00 |
| 185 | 140680244 | 14023066 | 03/09/14 | 18:40:44 | 18:47.54 | 18:55.19 | KM02 | | 1001 POLK | 3 | 6D2 | SOB DIF S TH2 | KM02 | | STF | 44.85 |
| 186 | 140690031 | 14023168 | 03/10/14 | 03:58:33 | 04:01.53 | 04:05.30 | | 81 | 1001 POLK | 3 | 6D2 | SOB DIF S NOM | | | | 6.97 |
| 187 | 140690279 | 14023371 | 03/10/14 | 17:43:35 | 18:08.50 | 18:29.16 | AM06 | | 1001 POLK | 2 | 26A10 | SICK UNW TH2 | AM06 | | STF | 74.92 |
| 188 | 140690369 | 14023447 | 03/10/14 | 23:12:31 | 23:16.37 | 23:25.06 | | 84 | 1001 POLK | 2 | 26C2 | SICK ABNL TH2 | | 84 | STF | 76.32 |
| 189 | 140700009 | 14023466 | 03/11/14 | 00:57:43 | 01:00.42 | | | 54 | 1001 POLK | 2 | 1A1 | ABDOMIN/ TH2 | | 54 | | 0.00 |
| 190 | 140700009 | 14023466 | 03/11/14 | 00:57:43 | 01:06.36 | 01:12.43 | KM07 | | 1001 POLK | 2 | 1A1 | ABDOMIN/ TH2 | KM07 | | VAH | 62.85 |
| 191 | 140700011 | 14023467 | 03/11/14 | 01:04:55 | 01:05.32 | 01:05.41 | | 54 | 1001 POLK | 2 | 29B1 | MVA+INJU TH2 | | 54 | SFG | 56.10 |
| 192 | 140700345 | 14023755 | 03/11/14 | 19:33:14 | 19:40.50 | 19:44.42 | | 82 | 1001 POLK | 2 | 33C5T | INTERFAC TH2 | | 82 | STF | 26.22 |
| 193 | 140710269 | 14024030 | 03/12/14 | 16:01:06 | 16:01.35 | 16:05.39 | KM09 | | 1001 POLK | 3 | XM | CODE 3 MI TH2 | KM09 | | UCM | 85.53 |
| 194 | 140720041 | 14024204 | 03/13/14 | 02:45:48 | 02:46.41 | 03:13.53 | | 94 | 1001 POLK | 2 | XR | CODE 2 AN TH2 | | 94 | SFG | 77.65 |
| 195 | 140720043 | 14024206 | 03/13/14 | 02:49:10 | 02:50.21 | 02:52.51 | AM22 | | 1001 POLK | 3 | 10C1 | CP ABNL B TH2 | AM22 | | SFG | 85.72 |
| 196 | 140720064 | 14024226 | 03/13/14 | 05:20:18 | 05:33.31 | 05:43.13 | | 88 | 1001 POLK | 3 | 6C1A | SOB-ASTH TH2 | | 88 | STF | 46.08 |
| 197 | 140730278 | 14024721 | 03/14/14 | 16:36:40 | 16:39.38 | 16:45.21 | | 84 | 1001 POLK | 2 | 17A2 | FALL >6HR TH2 | | 84 | STF | 53.00 |
| 198 | 140730356 | 14024792 | 03/14/14 | 20:03:12 | 20:05.32 | | | 83 | 1001 POLK | 2 | 1A1 | ABDOMIN/ TH2 | | 83 | DMC | 56.80 |
| 199 | 140740361 | 14025163 | 03/15/14 | 19:36:20 | 19:38.10 | 19:52.22 | | 94 | 1001 POLK | 2 | 1C4 | ABD PAIN TH2 | | 94 | CPP | 75.03 |
| 200 | 140750045 | 14025275 | 03/16/14 | 02:15:44 | 02:29.59 | 02:53.40 | | 67 | 1001 POLK | 2 | 1A1 | ABDOMIN/ TH2 | | 67 | STM | 86.77 |
| 201 | 140750051 | 14025278 | 03/16/14 | 02:35:50 | 02:38.08 | 02:48.49 | | 68 | 1001 POLK | 3 | 28C1U | CVA N ALR TH2 | | 68 | STF | 78.72 |
| 202 | 140750275 | 14025466 | 03/16/14 | 17:41:00 | 17:48.21 | 18:06.13 | | 72 | 1001 POLK | 2 | 5A1 | BCK PN N TH2 | | 72 | VAH | 68.32 |
| 203 | 140750340 | 14025525 | 03/16/14 | 21:28:09 | 21:31.04 | 21:32.06 | | 89 | 1001 POLK | 2 | 17A1G | GROUND I NOM | | | | 44.12 |
| 204 | 140750346 | 14025531 | 03/16/14 | 21:47:27 | 21:49.55 | 21:54.23 | KM03 | | 1001 POLK | 2 | 17A1 | FALL-MINC DUP | | | | 0.00 |
| 205 | 140760235 | 14025757 | 03/17/14 | 15:11:06 | 16:19.24 | 16:19.24 | | 66 | 1001 POLK | 2 | 26C1 | SICK ALOC TH2 | | 66 | STF | 8.53 |
| 206 | 140770012 | 14025924 | 03/18/14 | 01:25:29 | 01:27.10 | 01:29.55 | KM07 | | 1001 POLK | 3 | 6D2 | SOB DIF S TH2 | KM07 | | STF | 58.98 |
| 207 | 140790214 | 14026743 | 03/20/14 | 14:11:06 | 14:13.14 | 14:16.33 | | 65 | 1001 POLK | 3 | 10C4 | CP >=35 N TH2 | | 65 | CPP | 70.53 |
| 208 | 140800035 | 14026915 | 03/21/14 | 03:56:28 | 03:58.19 | 04:02.22 | | 67 | 1001 POLK | 3 | 6D2 | SOB DIF S TH2 | | 67 | SFG | 69.30 |
| 209 | 140810284 | 14027451 | 03/22/14 | 18:30:13 | 18:31.09 | 18:40.50 | KM10 | | 1001 POLK | 3 | XM | CODE 3 MI TH2 | KM10 | | STF | 54.63 |
| 210 | 140820020 | 14027562 | 03/23/14 | 01:27:37 | 01:31.45 | 01:41.26 | | 55 | 1001 POLK | 2 | 4B1A | ASSAULT TH2 | | 55 | SFG | 81.18 |
| 211 | 140830097 | 14027922 | 03/24/14 | 09:44:45 | 09:48.02 | 09:54.28 | KM04 | | 1001 POLK | 2 | 26A1 | SICK EVAL TH2 | KM04 | | UCM | 59.55 |
| 212 | 140830241 | 14028038 | 03/24/14 | 16:21:18 | 16:22.44 | 16:27.19 | KM03 | | 1001 POLK | 3 | 31D2 | UNCONSC TH2 | KM03 | | STF | 52.65 |
| 213 | 140850374 | 14028799 | 03/26/14 | 23:10:37 | 23:11.38 | 23:15.57 | AM10 | | 1001 POLK | 3 | 6D2 | SOB DIF S TH2 | AM10 | | STF | 76.65 |
| 214 | 140860065 | 14028859 | 03/27/14 | 08:27:27 | 08:28.14 | 08:31.18 | | 66 | 1001 POLK | 3 | 31D1 | UNCONSC TH2 | | 66 | STF | 62.52 |
| 215 | 140870193 | 14029281 | 03/28/14 | 13:20:40 | 13:22.28 | 13:26.38 | AM04 | | 1001 POLK | 2 | 17B1 | FALL DELT TH2 | AM04 | | STF | 65.55 |
| 216 | 140870209 | 14029295 | 03/28/14 | 14:06:50 | 14:09.03 | 14:29.47 | | 77 | 1001 POLK | 2 | 1A1 | ABDOMIN/ TH2 | | 77 | STM | 81.13 |
| 217 | 140870320 | 14029394 | 03/28/14 | 18:41:47 | 18:43.57 | 18:49.09 | AM18 | | 1001 POLK | 3 | 31D2 | UNCONSC TH2 | AM18 | | STL | 56.78 |
| 218 | 140880159 | 14029626 | 03/29/14 | 11:56:36 | 11:57.00 | 12:13.33 | | 66 | 1001 POLK | 2 | 21D2 | BLEEDING TH2 | | 66 | STF | 64.42 |
| 219 | 140880342 | 14029795 | 03/29/14 | 22:47:16 | 22:49.17 | 22:50.32 | AM10 | | 1001 POLK | 2 | 1C4 | ABD PAIN TH2 | AM10 | | UCM | 86.43 |
| 220 | 140930011 | 14031129 | 04/03/14 | 00:28:27 | 00:30.18 | 00:32.09 | | 77 | 1001 POLK | 3 | 27D3S | CENTRAL TH3 | | 77 | SFG | 42.15 |
| 221 | 140930011 | 14031129 | 04/03/14 | 00:28:27 | 00:30.18 | | RC1 | | 1001 POLK | 3 | 27D3S | CENTRAL TH3 | RC1 | | | 5.17 |
| 222 | 140930276 | 14031349 | 04/03/14 | 16:39:52 | 16:53.06 | 16:58.11 | | 83 | 1001 POLK | 2 | 1A1 | ABDOMIN/ TH2 | | 83 | ERR | 75.05 |
| 223 | 140950180 | 14031941 | 04/05/14 | 12:03:19 | 12:03.23 | | | 72 | 1001 POLK | 3 | XM | CODE 3 MI DUP | | | | 0.00 |
| 224 | 140960141 | 14032271 | 04/06/14 | 10:13:36 | 10:16.52 | 10:23.56 | | 54 | 1001 POLK | 2 | 21B1 | SERIOUS I PDT | | | | 40.15 |
| 225 | 140970388 | 14032836 | 04/07/14 | 19:58:00 | 20:00.37 | 20:06.41 | AM08 | | 1001 POLK | 2 | 26A11 | SICK VOM TH2 | AM08 | | CPP | 54.93 |
| 226 | 140970393 | 14032839 | 04/07/14 | 20:07:46 | 20:11.34 | 20:16.24 | | 77 | 1001 POLK | 3 | 10D4 | CP CLAMM TH2 | | 77 | STF | 44.38 |
| 227 | 140980213 | 14033051 | 04/08/14 | 12:08:43 | 12:13.31 | 12:18.34 | KM01 | | 1001 POLK | 2 | 26O7 | SICK CON/ TH2 | KM01 | | STF | 51.98 |
| 228 | 140990379 | 14033587 | 04/09/14 | 21:35:03 | 21:38.09 | 21:45.44 | | 96 | 1001 POLK | 2 | 26A1 | SICK EVAL TH2 | | 96 | CPP | 56.45 |
| 229 | 141000080 | 14033681 | 04/10/14 | 08:11:06 | 08:13.27 | 08:17.37 | AM16 | | 1001 POLK | 3 | 10C1 | CP ABNL B TH2 | AM16 | | ERR | 86.48 |
| 230 | 141020069 | 14034341 | 04/12/14 | 06:07:25 | 06:10.04 | | | 82 | 1001 POLK | 2 | 4A2A | TRAUMA E TH2 | | 82 | | 2.57 |
| 231 | 141020069 | 14034341 | 04/12/14 | 06:07:25 | 06:12.25 | 06:23.42 | | 93 | 1001 POLK | 2 | 4A2A | TRAUMA E TH2 | | 93 | UCM | 69.43 |
| 232 | 141020357 | 14034593 | 04/12/14 | 22:08:43 | 22:10.53 | 22:17.35 | AM22 | | 1001 POLK | 2 | 4B1A | ASSAULT TH2 | AM22 | | KSF | 52.32 |
| 233 | 141050254 | 14035471 | 04/15/14 | 15:46:47 | 15:48.29 | 15:56.04 | KM11 | | 1001 POLK | 3 | 10C1 | CP ABNL B TH2 | KM11 | | CPP | 26.45 |
| 234 | 141060171 | 14035728 | 04/16/14 | 10:32:11 | 10:38.38 | 10:47.25 | KM02 | | 1001 POLK | 2 | 32B3 | UNKNOWN TH2 | KM02 | | UCM | 112.15 |
| 235 | 141060187 | 14035741 | 04/16/14 | 11:14:56 | 11:17.04 | 11:28.13 | KM12 | | 1001 POLK | 3 | 30B1 | TRAUMA/II TH2 | KM12 | | CPP | 61.37 |

Shelter Health Evolution

- Sicker older population
 - Shelters are highest users of 911 per address in the city. Next Door and MSC South top two
 - Shelter Staff are not medically trained
 - Hospital d/c clients to shelter who are not appropriate
- HSA Comes to DPH in 2012-13 asking for help
 - Two groups form
 - “Sicker Clients in Shelter” Workgroup
 - 911 Shelter Workgroup



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Shelter Health Evolution

- Recommendations of workgroups
 - On site RNs in shelters
 - Community Paramedic program
 - Custodial Care Beds for non acute functionally challenged clients
- 2014 Two RN positions created (1 FTE and 0.9 FTE)
- 2015 one FT RN placed at ND and one 0.9 placed at MSC South
- 2015-16 FY added 2.6 FT Health Worker
- 2016 dedicated as needed RN time 1FTE
- 2016 EMS and Homeless Outreach forms special team (EMS6)



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What Do Shelter Health RNs Do?

- Provide Urgent Care Nurse Clinic daily on site:
 - Treat low acuity presentations utilizing RN protocols and verbal orders from providers
- Get clients into appropriate level of care:
 - PC referrals and reconnection, coaching, assist with transport
 - Transport to UC vs. ER as appropriate
 - Advocacy for ER and In patient clients
- Prevention
 - Daily RN rounds on the floor
 - Weekly HOT/SH joint rounds
 - Assistance with chronic disease management (screenings, medication assistance, teaching)
 - Tb testing, flu campaigns etc



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What Do Shelter Health RNs Do?

- Short term case management for the most complex clients
 - Referred by shelter staff/SF START or identified by RN in clinic
 - Collaboration with multiple agencies to:
 - Stabilize clients to have a safe and dignified stay in shelter
 - IHSS, Health at Home, DME
 - Get clients to appropriate level of care
 - ER, UC, PC
 - SNF, Board and Care etc.



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Respite Expansion



Expansion of Medical Respite: Background

- San Francisco Supervisor Jane Kim spent a night at a local homeless shelter
- Worked with Director of Shelter Health to discuss options
- Advocated for an expansion of Respite services to include referrals from Shelter
- Former Mayor Ed Lee mandated 30 new beds for Shelter Respite services.
- Expansion targeted shelter residents who are failing in a shelter setting due to medical conditions or functional impairments

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Programmatic Considerations

- Custodial care Identified as a necessary service for a successful expansion
- To license or not to license as B&C or SNF
- Determine new staffing patterns
 - Additional staff
 - Addition of the PCA
 - Define definition of “custodial care” under a Primary Care license



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Programmatic Considerations

- Planning the layout of the facility
 - Sobering
 - Facility layout: shelter health clients on one side, men/women, trans clients
 - Bathrooms
- Work flow planning, clinical care
 - Incorporating employee feedback
 - Brown bag meetings: work flows, changing roles, admission criteria, identifying resources



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Relationship Building

- Many meetings with Shelter Health and Street Medicine
- Worked to create/agree upon admission criteria
- Policy and protocol development around referral and admission
- Agreements and finalization of Shelter Health admission criteria to Respite
- Agreements on discharge disposition and support of Shelter Health clients



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Respite Referral Coordination and Collaboration

- Referral process to Respite from hospitals
- Shelter health manages all referrals to MR shelter health beds
- One RN and One CHW
 - Assess clients in shelters, streets, drop-in centers and in-patient facilities
 - Get clients “wrapped up” for transfer to Respite
 - Assist with transport, meds, DME, IHSS etc
 - Ongoing collaboration with Respite Staff to meet goals
- Symbiotic relationship
- Discharge process
 - Assist with clients returning to shelter (both clients referred by our team as well as hospital d/c clients who access shelter post Respite)

Medical Respite now:

- May 2017: Completed \$3.78 million expansion
- 30 new beds earmarked for clients coming from shelter
- Now 75 total Respite beds: 21 female, 54 male
- Designed to offload the burden of these clients in the shelter
- Promotes a safer and healthier shelter environment for all individuals living in shelters



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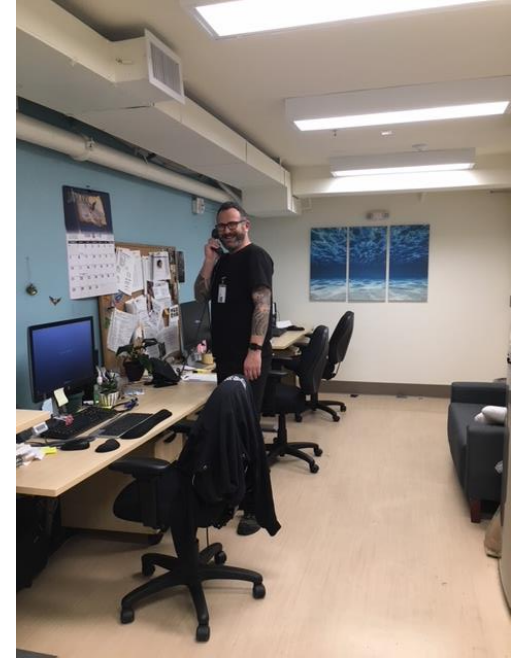
Expanded Services

- Shelter Respite clients receive all the services of Hospital Respite clients in addition to:
 - Intensive team-based care and care coordination
 - Provide early intervention prior to worsening of health conditions
 - Prevent hospitalizations
 - Ongoing care coordination with Shelter Health
 - Additional CNA/PCA staff not before provided at Respite
 - Provides a unique period of intense engagement for very vulnerable people for whom it has been historically difficult to provide medical care



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Pictures of Expanded Space



Additional Impacts of Respite Expansion on the Health Care System

- Lower Level of Care Support to ZSFG
 - Offload LLOC clients from ZSFG during times of hospital overcrowding
- Emergency response
 - Provide system level support for Emergency Operations
 - Help hospital create available beds for emergency preparedness
 - Provide additional community support during recent heat waves, air quality emergencies, New Year's Eve

Impact of Access to Respite Beds on Clients, Shelter Staff and Nursing Teams

- Most importantly, clients are able to be cared for in an appropriate supportive environment
- Sharp decrease in DOS's (Denial of Service) for inability to self care/medically inappropriate
- Decrease in EMS transports
- Decrease in ER visits
- Decreased burden Shelter Staff and Management who are not medically trained

Impact of Access to Respite Beds on Clients, Shelter Staff and Nursing Teams

- Safe holding place for clients needing a permanent higher level of care
 - Many clients are reconditioned and return to shelter (medical stabilization, OT,PT, improved ability to manage self care)
 - Freeing up RNs
 - To see more clients for urgent needs
 - To provide more preventative, chronic disease management
- “I have noticed a significant improvement in my ability see more clients and do more with them”

-Kristin Matteson RN

Shelter Respite Client Outcomes

“Shelter health clients are definitely different from hospital clients. I’m seeing the deficits in functional living skills and safety that went under the radar in the community. They are brilliant people who’ve managed to stay safe and navigate the shelter system. We are connecting clients to clinics, case management, and services for functional deficits such as IHSS. Most long term clients who don’t have a clear discharge option are shelter health clients”

- Jackie Berrios, MSW, Medical Respite Social Worker



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Outcomes: Year 1 Post Expansion

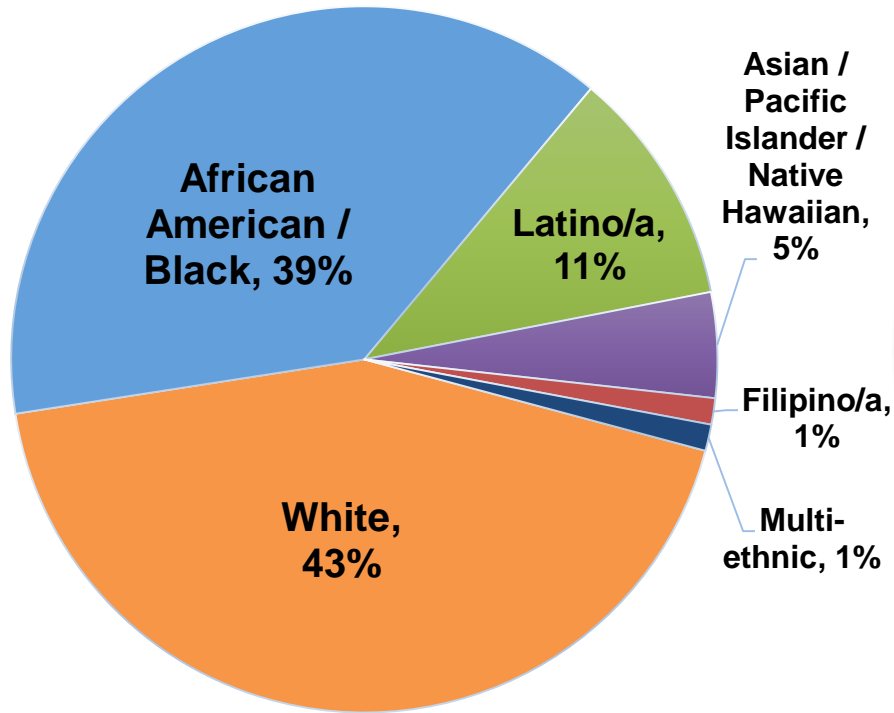
Hospital Referrals

- 306 Hospital clients
- Average LOS is 39 days

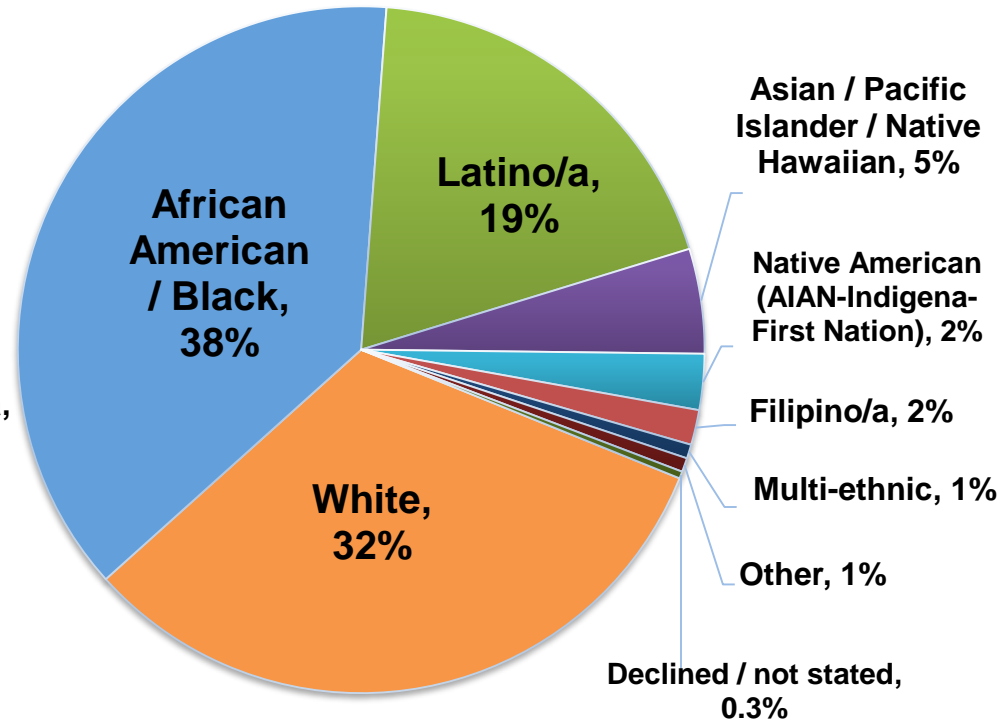
Shelter Referrals

- 83 Shelter clients
- Average LOS is 60 days
- 1/3 of Shelter Respite beds are occupied by client awaiting housing/placement
(Point in Time Average LOS is 168 days)

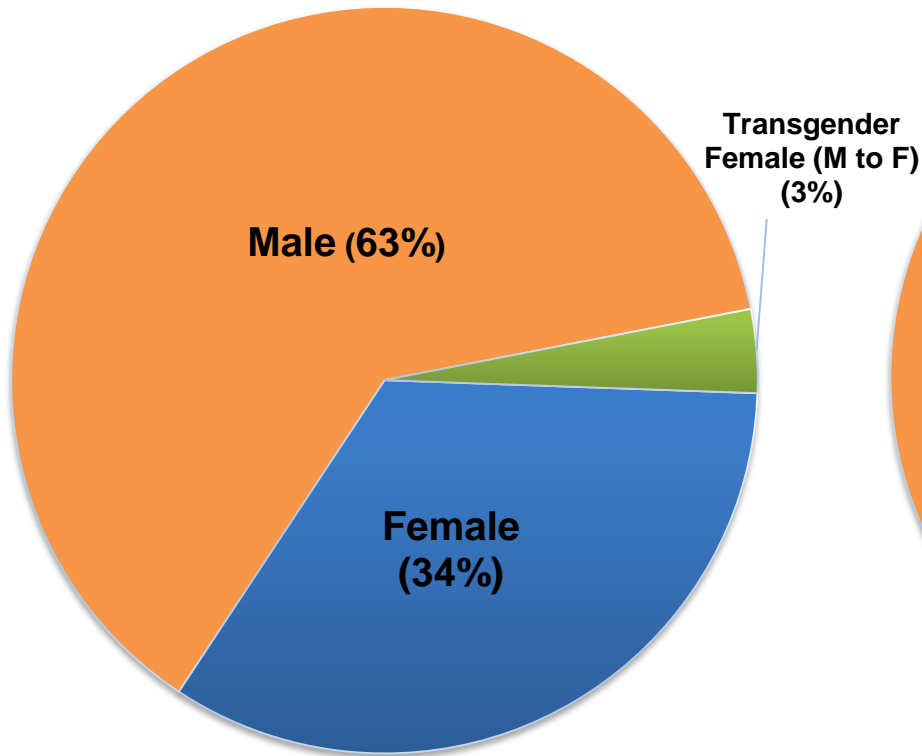
Race (Shelter)



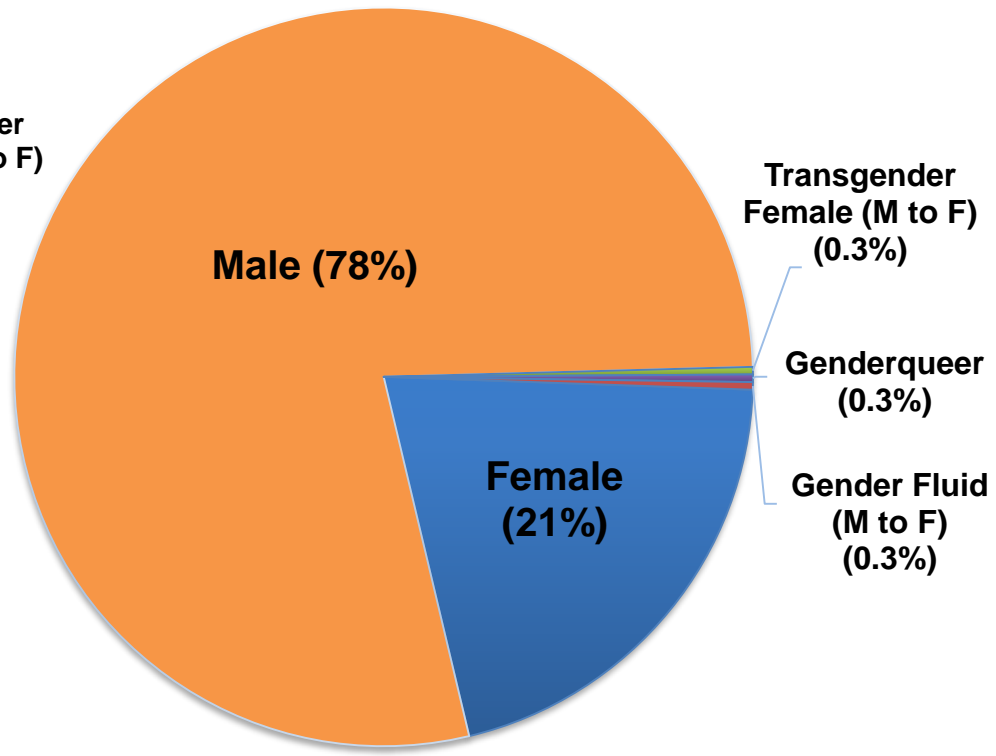
Race (Hospital)



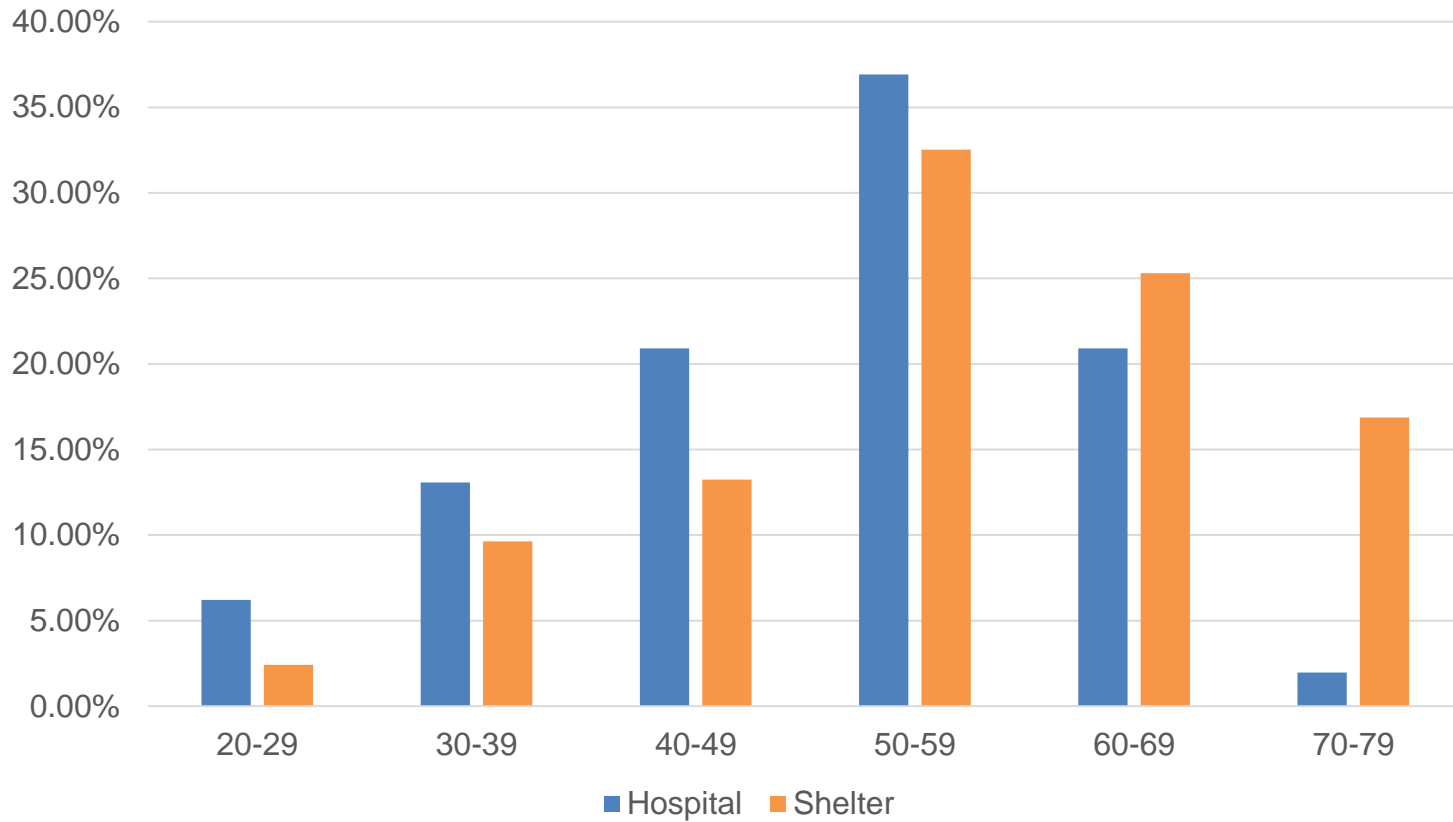
Gender (Shelter)



Gender (Hospital)



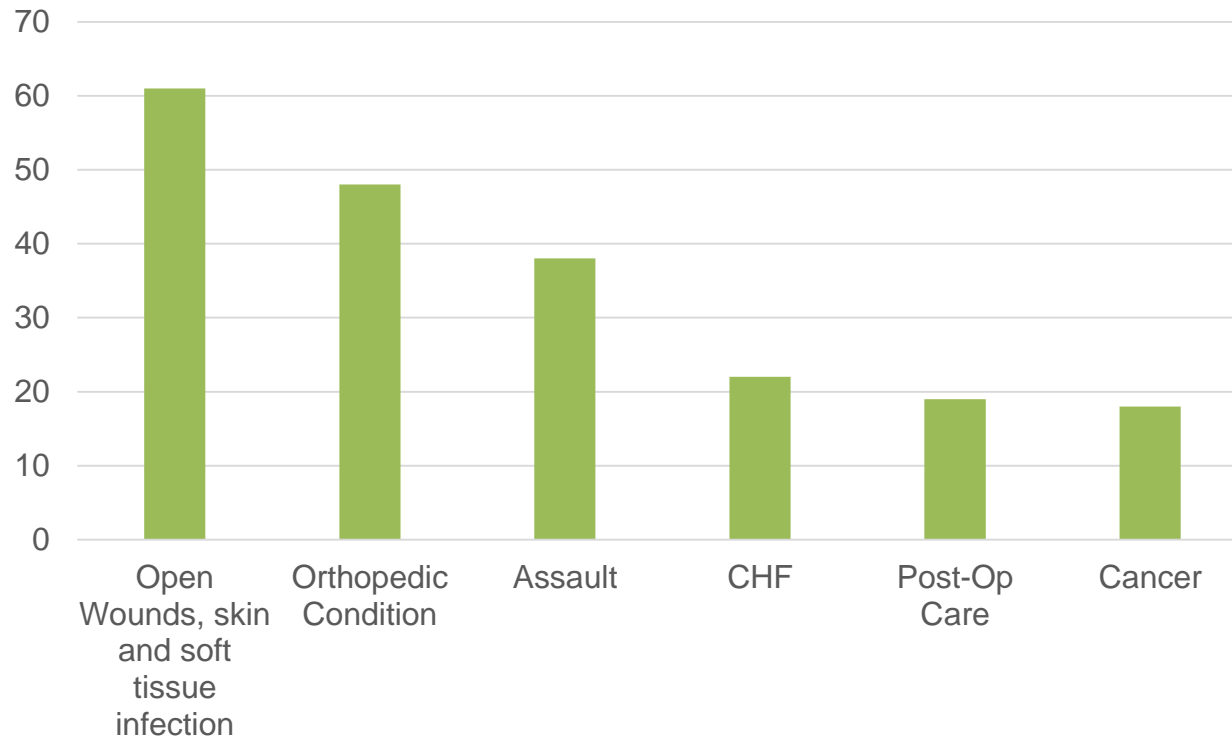
Comparing Age Range



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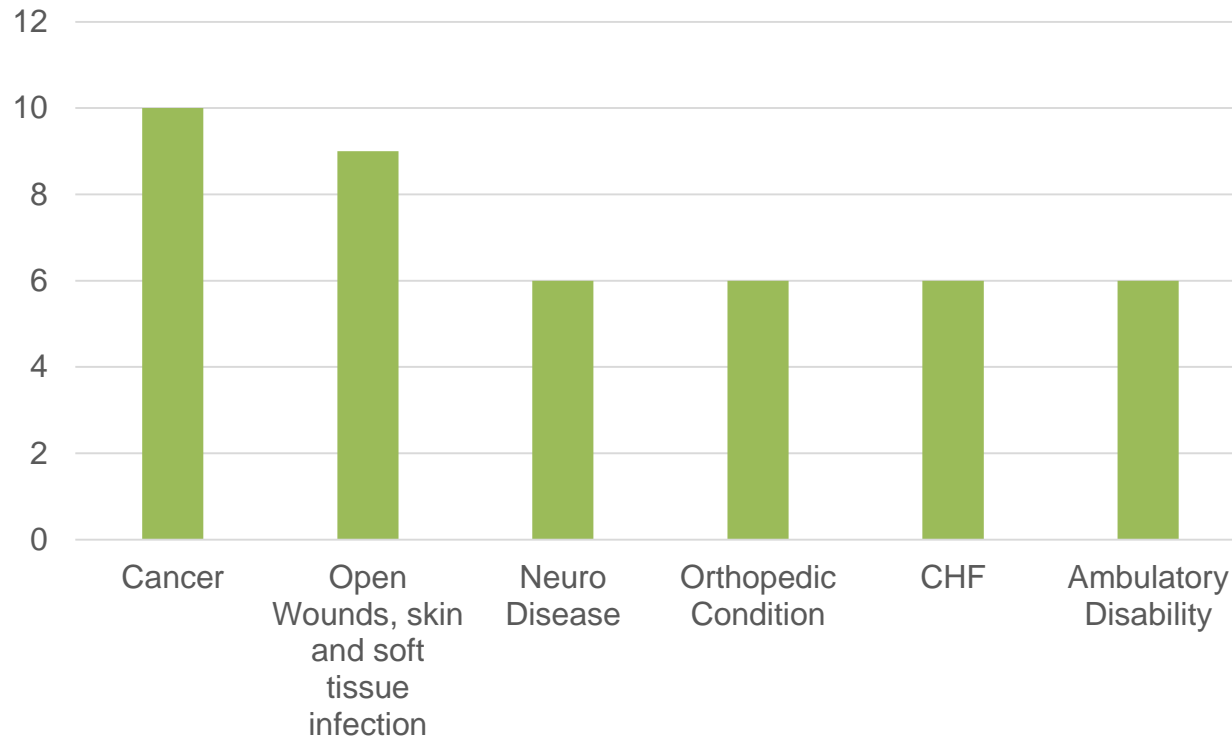
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Top 6 Diagnoses (Hospital)



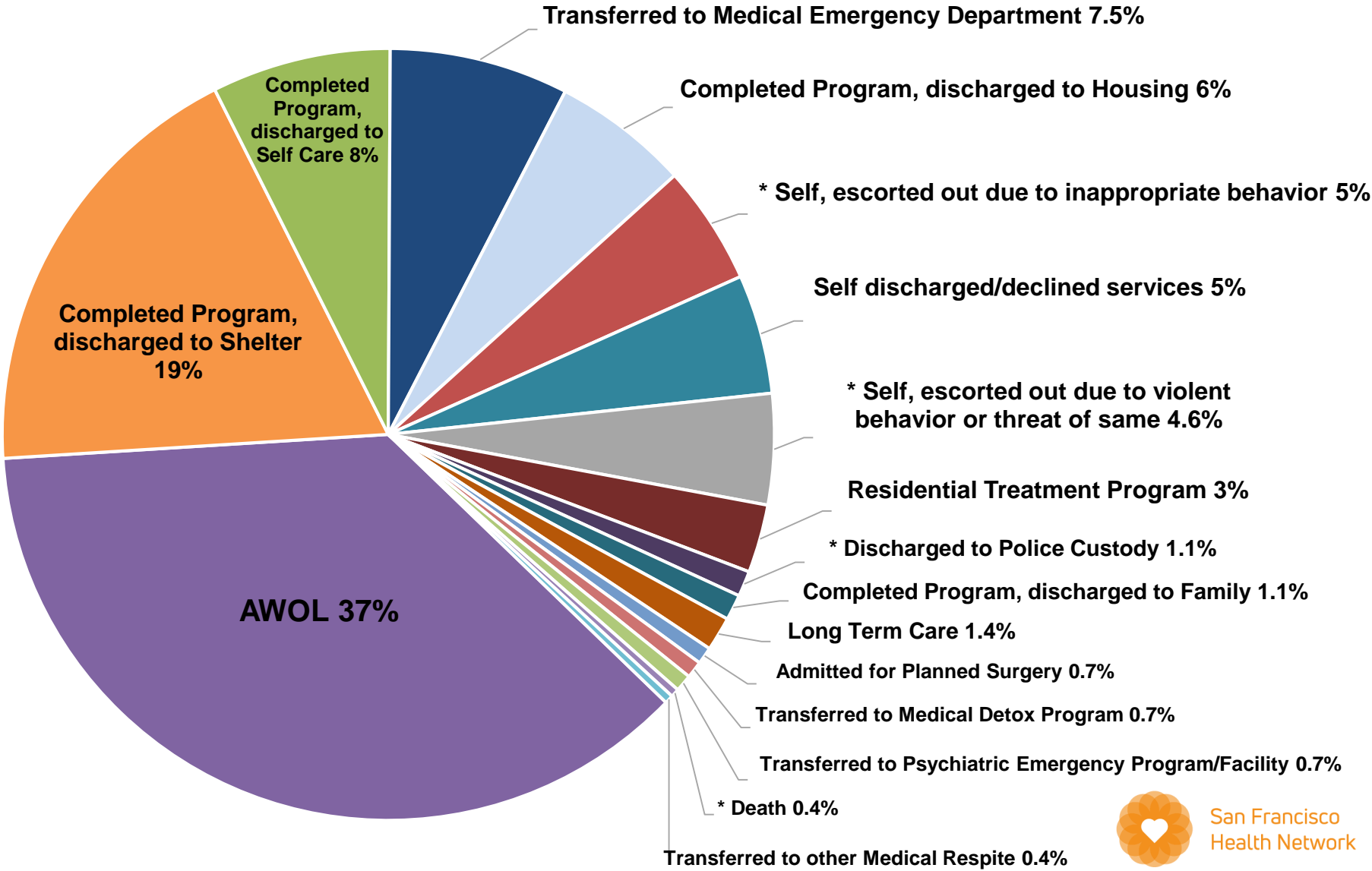
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Top 6 Diagnoses (Shelter)

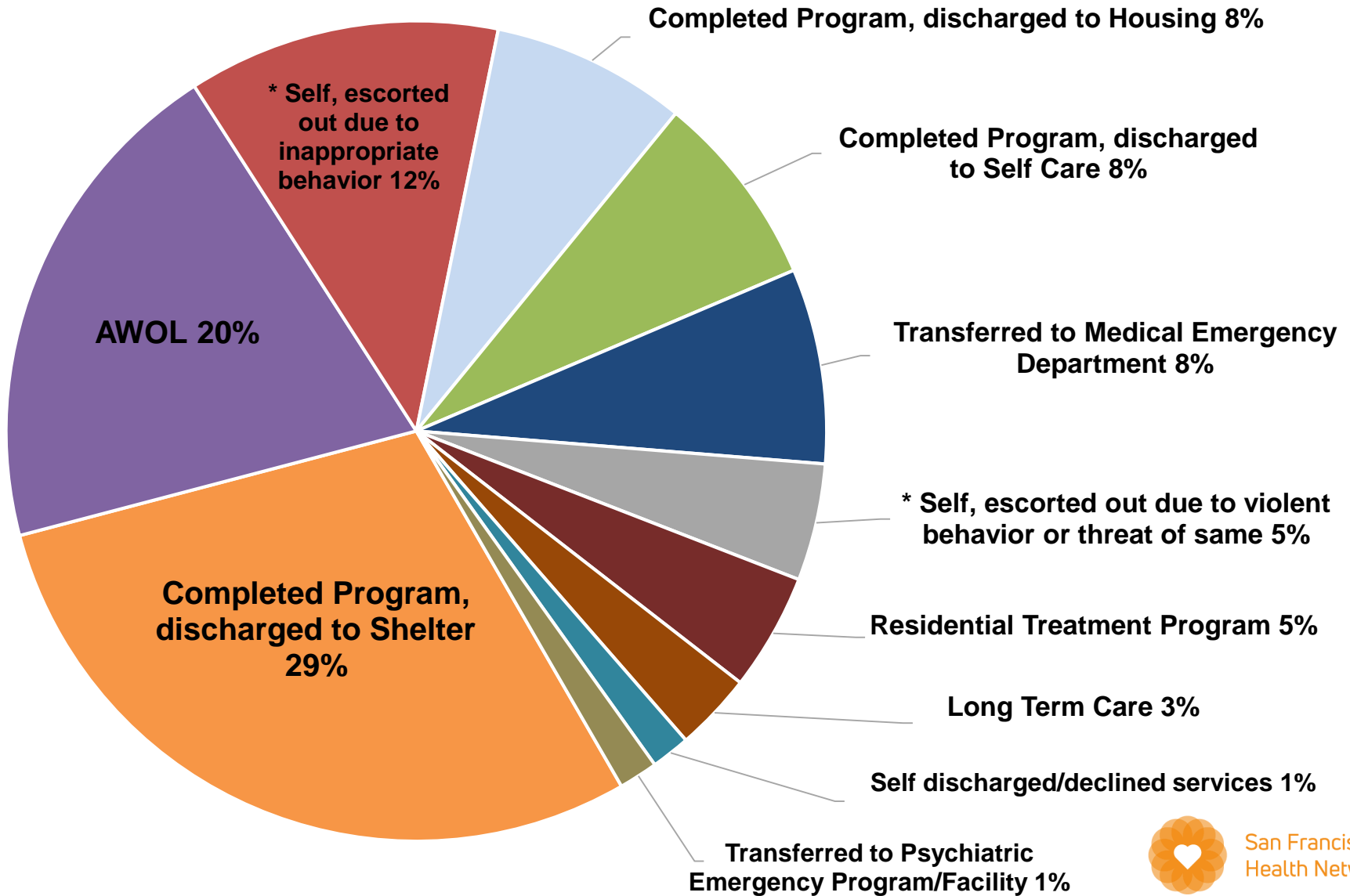


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Of the 280 Hospital clients discharged,



Of the 65 Shelter clients discharged,



Medical Respite Expansion: Social Services and Disposition



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Current Model of Social Services

- 3 Social Workers (MSWs/LCSWs)
- 5 Case Managers
- Services are optional, all clients are outreached



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Shelter Health Clients: Presentations

- RESILIENCY
- Co-occurring disorders
- Chronic homelessness
- High utilizers of services
- Impaired ADLs/IADLs



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Shelter Health Clients: Presentations (Continued)

- APS current/recent involvement
- Behavioral challenges
- 'Not fitting' in services system
- Have been tried to be housed and not successful



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Shelter Health Clients: Presentations (Continued)

Cognitive impairment

- **42.2%** of Shelter Health clients are over the age of 60, compared to **22.9%** of Hospital clients are over the age of 60.
- **16.87%** of Shelter Health clients are over the age of 70, compared to **1.96%** of Hospital clients are over the age of 70.
- *Dementia incidence doubles every 5 years from ages 65 to 90 years.* (Corrada M.M. et al. 2010)
- **29%** of Shelter Health clients have diagnosis of cognitive impairment/dementia compared to **3%** of Hospital clients have diagnosis of cognitive impairment/dementia



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Shelter Health Clients: Psychosocial Needs

- Related to vulnerability, risk, complexity
- Support in functioning
- Suitability for discharge back to shelter
- Custodial SNF level clients or those in 'grey area'



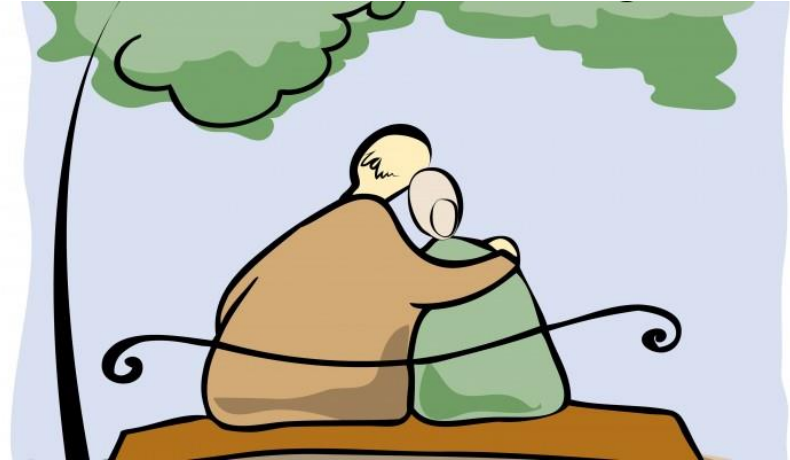
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Shelter Health Clients: Psychosocial Needs (Continued)

Cognitive Impairment

- Appropriateness for independent living
- Dementia-informed care and environment.
- Challenges around behaviors and threshold for discharge.
- Capacity to make decisions related to:
 - Finances
 - Health care
 - Family involvement for decision-making



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Shelter Health Clients: Social Services Goals

Overall:

- Looking for gains that are most impactful and sustainable.
- Reducing risk.
- Increasing independence and community supports.
- And always meeting client where they're at.



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Shelter Health Clients: Social Services Goals (Continued)

More Specific to Shelter Health clients:

- Intensive community services
- APS reporting
- Caregiving oversight/interventions
- Cognitive testing
 - GP-COG
 - Neuropsychological evaluation
- Decision-making and probate conservatorship



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Shelter Health Clients: Social Services Goals (Continued)

More Specific to Shelter Health clients:

- Independent living skills
- Building a case for the appropriate level of care and coordinating placement when needed
- Escorting for clients with difficulty path-finding and learning/retaining new information
- Intensive wraparound services for move-ins to housing
- Communication with community providers



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Shelter Health Clients: Case of Ms. A

- 68 yo female, quadruple amputee admitted to Respite from shelter for goal of stabilizing while waiting new prosthetics
- Housed with great difficulty, then gave up own housing. Recent SNF stay
- Declined to pay SOC, so not currently on MediCal. As a result, not eligible for caregiving
- Hx of PTSD and depression. 2 recent sexual assaults. Utilizer of PES
- Hx cocaine and ETOH



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Shelter Health Clients: Case of Ms. A

While at Respite:

- Free clothing & housing resources
- Identified eligibility for board and care. Client declined
- Neuropsychological evaluation completed. Retained capacity
- Client intention and preference to d/c to shelter
- Referred for alternative intensive case management-mental health services
- APS report was made at discharge due to self-neglect



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Shelter Health Clients: Case of Ms. A

In this case, moment of stability:

- Achieved referral goal (*replacing prosthetics*)
- Ruled out cognitive disorder, and poor decision-making likely due to personality traits
- Established client retained capacity to make decisions
- Completed a referral to more intensive case management/mental health services



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Shelter Health Clients: Case of Ms. B

- 44 y/o female with moya moya disease, major neurocognitive disorder due to multiple etiologies with behavioral disturbance, vascular dementia, and hx of stroke, at Respite s/p assault by her partner at the time. Referred to Respite for goals of rest and recovery, case management assistance, specialist f/u, and neuropsychology evaluation
- Homeless in San Francisco for decades
- At admit, Ms. B reported her partner at the time had been abusing her. SW completed Adult Protective Services (APS) report



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Shelter Health Clients: Case of Ms. B

While at Respite:

- Referred for payee, glasses, clothing, community transportation program
- Blind MOCA indicating significant cognitive impairment
- Neuropsychological evaluation. Did not retain capacity for medical decision making or financial management, and not appropriate for independent living
- Coordination with on-site PCA for specialized caregiving



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Shelter Health Clients: Case of Ms. B

While at Respite (continued):

- Located client's mother, agreeable to be surrogate, unable to house & care
- Assisted client to make regular phone calls to maintain family connection and support
- Referred to community SNF x2, not accepted
- Ms. B eventually had series of falls, hospitalizations, worsening mentation and functioning, and sent to local safety net hospital
- **ADVOCACY** for client admission and placement from hospital



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Shelter Health Clients: Case of Ms. B

In this case, moment of stability:

- Achieved referral goals (*rest and recovery, case management assistance, specialist f/u, and neuropsychology evaluation*)
- Evaluated and monitored level of cognitive and functional impairments
- Established surrogate decision maker for healthcare
- Resulted in Ms. B being placed in appropriate level of care, no longer at risk in community.



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Shelter Health Clients: Case of Mr. C

- 47 yo with BLE chronic venous stasis ulcers, referred to Respite for goals of rest and recovery, BLE elevation and wound care, bridge to SAT
- Homeless for over 20 years in shelters and on the streets
- Mr. C self-reported hx of PTSD, and stated he had anger issues growing up
- At admit, Mr. C reported using ETOH daily, 'every chance he got'



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Shelter Health Clients: Case of Mr. C

While at Respite, Mr. C:

- Established mental health services.
- Referred to outpatient programming, which he attended several days per week.
- Was referred for income, community case management, glasses and clothing.
- Worked on independent living skills, such as calendaring.
- Moved into permanent housing with supportive services.



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Shelter Health Clients: Case of Mr. C

In this case, moment of stability:

- Achieved referral goal (*wound healing*)
- Allowed client stability and support to access substance abuse and mental health treatment
- Learned skills to live indoors, advocate for his needs, and manage his schedule
- Resulted in permanent housing for chronically homeless client
- Established wraparound services for continued stabilization after discharge



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References

Corrada, M. M., Brookmeyer, R. , Paganini-Hill, A. , Berlau, D. and Kawas, C. H. (2010), Dementia incidence continues to increase with age in the oldest old: The 90+ study. *Ann Neurol.*, 67: 114-121. doi:10.1002/ana.21915



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Lessons Learned: Challenges

- Increased clients meant increasing activity on the sidewalk in front of our facility
 - NIMBYISM as well as community support
- Dementia, cognitive impairment increase
 - knowledge gap for staff – both support staff and clinical staff
- Increased need for Social Service/Behavioral Health staff
 - Planning focused on medical need more than behavioral needs
 - Tremendous amount of social work time
- Few discharge options for clients with cognitive and functional impairments



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Lessons Learned: What Worked



- Collaboration, communication, more collaboration, more communication
- Strengthened relationships between previously siloed programs caring for many of the same clients
- Brought to the forefront the challenges of the LLOC clients
- Despite all the challenges, its strengthened us as a team: both within MR and with SH



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Summary

- The Medical Respite program is addressing the needs of a highly vulnerable subset of the homeless population, specifically those who are medically ill and may have cognitive and functional impairments as well.
- This expansion is the first of its kind in the country and is proving to be an innovative way to address these needs
- Ongoing challenge how to best to address the short term and long term needs of people with severe cognitive impairments
- Already starting to see the positive impact on clients and staff in the shelter system
- Story of Hope



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Thank You to the Amazing Medical Respite and Sobering and Shelter Health staff who are here today

Hazel Demonteverde, RN

Sarah Dobbins, RN

Carli Hanbury, RN

Megan Kennel, RN

Joel Parker, RN

Carolina Puentes, RN



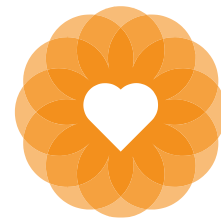
*And thank you to all our team caring for our clients in

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Questions?