

MEDICAL RESPITE

Proposal for Alternate Use of Funds
targeted to St. Louis Sobering Center

October 20, 2022

Reason for reallocation of Funds

FY21:

Funds were committed from St. Louis Mental Health Board, Missouri Foundation for Health, Mercy, SSM Health and BJC Healthcare to support operations of a 3-year pilot Sobering Center at Preferred Family Healthcare

FY22:

Missouri Department of Mental Health allocated funding to Preferred to sustain operations on an ongoing basis.

FY23:

Funders noted they would be willing to repurpose funds if they support safety net population, emphasize individuals with Substance Use disorders (SUD)s

Available Funding

Year 1: \$1,028,863

Year 2: \$827,133

Year 3: \$500,000

Total: \$2,355,996

Criteria for new initiative

Feasibility: can we get it up and running in relatively short timeframe?

Sustainability: can the program stand on its own after funding ends?

Impact: what will give us the biggest bang for the buck and improve the safety net system of care for uninsured/underinsured with SUD?

Decision-making Process

- Three meetings held with hospital and community healthcare leadership to present strategy options
- Hospital and community healthcare leadership voted on top two priority strategies.
- Concept papers for two priorities were presented: Medical Respite and Complex Care for Pregnant Women with SUDs
- Medical Respite was chosen because of high need and lack of available services.
- Full proposal drafted for Medical Respite

Dunnica Sobering Center vs. Medical Respite

	Sobering Center	Medical Respite
Target Population	Adults experiencing acute alcohol/drug intoxication, may or may not be experiencing homeless	People Experiencing Homelessness with Substance Use Disorders who are discharged from hospitals with need for post-discharge care
Length of Stay	Average 8-12 hours	15-30 days; varies by facility
Medical Services provided Onsite	No	Yes through visiting nurse, home infusion organizations, etc.
Connection to treatment and SDOH services	Yes	Yes

PROBLEM/NEED



Problem/Need

People experiencing homelessness (PEH) often live with chronic illnesses, complicated by BH disorders, requiring medication or other treatment post ED or hospital discharge

Without alternatives, PEH are not able to complete post-discharge treatment and require frequent readmissions

Result is high healthcare costs and poor health outcomes

Medical Utilization of Individuals Experiencing Homelessness

Type of Utilization	Homeless	Control
Single Men ED Visits	9 X higher	
Single Women ED Visits	12 X higher	
Single Men Hospitalization Rates	8.5 X higher	
Single Women Hospitalization Rates	4.6 X higher	
Average ED Cost/year/patient	\$1436	\$175
Average Hospitalization Cost/year/patient	\$2448	\$517
Maximum ED Visits per year	108	14
Maximum Hospital Admits per year	14.9	2.5

Behavioral health issues among People experiencing homelessness (PEH)

Review of 64,000 housing prioritization surveys in 15 states found that **78%** of unsheltered PEH had a mental health condition and **75%** had a substance use condition

837 individuals in Greater St. Louis region admitted for substance use disorder treatment in FY21 identified as homeless.

Point in time survey of 772 homeless households in St. Louis City: mental health disorders present in at **50%** of the households; substance use disorders present in at least **30%**

What is needed?

Alternative to unnecessary long hospital stay or premature discharge to the streets/shelters

Short-term residential care that allows PEH the opportunity to rest, recovery, heal in safe environment

Opportunity to access medical care and other supportive services

PROPOSED
STRATEGY

MEDICAL RESPITE



What is Medical Respite?

(Used interchangeably with
Recuperative Care)

- Medical Respite/Recuperative care is acute and post acute **medical care** for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital.
- Short term residential care that allows people an opportunity to rest, recover and heal in a safe environment while also accessing clinical care and support services.

System Stressors Addressed by Medical Respite Care

The acute health and social needs addressed by medical respite programs commonly occur within:

- Client segment accounting for a disproportionate amount of staff time and energy at shelter, housing, outreach and other homeless services agencies.
- The high utilizer population for emergency rooms and hospital inpatient beds
- The segment of hospital inpatients with the highest readmission rates

System Issues Impacted by Medical Respite Care

- ❑ Increasing unreimbursed costs for hospitals
- ❑ Increasing staff costs for the homeless response system and social service providers
- ❑ Decreasing performance against performance metrics
 - *Quality of care metrics, often tied to reimbursement rates*
 - *Exits from homelessness*
- ❑ Reduced staff morale in both health care and social service settings
- ❑ Reduced capacity to fulfill mission

Advantages to Medical Respite Care

- Offers safe and cost-effective discharge option
- Connects vulnerable patients to broad range of community care and public benefits
- Improves health by addressing most immediate health care and social services
- Develops more comprehensive care plan and coordinates care across venues
- Provides time and space for healing and health education

Medical Respite Care Impacts

Effect on Hospital Use

- Several studies identified decreased re-admission rates following MRC stays
- Studies also found time spent as an inpatient and ER visits decreased for those who discharged to MRC

Effect on Services Utilization

- Individuals discharged to MRC were more likely to increase outpatient service use
- One study found increased time spent in housing and decreased time spent in other institutions

Cost Savings

- MRC results in cost savings for hospitals even when hospitals fund the MRC stay
- Specialty medical care conducted at MRC settings was a significantly lower cost than receiving the same care in the hospital

Source: National Institute for Medical Respite Care

Medical Respite Care Impacts

Impact on Consumers

- MRC was found to improve health-related quality of life and positive impact health management
- Women may be more likely to leave MRC early: lack of privacy, power dynamics, and history of victimization

MRC Specific Outcomes

- A harm reduction focused intervention resulted in high rates of treatment completion
- Screening for brain injury resulted in positive health outcomes (case studies)
- Factors associated with leaving MRC early included being a women, >50 y.o., living outside prior to MRC, lack of income and/or ID, and substance use

Reducing Gaps in Services

- MRC consumers overall had high rates of connection to Medicaid, income, PCPs, and behavioral health
- Connection to PCP reduced readmission rates
- High referral rates indicate a need for MRC within communities

Medical Respite Outcomes



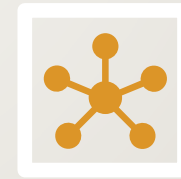
Improved
health



Coordination
of health/SU
care



Decrease in
ED/hospital
use



Connection
to benefits
and SDOH
services



Cost savings
to hospitals

RANGE OF SERVICES AND CARE MODELS

Medical Respite



Medical respite model



Offers alternative to keeping PEH longer than medically necessary or discharging them to streets/shelters



Provides post-acute care in residential setting to allow for rest, recovery, and healing in safe environment.



Opportunity to access medical care and other supportive services



Uses harm reduction model

Medical Respite Model

Program Model: Medical Respite

Hospital/ER



Medical Respite



Housing Support



Permanent
supportive
housing



Temporary
housing, other
social services

Respite services include:

- Clinical care
- Case management

- Room and board
- Peer support

Key Components of All Models

- 24 hour access to a bed
- Transportation to any and all medical appointments
- Access to a phone for telehealth or coordination of follow up appointments

- 3 meals per day
- Safe space to store items
- Wellness check at least 1 time every 24 hours by medical respite staff (medical or non-medical)

Program Models

Coordinated Care

- Coordination of appts
- Connection to PCP
- Referral to case management services

Coordinated Clinical Care

- Case management/care coordination for medical appointments
- Connection to Primary Care Provider (PCP)/health home
- Care coordination with home health and home-based clinical care services
- Connection to community behavioral health and/or substance use program

Integrated Clinical Care

- Onsite clinical services include:
 - Daily evaluation by clinical provider
 - Provision of medical clinical services within scope - Dispensing or administration of medication, medication reconciliation, medication monitoring

Comprehensive Clinical Care

- Daily evaluation
- Palliative/hospice care
- OPAT services
- PT/OT
- Onsite substance use treatment & behavioral health care
- Peer support

Medical respite across the US

- **133** medical respite programs across 38 states and territories.
- Missouri is one of **13** states that has not widely adopted the medical respite model.
- Can be shelter-based, standalone facilities, transitional housing, apartments or other settings.
- National Institute for Medical Respite Care determined seven standards that are required of certified programs.

Diversity of Program Types

Bed number

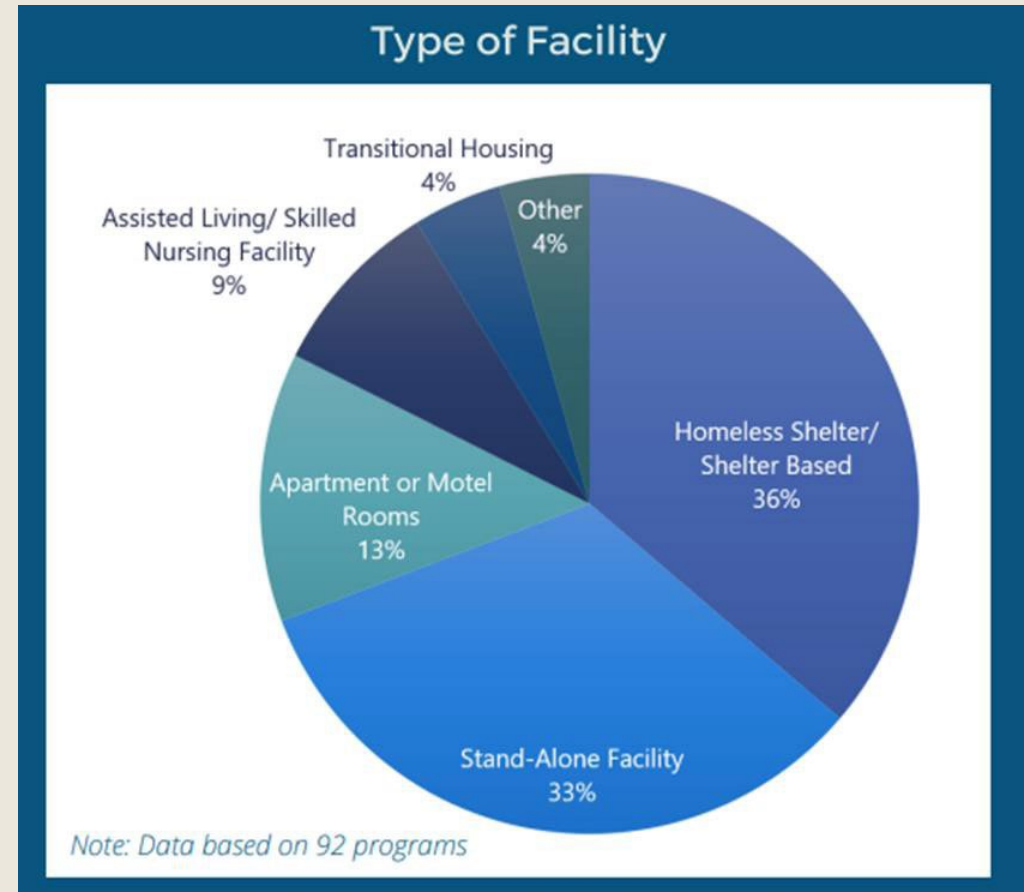
Facility type

Length of stay

Staffing and services

Referral sources

Admission criteria



National Standards for Medical Respite

(Established by the National Health Care for the Homeless Council)

- Provide safe and quality accommodations
- Provide quality environmental services
- Manage timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings
- Administer high quality post-acute clinical care
- Assist in health care coordination and provides wrap around support services
- Facilitate safe and appropriate care transitions out of medical respite care
- Driven by quality improvement

Partners

- Referral partners: hospitals, Sobering Center, infectious disease clinics
- NARR-certified recovery housing providers with respite interest/experience
- SUD and BH treatment providers
- Federally Qualified Health Centers (FQHCs)
- Shelters, Continuum's of Care

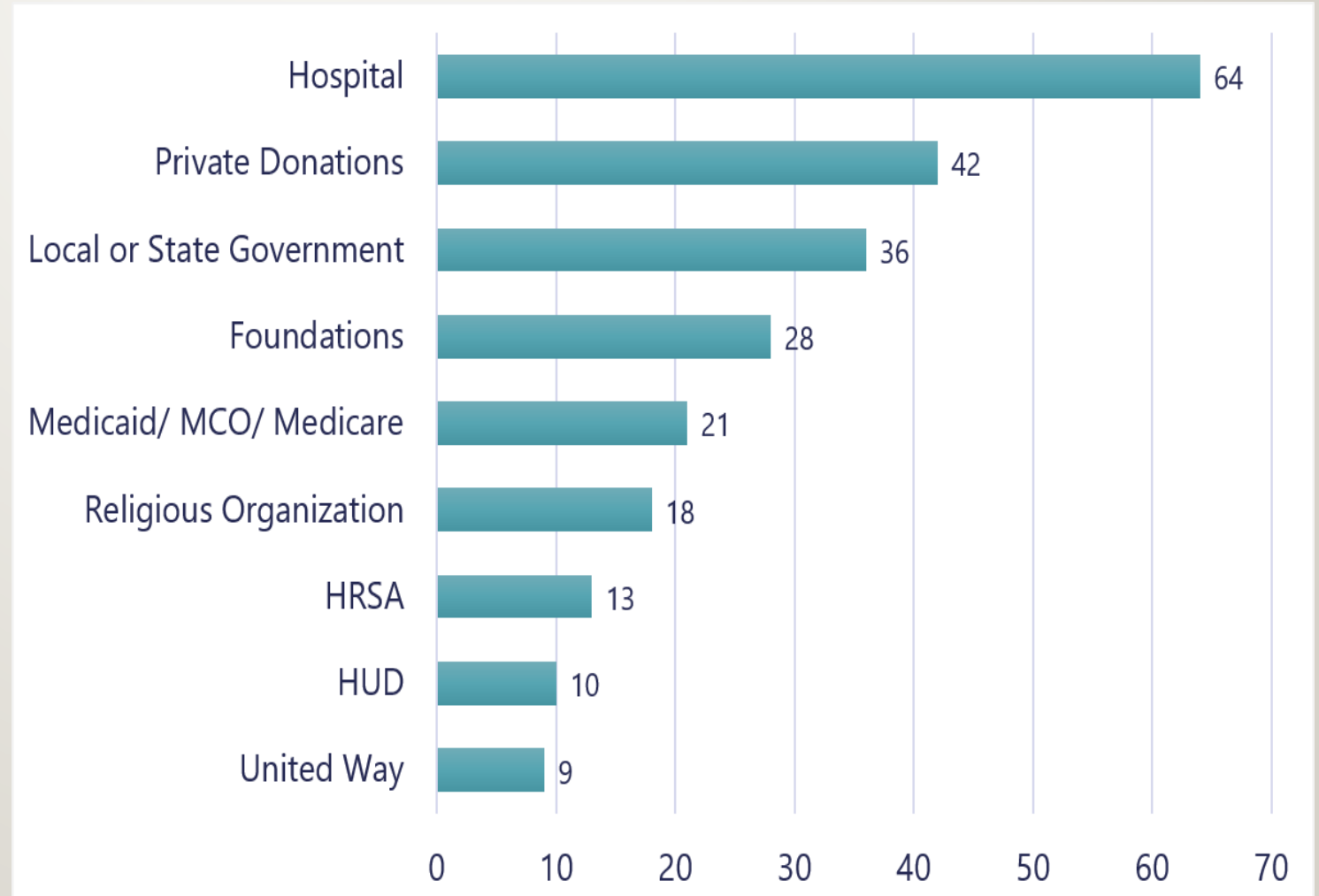
MEDICAL RESPITE CARE FUNDING

SUSTAINABILITY

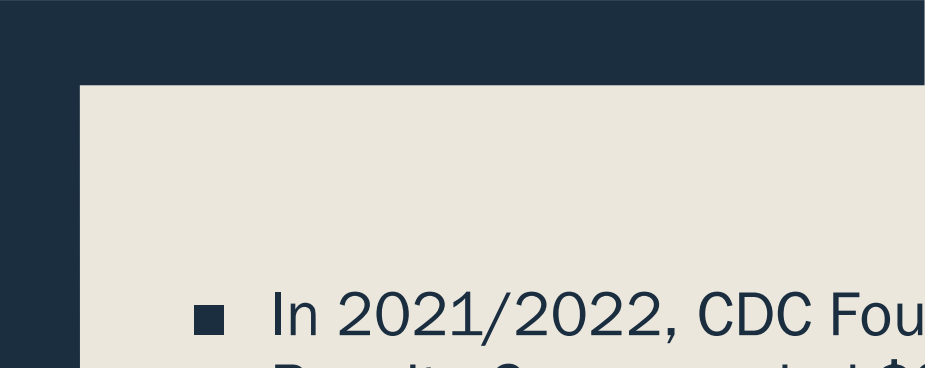



FUNDING SOURCES

- A small percentage have a single source of funding
- Most programs have multiple funding sources



Source: National Institute for Medical Respite Care

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- In 2021/2022, CDC Foundation and National Institute for Medical Respite Care awarded **\$2.5 million** to 14 medical respite programs to determine the model's value and potential for large-scale investment.
 - Medicaid/Medicaid Managed Care have created models in multiple states to fund Medical Respite.
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What Is Being Covered?

	Boston	Chicago	Los Angeles	Phoenix	Santa Barbara	Seattle	Yakima
Onsite health care services	X			X		X	
Support services (case management, care coordination, benefits, health education, medication management)	X	X	X	X	X	X	X
Food	X	X	X		X	X	X
Beds/housing	X*	X	X		X	X	X
Transportation	X	X	X				X
Administration/indirect costs	X		X	X	X	X	X

Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care (March 2020)

Source: National Institute for Medical Respite Care

NEXT STEPS

WHERE ARE WE NOW AND WHERE ARE WE HEADING?



Where we are now:

October 2022

- Hospital Vice Presidents have all agreed to re-purpose the funds and that medical respite is a viable alternative
- VPs in process of vetting proposal with hospital Executive Leadership Teams
- Funders are reviewing the proposal to agree upon the model

Next steps

01

Final approval
from remaining
funders

02

Establishment of
location(s) and
partners

03

Establishment of
budget/model

QUESTIONS?



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