Edward Thomas House

MEDICAL RESPITE PROGRAM
Respite Focus

• **Short-term care** for medically ill/injured; too ill for shelter, don’t need hospitalization

• **Services:**
  • Shelter, meals, laundry
  • Medical care: RN (1-2X/day) & Provider
  • Case Management assistance: funding, shelter, ID
  • Assessment/Referral for MH Care and Substance Use
  • Facilitation of follow-up medical care
  • Referral to PCP to establish medical home
  • Groups: education, yoga, mindfulness
Goals of Respite Care

◊ Resolution of acute medical process
◊ Window of opportunity to engage into services
◊ Initiate the process of lifestyle stabilization
◊ Decrease hospital utilization and costs
Admission Criteria

- Experiencing homelessness
- Acute Medical Illness/Injury
- Independent in ADLs, not a fall risk
  - Sufficient function to discharge to shelter
- Not in active Alcohol Withdrawal
- Behaviorally Appropriate for a Group Setting
  - No active SI or HI

Discharge Criteria: Acute process is resolved
Respite Admissions

- Wounds: Abscesses, ulcers, frostbite, burns, post-op
- Extended Antibiotics (IV and Oral)
  - Heart valve, joint, deep bone infections
- Cancer: Radiation/Chemotherapy
- Hospice/Palliative Care
- Elective procedures
  - Colonoscopy, ambulatory surgery
Respite Admissions

- Would consider acutely decompensated chronic medical problems
- Diagnostic work-up if disenfranchised
  - Lung nodule, breast mass
- High Utilizer Admissions
- SNF to Respite Protocol
- Suboxone Induction
- Low Census Protocol
Shelter-based Respite

- Limited Acuity
- Shelter oversaw behavioral management
  - Not trained in De-escalation or Trauma-informed Care
- Substance Use Disorder (SUD) prevalence
- Not Harm Reduction-based
- Patients discharged for using substances or behaviors
- Readmissions, complications
- Not fulfilling our mission
THE FACILITY

Two exam rooms

Common areas
THE FACILITY
Respite Program Partners

**Hospital & Health Partners**
- PHD
- Evergreen
- Harborview
- Northwest
- Swedish
- UWMC
- Valley
- Virginia Mason
- MCOs
- Steering Committee

**Program operator**
- Harborview Medical Center

**Key Partners**
- Plymouth Housing
- REACH
- ETS
- RCPN

**Site**
- Seattle Housing Authority

**Funding**
- Hospitals
- MCO Billing
- MIDD
- PHD/Grant
Outcomes Data CY 2018

- 564 admits
- 10,520 bed days
- Length of Stay 22 days average (wide range)
- 13% directly placed in transitional or permanent housing—(more post-respite housing)
- 126 patients initiated in CD treatment programs (CY2016, primarily MMT or suboxone)
Respite Cost Advantage

- Homelessness = ↑ utilization, ↑ inpatient LOS, ↑ costs
  - HMC Medicine LOS ≤ 6 days vs 9-10 days if homeless
- Respite decreases admissions
  - Direct transfers from ED or clinics
- Decreased post-respite ED and inpatient use
- Initiation of benefits for reimbursement
- May impact Patients with High Utilization
  - Million Dollar Murray (New Yorker, 2006)
Seattle Respite Health Care
Utilization N=69

Comparison 180 days pre and post respite

- 67% reduction in inpatient episodes
- 10% reduction in ED visits; of those visiting the ED the proportion of encounters resulting in inpatient admission decreased by 50%
- 35% increase in outpatient visits
CMS Innovation Grant

- Multicenter trial 5 medical respite programs (including Seattle)
- ED and inpatient utilization 1 year before & after respite stay (Edgington, 2016, interim data)
- 45% decline in ED visits
- 35% decline in Hospital Admissions
- Calculated cost avoidance, based on utilization decrease & 2-day decrease LOS (2 medical centers)
  - Every $1 invested in respite associated with $1.81 cost avoidance for health system (Shetler, 2018)
IV Antibiotic Data CY 2018

- 106 patients admitted for IV antibiotics
- 1,474 days of IV Rx provided
- $407/day respite vs $1200/day inpatient
- Cost Avoidance of $ 1.8 million
- Highest-risk patients, opportunity!
FIGURE. Percentage of opioid overdose deaths testing positive for fentanyl and fentanyl analogs, by state — 10 states, July–December 2016

O’Donnell et al. MMWR 10/27/17
Number of Fentanyl Deaths King County

Overdose death Report, kingcounty.gov, January 16, 2019
Why won’t respite accept lower acuity colds, headaches, limited mobility?

- Need to ration beds for highest acuity patients who require hands-on daily nursing care
  - Limits access for cancer Tx, wounds . . .
- An expensive bed for dayrest
- Numerous HCHN dayrest options exist
  - Dayrest + RNs at DESC, Angelines, St. Martins
  - UGM dayrest & extended care program
- Limits access to acute care inpatient beds
Wound Photo Next
Why does respite decline chronic stable illnesses or inability to function independently?

- Ex: Chronic Renal Failure/dialysis, TBI + Diabetic - can’t manage insulin/find bed, stool incontinence, can’t safely mobilize
- No short-term achievable acute care goal
- Lack staffing for mobility assist to prevent falls, clean patients after every bowel movement
- Timely housing access not available, discharge to shelter not appropriate
- Limits access for high-acuity acute illnesses/injuries
- Limited SNF/AFH access for HCHN patients
- Shelters need to draw lines/push back on inappropriate discharges
What are the most critical service gaps?

- Do we need more respite beds?
- Do we need “Respite Light”?
- Adult Family Home & Nursing Home care for those inappropriate for shelters
- Revised vulnerability index that highlights medical vulnerability in prioritizing housing
- We need more low-income housing