PROPOSAL EXECUTIVE SUMMARY

St. Louis Mental Health Board

Medical Respite

Overview: Our goal is to provide a St. Louis **Medical Respite Home as a recuperative care** option for safe, short-term residential care. Services will be targeted to people experiencing homelessness (PEH) with co-occurring chronic illness and indicators of Substance Use Disorder (SUD) so they can complete a course of post-discharge treatment, avoid hospital re-admission, and be connected to SUD harm reduction or recovery services.

Rationale: People experiencing homelessness (PEH) often live with chronic illnesses, complicated by mental health (MH) or substance use (SU) disorders (behavioral health, BH), that require post-acute care services, hospital discharge medication, or other treatment. These individuals are typically underserved, stigmatized and experience gaps in services, resulting in poor healthcare outcomes and readmissions to the hospital, often presenting at emergency departments (ED). This results in **high healthcare costs** and **poor health outcomes.** A study of PEH in Toronto, Canada found that the number and costs of ED visits/hospitalizations were as much as 12 times higher than that of housed individuals. The prevalence of behavioral health conditions among PEH has been documented, with PEH having anywhere from two to five times higher rates of mental disorders, alcohol use disorders, drug use disorders, and opioid use. An alternative model is needed to current practices of either keeping PEH in hospitals longer than medically necessary, or discharging them to the streets where they are unable to complete follow up treatment.

Target Population	The proposed St. Louis Medical Respite Home will target PEH with a SUD and a recent hospitalization or ED visit that requires a course of follow up treatment that would need to be delivered by a medical provider (e.g., wound care or IV antibiotics or other IV medication, follow up care post-surgery).
Geography	Respite home patients may live anywhere in the Eastern Region - St. Louis City, St. Louis, St. Charles, Franklin, Jefferson, Lincoln, Warren Counties.
Partners	Hospitals, recovery housing providers, Federally Qualified Health Centers (FQHCs), MH and SUD (BH) treatment providers, shelters, managed care companies, Continuum of Care entities.
Medical Respite Model	Medical respite programs provide post-acute care to PEH who are too ill to recover on the streets, but not ill enough to require a hospital or skilled nursing facility. Medical respite is short-term residential care that allows PEH the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services. Medical respite length of stay varies by program and can range from two weeks to 90 days. The National Institute for Medical Respite Care requires that medical respite providers meet a set of national standards in order to be accredited. The model has seen increasing national attention and support, including funding from the CDC Foundation. Missouri is one of 13 states that has not widely adopted the medical respite program. Medical respite baseline services include medical care, case management, BH needs, and a housing component, including peer support. Medical care is provided by contracted staff through home health and infusion therapy agencies, although co-location or partnerships with primary care clinics is another option. On-site peers provide care that would normally be delivered by family members or home health aides. Additional staffing may include a site coordinator and a health/BH assessor. Positive outcomes from current medical respite programs include: reduction in admission/readmission rates, cost savings, improved health outcomes for residents, and increased connection to BH services, Medicaid and primary care.
Impact	Preliminary metrics include the following, and will be expanded as the specific St. Louis model is developed: • Improve quality of care for people experiencing homelessness • Reduce fragmentation of care and coordination of physical and BH care

- Reduce cost of care associated with hospitalization (cost avoidance)
- Improved housing stability
- Increase access to MH and SUD treatment
- Connection to benefits and SDOH related services

Sustainability

More than half of medical respite programs (57%) report having three or more funding sources, with hospitals being the most common, as they have an interest in reducing lengths of stay, preventing readmission, and ensuring safe patient discharge. There are several additional approaches for medical respite funding, which will be explored in greater depth during the pilot program period:

- Local/State government
- Partnership opportunities with Managed Care Plans
- Local hospitals/health systems
- Negotiated per diem rate paid to the program by participating managed care organizations, or local hospital partners.
- Foundations/private donations
- Partnerships with FQHCs
- Veterans Administration

Project Budget/Committed Funds

The next steps are to identify partners who will participate in the project, establish the final model and level of care provided on-site and establish a more detailed budget. BHN is requesting to utilize the remaining funds, which were originally established to support the region's first Sobering Center. This includes:

		Grant/Contract Amount - OPERATIONS			
Funder	**Timeline**	**Total Commitment**	**Year 1**	**Year 2**	**Year 3**
St. Louis Mental Health Board+*	3 years	$ 600,000	$ 200,000	$ 200,000	$ 200,000
Missouri Foundation for Health (10/1/21 - 10/1/23) ($798,470)	2 years	$ 455,995	$ 228,863	$ 227,133	$ -
BJC*	3 years	$ 500,000	$ 250,000	$ 150,000	$ 100,000
Mercy*	3 years	$ 300,000	$ 100,000	$ 100,000	$ 100,000
SSM Health	3 years	$ 500,000	$ 250,000	$ 150,000	$ 100,000
TOTAL		**$ 2,355,995**	**$ 1,028,863**	**$ 827,133**	**$ 500,000**

If final approval is given to divert these funds, the model, partners and budget will be fully established. It is anticipated that the medical respite model established, including utilization of other billing, as appropriate, can be accomplished within the committed funding levels.

For more information contact:

Wendy Orson
Chief Executive Officer
worson@bhnstl.org | 314.308.6368.

Behavioral Health Network
of Greater St. Louis

MEDICAL RESPITE

Eastern Region Proposal

9/16/22

Overview

Our goal is to provide a **medical respite/recuperative care** option as safe, short-term residential care for unhoused patients with co-occurring chronic illness and indicators of Substance Use Disorder (SUD) so they can complete a course of post-discharge treatment, avoid hospital re-admission, and be connected to SUD harm reduction or recovery services.

Background

In 2020, Behavioral Health Network and community partners, including law enforcement, designed and implemented the region and state's first Sobering Center at Preferred Family Healthcare. Funding for a three-year pilot project was made possible through generous funding commitments from three hospital systems, foundations/funders and local state government. The Sobering Center opened in December 2021. Within eight months, after a successful advocacy campaign, a sustainable solution for funding was achieved through Preferred Family Healthcare. Thus, the funds to operationalize the clinical component of the pilot were no longer needed. Preliminary conversations with the funders noted that they would be willing to re-purpose the funds, provided it supported the safety net population with an emphasis on individuals with Substance Use Disorders (SUD). Meetings were held with hospital and community healthcare leadership on 5.18.22, 7.8.22, and 9.6.22. Multiple strategies were presented, and after much discussion, it was determined that the establishment of Missouri's first Medical Respite pilot project would address a significant need in the region for individuals with SUD, who are experiencing homelessness, and who are not sick enough to warrant inpatient hospitalization, but still have critical need for health care and support services to improve their medical condition. This plan includes an outline of key models and incorporates best practice recommendations from the National Healthcare for the Homeless council and feedback from multiple partners across the United States who are currently operating Medical Respite models. [1]

Problem/Rationale

People experiencing homelessness (PEH) often live with chronic illnesses, complicated by mental health (MH) or substance use (SU) disorders (behavioral health, BH), that require post- acute services / hospital discharge medication or other treatment. These individuals are typically underserved, stigmatized and experience gaps in services, resulting in poor healthcare outcomes and readmissions to the hospital, often presenting at the emergency department. This results in **high healthcare costs** and **poor health outcomes.**

A study conducted by the Agency for healthcare Research and Quality (AHRQ) enrolled a random sample of 1190 homeless individuals in Toronto, Canada. Findings from this study further demonstrate the need to find innovative solutions to support this vulnerable population.[2]

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

The prevalence of behavioral health conditions among PEH has been documented, with PEH having anywhere from two to five times higher rates of mental disorders, alcohol use disorders, drug use disorders, and opioid use. A review of more than 64,000 housing prioritization surveys (VI-SPDAT[3]) across 15 states found that 78% of unsheltered PEH (and 50% of sheltered PEH) self-reported having a mental health condition; the rates for a substance use condition were 75% and 13%.[4]

Status reports from the Division of Behavioral Health in Missouri note that in FY2021, there were 837 individuals in the Greater St. Louis region who were admitted to treatment for substance use disorders and were identified as homeless.[5] Point in time data for the City of St. Louis in 2021 noted that 772 homeless households were actively seeking housing through the continuum of care and 210 reported they lived on the streets. Half of these households had been homeless for at least 255 days (more than eight months). Mental health disorders are present in at least 49.5% of these households and substance use disorders are present in at least 29.4%. (Institute of Community Alliances 2022). The county adds another 341 people to that total. These totals don't include additional individuals living in the more rural areas of the Eastern Region.

The Need for a New Care Model

Medical respite programs offer hospitals an alternative to keeping PEH longer than medically necessary or discharging them to the streets or shelters. They provide post-acute care to PEH who are too ill to recover on the streets, but not ill enough to require a hospital or skilled nursing facility. Medical respite is short-term residential care that allows PEH the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services. Medical respite length of stay varies by program and can range from two weeks to 90 days.

The model has seen increasing national attention and support. In February 2022, the CDC Foundation and the National Institute for Medical Respite Care awarded $953,000 and two years of technical assistance to five medical respite programs to integrate behavioral health services and medical care to unhoused people who are medically vulnerable. In 2021, nine medical respite programs shared $1.6 million to support their medical respite care services.[6] The CDC is interested in determining the value of medical respite to determine if this is a sweeping investment opportunity.

While recovery houses[7] are well established in Missouri, there have been fewer respite home models, due to slow adoption of the harm reduction model.[8] There are several peer-staffed respite homes, but none that can offer medical respite to individuals with a medical condition co-occurring with a substance use disorder, and none that have been certified by the National Institute for Medical Respite Care (NIMRC) as meeting their standards.

DRAFT

Medical Respite Models Across the US

There are currently 133 medical respite programs across 38 states and territories. **Missouri is one of 13 states that has not widely adopted the medical respite model**. These programs vary significantly in the level of care provided. Across the current programs:

- Bed capacity ranges from 3 – 210, with median capacity of 17
- Length of stay ranges from 14 – 90+ days, with the most common being 15-30 days or 31-45 days.
- Beds and services are shelter based (43%), standalone facilities (28%), transitional housing (10%), apartments (6%), and other facilities including motel/hotel rooms and assisted living/skilled-nursing facilities.[9]

Medical Respite Model Examples

Ascending to Health Respite Care (ATHRC) is located in Colorado Springs, CO. They serve homeless persons who need a place to recuperate after a stay in the hospital. ATHRC provides interim shelter, daily case management, access to healthcare, logistical support, and maintain continuum of care after discharge. Their program outcomes include: 90% of clients connected to a primary care provider (PCP), 52% decrease in ED use, 70% adhere to filling prescriptions one year after respite discharge, more than half engaged with SU/MH counselors, 45% enrolled in benefit program they were not already receiving. Local hospitals have seen savings to their bottom line due to shorter inpatient care and fewer readmissions after using ATHRC services.[10]

Haywood Street Respite is located in Asheville, NC. They have served more than 1,000 clients since opening in 2014. Clients have fewer hospital readmissions and are more likely to attend follow up clinical appointments. 70% go somewhere other than the streets/camping upon discharge.[11]

A collaborative community approach: **Maine Medical Center/Greater Portland Health and Preble Street** established a business plan and model for Medical respite in 2019. These partners shared operations, social services and clinical support to deliver quality care.

Volunteers of America Chesapeake (VOAC) has been operating a Medical Respite program since September 2019. It has a unique program structure that combines medical support and intensive case management services along with behavioral health and substance use interventions, peer supports and access to housing. These services are provided in the form of a formal, contractual partnership between four distinct, but collaborating entities. This partnership includes two managed care entities who support the funding through a per diem rate paid to the program, a behavioral health agency, who provides the licensed clinical social worker to oversee case management functions and housing acquisition, a federally qualified health clinic, who provides the APRN and medical supervision, and a faith-based organization which provides shelter, facility support, daytime staffing, and recovery coaches, and the overall program oversight.

DRAFT

Nightingale Respite Care Program (Catholic Charities), in Santa Rosa, CA, partners with three hospitals to provide medical respite services. Participating hospitals saved $17 million in the first three years. Qualified patients received respite in a federally qualified health center, and three meals a day.

National Standards

The National Healthcare for the Homeless Council launched the National Institute for Medical Respite Care (NIMRC) in 2020. NIMRC established their original standards in 2016 to establish core practices that align with other health industry standards related to patient care; reflect the needs of the patients being served in the medical respite care setting, promote quality care and improved health, and are achievable for a range of medical respite programs with varying degrees of resources. The standards are reviewed and updated regularly (most recently in 2021) to reflect growth, changes and newly established evidence to guide best practices in medical respite care. The seven standards outline requirements for medical respite programs.

Standards for Medical Respite Care:

- 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, provide wrap-around support services, and facilitate access to comprehensive support services
- Facilitate safe and appropriate care transitions out of medical respite care
- Are staffed by personnel who are equipped to address the needs of people experiencing homelessness.
- Are driven by quality improvement [12]

Outcomes of Medical Respite

In addition to the outcomes noted in the two medical respite programs described above, a literature review found positive outcomes in several dimensions.[13]

Effect on Hospital Use

- Consumers of respite had a 5% hospital readmission rate over a 1-year period.
- Hospital admissions decreased by 37% and inpatient days decreased by 70% in one year after the Medical Respite stay.
- One program had a 40% reduction in ER visits and 56% reduction in overall hospital charges following connection to medical respite.

Cost / Financial benefits

- Respite care, a transition into housing, and case management resulted in $6,300 of cost savings per participant compared with those who received care as usual.

- Completing outpatient IV antibiotic treatment at medical respite resulted in $25,000 cost savings per episode.
- Medical respite stays overall resulted in $1.81 cost savings for the hospital for each dollar they invested.

A study completed in Denmark was conducted using a randomized controlled trial and cost-utility analysis post medical respite care for homeless people. The intervention group was offered a 2-week medical respite care stay at a Red Cross facility and the control group was discharged without any follow up care. The outcome was the difference in healthcare costs at 3 months. Crude costs at three months were 8448 euro for those who received medical respite compared to the control group which was 13,553 euro.[14]

Impact on Consumers

- Health-related quality of life improved for those who had a medical respite stay (although not statistically significant).
- Consumers reported that medical respite had a positive impact and especially should include: basic needs, social support, a safe space to provide security and comfort; and opportunity for reflecting.
- Due to negative experiences with health institutions, hospital settings intimidate many consumers. Medical respite providers have an opportunity to restore faith and trust in the health care system by providing person-centered care.

Reducing Gaps in Services

- 45% of medical respite consumers were approved for Medicaid and 48% secured income.
- 24% of medical respite consumers were connected with a PCP and 31% connected with behavioral health.

Target Population

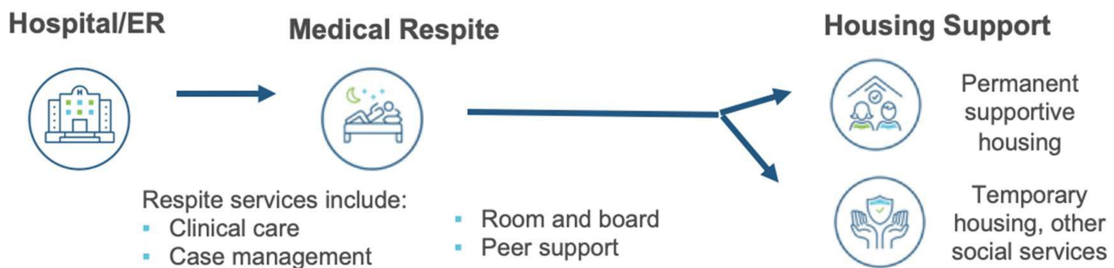
The target population for the proposed St. Louis Medical Respite Home will be unhoused or housing insecure individuals (following SAMHSA SOAR definitions[15]) with a SUD and a recent hospitalization or ED visit that requires a course of follow up treatment that would need to be delivered by a medical provider, e.g., wound care or IV antibiotics or other IV medication, follow up care post-surgery. The severity of mental illness that a Medical Respite Home provider can accept will vary based on services and staff.. While the project will serve the Greater St. Louis Region, efforts will be made to locate medical respite services in the region's "Promise Zone"[16] 25 zip codes, which are predominately populated by Black residents.

Building the Model / Scope of Service Planning Process

We seek funding to support a pilot medical respite program for People experiencing homelessness (PEH), who are discharged from Mercy, SSM and BJC hospitals in the eastern region of Missouri.[17] This provides an alternative to long term hospital stays for individuals with comorbid acute health conditions and substance use, while providing an environment that promotes harm reduction, low barrier access to

SUD services and recovery supports. There are four regional accredited housing partners who have submitted informal proposals to support the respite housing model, including possible locations, lead time needed, number of beds, and staffing models. Collaboration with a primary care clinic (FQHC), SUD treatment and behavioral health providers, and the regional continuum of care partners will be key to this work. These relationships and partners will be further solidified as the project moves forward during the planning phase.

The diagram below depicts a sample medical respite program model:



Research into established medical respite programs across the United States demonstrate a vast difference in the staffing model, levels of care and budget. Baseline services typically include clinical care, case management, and a housing component that focuses on peer support and behavioral health needs; however, all will accept referrals from healthcare and community-based agencies. Medical care for the respite residents may be provided by contracted staff through home health and infusion therapy agencies, as contracted with the hospital and/or the medical respite home. Co-location or partnerships with a primary care clinic for the medical services is an additional option. This allows the medical community to address medical needs, while the medical respite provider coordinates their social needs and provides a safe space to recuperate. On-site supports will be provided by peers or technicians who provide care that would normally be performed by family members or home health aides, including assisting patients with movement in and out of bed; prescribed exercises; eating, bathroom assistance; and reporting changes in the patient's conditions and needs to the home health staff. A site coordinator will be added to coordinate intake and provide overall site management. The assessor will visit the patient in the hospital, assess for eligibility, explain the program and begin to develop a relationship. This ensures that the respite staffing is appropriate to adequately handle the needs of the individual. Depending on the program model and respite home's staffing and the patients' condition, IV antibiotics may be self-administered. The medical respite program will operate based on commitment to harm reduction basis. Unlike approaches that insist that people stop using drugs prior to services, harm reduction acknowledges that abstinence should not be a precondition to obtain care for primary health needs.

If the individuals indicate the desire for SUD/BH treatment services spent during their respite housing stay, the above noted National Association of Recovery Residences (NARR) housing partners are able to access alternative funding and services through their current recovery support service (RSS) contracts. In

DRAFT

addition, they have historical collaborative relationships with the regional SUD treatment providers and ancillary programs that assist in meeting clients' SDOH needs.

The planning process will establish workgroups to address:

- Governance
- Implementation/Utilization
- Wraparound Services
- Metrics
- Consumer Voice
- Sustainability

Benchmarks / Impact /Deliverables

The following is a preliminary list of metrics, and will be expanded as the specific model is developed:

- Improve quality of care for people experiencing homelessness (or at risk of homelessness)
- Reduce fragmentation of care and Coordination of mental health/SU care
- Reduce cost of care associated with hospitalization (cost avoidance)
- Improved housing stability
- Increase access to SUD treatment
- Connection to benefits and SDOH related services

Collaborating Partners

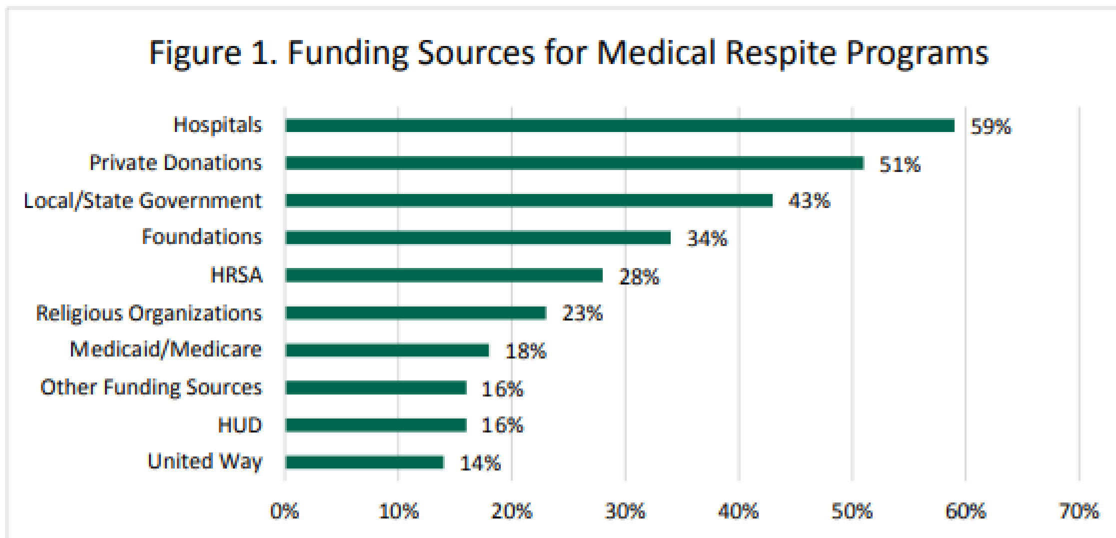
Medical respite programs depend on robust partnerships among agencies from numerous sectors. Collaborative partnerships such as Baltimore Healthcare for the Homeless connects the medical respite program, shelter partners, and city government through the local continuum of care. [18] The following is a preliminary list of partners for the St. Louis medical respite program. Specific agencies will be identified during the planning process.

- Referral partners: hospitals, Dunnica Sobering Support Center (DSSC), infectious disease clinics of hospitals
- Current recovery housing providers with respite interest/experience: LIV Recovery, Haven House, Child & Family Empowerment Center and ARCA
- Federally Qualified Health Centers (FQHCs)
- SUD and BH treatment providers
- Local, regional hospitals
- Shelters
- Managed care plans
- GROW[19] agencies (discharge/supportive services)
- Local Continuum's of Care

Sustainability/Financing Approaches

Medical respite programs typically do not receive sufficient Medicaid reimbursement to fully cover operating expenses and many of the individuals who utilize them may be uninsured. Over half of medical respite programs (57%) report having three or more funding sources with hospitals and private donations being the most common (see figure 1). [20]

DRAFT



Hospitals have an interest in reducing lengths of stay, preventing readmission, and ensuring a safe patient discharge. Having access to a medical respite program in the community can help achieve all of these goals which likely explains why over half of all known respite programs are funded using hospital resources.

As seen in Figure 1, there are several additional approaches for medical respite funding, which can be explored in greater depth during the pilot program period[21]:

- Local/State government
- Partnership opportunities with Managed Care Plans
- Health Systems to support navigation/case management services
- Foundations/private donations
- Negotiated per diem rate paid to the program by participating managed care organizations, or local hospital partners.

Further exploration around partnerships with Federally Qualified Health Centers to determine how reimbursable FQHC partnered services could be accessed through the Prospective Payment System (PPS) is warranted. Collaborative programs often partner with a FQHC to provide "recuperative care" and "medical respite," which can be used interchangeably (as outlined on HRSA Form 5-A). HRSA describes these services as follows: Recuperative care program services are short-term care and case management provided to individuals recovering from an acute illness or injury that generally does not necessitate hospitalization, but will be exacerbated by their living conditions (e.g., street, shelter or other unsuitable places). [22]

One Bayside area medical respite program, based on a collaborative model of care was able to partially bill for Medicaid services through the FQHC, thus supporting a funding source for the medical supports provided. Another FQHC, New Horizon Family Health Services in South Carolina, partners with a local

shelter and uses HRSA core operating funds and funding targeted to homeless people to cover most of its costs[23].

The Veterans Administration has a program called Hospital to Housing (H2H) designed to provide both proactive clinical follow-up care and housing case management seamlessly for homeless Veterans following an inpatient stay or emergency department visit. This could supplement the project for veterans who may need these supportive services.

Several collaborative projects note the ability to have multiple partners who use their own funding sources to support key components of the project. This includes partnering with a BH or SUD treatment provider to provide behavioral health services, medication assisted treatment, or case management services on-site to this population as appropriate.

Advocacy for Policy Change to Support Medical Respite

Medicaid, Managed Care Organizations have made encouraging progress in creating sustainable financing solutions for medical respite programs, since many individuals experiencing homelessness in need of medical care qualify for Medicaid. States and/or managed care plans are increasingly establishing reimbursements for medical respite care services, which are an important part of sustaining program operations. Likewise, stable program financing controls larger system costs, improves health outcomes, and better meets the needs of vulnerable people. California is in the midst of implementing a statewide benefit for medical respite care, and Washington and Utah have added a statewide benefit into their Medicaid 1115 waiver renewal requests to the federal government. Minnesota and New York are also taking steps toward formalizing a Medicaid benefit, with others actively investigating options.[24]

Throughout the three-year pilot project, advocacy for similar policy changes in Missouri and the identification of stable funding sources will be a key priority.

Budget/Committed Funds

As noted in the introduction, this pilot project, with final approval from the funders, will use the remaining dollars that were originally committed to the DSSC Sobering Center to create an intervention to support individuals with Substance Use Disorders. The chart below represents the committed funds available.

		Grant/Contract Amount - OPERATIONS			
Funder	**Timeline**	**Total Commitment**	**Year 1**	**Year 2**	**Year 3**
St. Louis Mental Health Board+*	3 years	$ 600,000	$ 200,000	$ 200,000	$ 200,000
Missouri Foundation for Health (10/1/21 - 10/1/23) ($798,470)	2 years	$ 455,995	$ 228,863	$ 227,133	$ -
BJC*	3 years	$ 500,000	$ 250,000	$ 150,000	$ 100,000
Mercy*	3 years	$ 300,000	$ 100,000	$ 100,000	$ 100,000
SSM Health	3 years	$ 500,000	$ 250,000	$ 150,000	$ 100,000
TOTAL		**$ 2,355,995**	**$ 1,028,863**	**$ 827,133**	**$ 500,000**

Additional information from the partners and the establishment of the final model (whether a collaborative model, or a per diem model) is needed to formalize the final budget. As noted in the research surrounding other successful medical models, the budget will vary significantly based on the model and the services provided. For example, a model that is mostly peer based, with limited medical intervention will cost significantly less than one which requires significant medical interventions and staff. A collaborative model, where other potential funds can be used, will reduce the amount of funds used for services which do not have a billable option. It is anticipated that the model established for this project may fall somewhere in between and will be operational within the committed funding.

BHN Role

BHN will play a short-term role in the development and launch of the medical respite program. As with the Dunnica Sobering Support Center, BHN will gradually decrease their involvement, and the program will be managed on an ongoing basis by one or more service partners. During the pilot period, BHN will:

- Provide overall project management; research and development of the model building new partnerships
- Staff/facilitate workgroups - Expedite collaborative process with all partners to determine policies, procedures, workflow, etc. Ensure policies and procedures are in place for service start date
- Coordinate training efforts for medical respite house staff and other appropriate partners
- Coordinate technical assistance to ensure respite providers are aware of best practices and establishing organizational processes to meet national standards
- Lead process to identify and contract with evaluation partner
- Lead efforts to create successful partnerships that will lead to long-term funding opportunities

Questions/Challenges to be addressed

The following is a partial list of issues to be addressed during the research and planning stages:

- Location/type of facility for medical respite (house, congregate sites, local motels, etc.).
- Key partners and the roles they will pay
- Final budget
- Eligibility/exclusion criteria
- Maximum length of stay
- Number of beds
- Costs: utilized vs open bed
- Need/resources for evaluation partner
- Sustainability including utilizing structured billing mechanisms through service delivery (whether recovery housing, treatment services or primary care services)
- Interface with other initiatives

BHN Contact:
Wendy Orson, CEO
Behavioral Health Network of Greater St. Louis (BHN)
2 Campbell Plaza, Entry 1B, St. Louis, MO 63139-1781
Office: 314-449-6713 worson@bhnstl.org

DRAFT

ENDNOTES

[1] https://dmh.mo.gov/sites/dmh/files/media/pdf/2022/06/sr2022-section-f.pdf

[2] https://meps.ahrq.gov/data_files/publications/workingpapers/wp_10002.pdf

[3] Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) is an assessment tool that helps providers better understand the severity of need of clients and helps determine which clients to prioritize for available permanent housing resources. The VI-SPDAT is the common assessment tool that has been adopted for use by the many regional Continuum of Care (CoC), including St. Louis and St. Louis County.

[4] National Institute for Medical Respite are: *Promising Practices: Providing Behavioral Health Care in a Medical Respite Setting*, August 2022.

[5] Missouri Department of Mental Health, *2022 Status Report on Missouri's Substance Use and Mental Health*. https://dmh.mo.gov/alcohol-drug/reports/status-report/2022

[6] National Institute for Medical Respite Care*, CDC Foundation and NIMRC award nearly $1 million to medical respite care programs in five states to strengthen behavioral health,* February 28, 2022. https://nimrc.org/news/cdcf_behavioral_health/

[7] Recovery Houses are residential treatment programs or a transitional residence for people who are overcoming the effects of drugs or alcohol or are recovering from other diseases or addictions. They traditionally require the resident to be substance free and do not provide medical oversight for health conditions.

[8] Harm Reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws.

[9] National Institute for Medical Respite Care website

[10] https://www.athrc.com/

[11] https://haywoodstreet.org/haywood-street-respite/

[12] National Institute for Medical Respite Care, *Standards for Medical Respite* Programs, 2021. https://nimrc.org/wp-content/uploads/2021/09/Standards-for-Medical-Respite-Programs_2021_final.pdf

[13] National Institute for Medical Respite Care, *Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care,* March 2021. https://nimrc.org/wp-content/uploads/2021/03/NIMRC_Medical-Respite-Literature-Review.pdf

[14] https://www.semanticscholar.org/paper/Post-hospital-medical-respite-care-for-homeless-in-Bring-Kruse/b0cf4e06f09b2406c1d409366d8e653996f2fd98

[15] SAMHSA SSI/SSDI Outreach, Access, and Recovery (SOAR) definitions of homelessness and at risk of homelessness, https://soarworks.samhsa.gov/article/definitions-of-homelessness.

[16] The St. Louis Promise Zone includes parts of North St. Louis City and North St. Louis County, designated in 2015 as a part of a federal program intended to improve health and wellness (and other needs) in high-poverty communities.

[17] BHN defines the Eastern Region as the contiguous counties of St. Louis City, Franklin, Jefferson, Lincoln, St. Charles, St. Louis, and Warren Counties.

[18] National Institute for Medical Respite Care*, Medical Respite Literature Review*.

[19] GROW (Grassroots Reinvestment for Optimal Well-Being) entity, in partnership with Missouri Institute of Mental Health (MIMH), BHN and five North StL community agencies.

[20] https://nimrc.org/wp-content/uploads/2020/08/policy-brief-respite-financing.pdf

[21] National Institute for Medical Respite Care, *Approaches to Financing Medical Respite/Recuperative Care Programs*, July 2021. https://nhchc.org/wp-content/uploads/2021/08/NIMRC-White-Paper_Approaches-to-Financing-MRRC-Programs-July-2021-2-1.pdf

[22] https://bphc.hrsa.gov/sites/default/files/bphc/compliance/form-5a-service-descriptors.pdf

[23] Personal communication from Brandon Cook, Director of medical respite program at New Horizon Family Health Services, September 15, 2022.

[24] https://nimrc.org/nimrc-at-two-policy-opportunities-for-medical-respite-are-rapidly-expanding/

DRAFT

partnering
investing
empowering

Community Mental Health Fund FY24-26

Application Cycle

Application Process [4 Months]

Review Process [2 Months]

ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME
Individual Review – Dedicated time to read and score assigned applications independently	Trustees, Staff, Community Reviewers	1 Week March 6 - 10
Staff Internal Review – Sort and group applications in preparation for Review Meetings	Staff	1 Week March 13 - 17
Joint Review Team Meetings – Teams meet to discuss their assigned applications and recommend ranked order.	Trustees, Staff, Community Reviewers *Note: Trustees will be equally divided among 3 – 4 review teams, depending on number of applications received.	2 Weeks March 20 - 31
Summary Documents – Presentations are prepared to summarize the discussion and recommendations of each team.	Staff	2 Weeks April 3 – 14
Full Trustee Review Discussion & Vote – Trustees hear presentations from each team and vote on a final combined ranking.	Trustees, Staff	April Board Meeting

saint louis mhb

Changes from CCSF Application Cycle

1. Program Committee members will not be the only Trustees responsible for participating in the Joint Review Team. All Trustees will be assigned to Joint Review Teams. This eliminates the need for two separate meetings.
2. During the April board meeting, Trustees will hear a presentation from each group to gain insight into how applications were ranked.
3. Trustees will then finalize a combined ranking to allocate funding across all applications instead of making allocations at the Team level.

Community Mental Health Fund Outcome & Priorities

CMHF Outcome:

Adults with mental health and/or substance use conditions initiate and sustain healthy behaviors.

CMHF Funding Priorities Based on Community Needs:

- MHB St. Louis Adult Behavioral Health Needs Assessment 2018
- Community Health Needs Assessment – City of St. Louis Department of Health and St. Louis County Department of Public Health 2022
- St. Louis Regional Health Commission Access to Care Databook 2022

saint louis mhb

partnering
investing
empowering

MHB Investment Approach

Strategic Plan Key Factors and Interventions Alignment

MHB Theory of Change Key Factors

Policy & Systems Change	Communities, Services, & Systems	Behavioral Health Services & Prevention Efforts
Changes to the social determinants of behavioral health Shared regional vision of health equity and racial justice	Increased coordination of care Improved quality of care	Improved continuously
	Increased access	Evidence-based & trauma-informed
Community-driven priorities	Increased community capacity to shape outcomes	Driven by community priorities and those most impacted

saint louis mhb

MHB Theory of Change Interventions

1. Core Funding for Essential Services

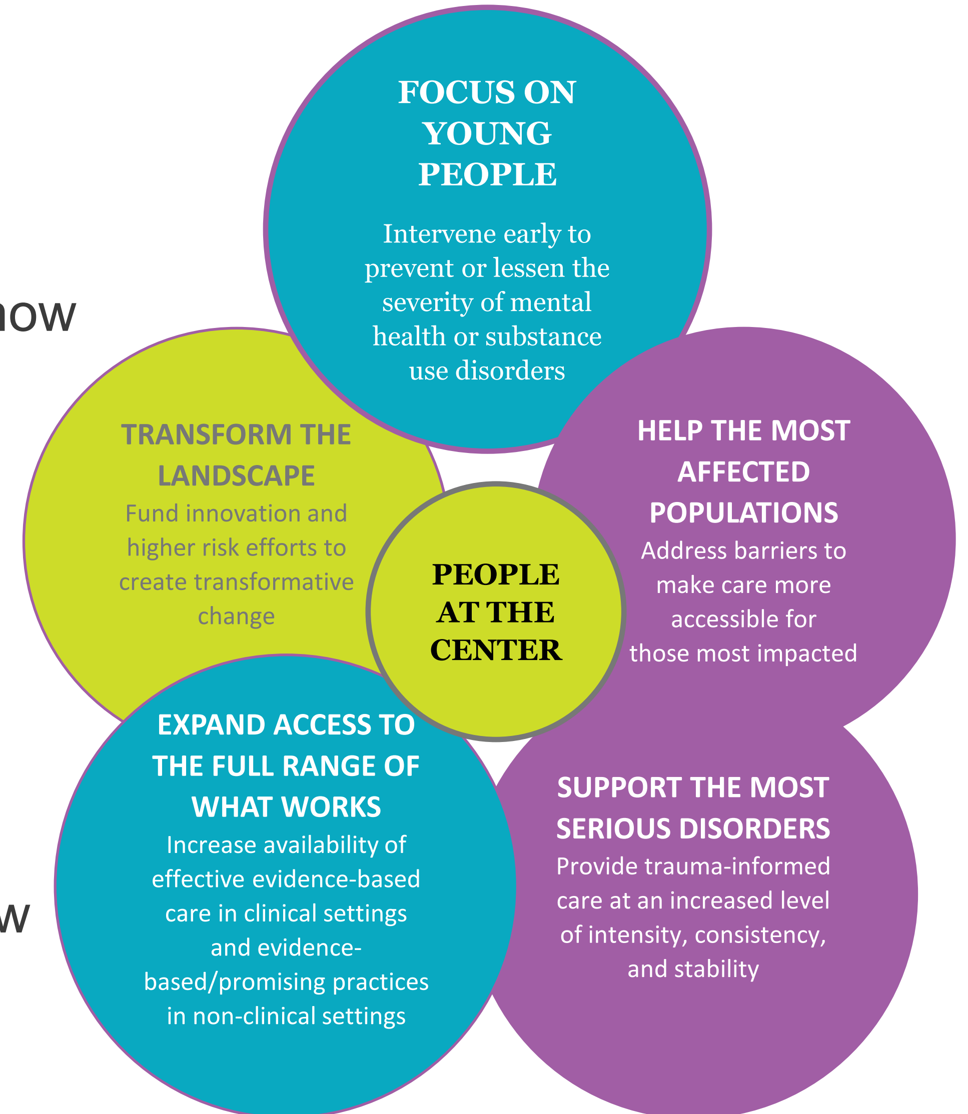
- Avg. length of investment 10 years
- Avg. award $220,000 prior to FY23 - $345,000 now
- Portion of total allocation - 34% prior to FY23 – 36% now

2. Flexible Funding for High Quality Services

- Avg. award $180,000 prior to FY23 - $230,000 now
- Portion of total allocation - 36% steady average

3. Community Building

- Avg. Award $116,000 prior to FY23 - $100,000 now
- Portion of total allocation < 1% prior to FY23 – 8% now



saint louis mhb

Investment Strategies

Multiple Levels of Engagement

Core Funding for Essential Services

Purpose: Sustain and improve critical infrastructure for equitable service delivery

- **SUPPORT THE MOST SERIOUS DISORDERS -** Provide trauma-informed care at an increased level of intensity, consistency, and stability
- **HELP THE MOST AFFECTED POPULATIONS -** Address barriers to make care more accessible for those most impacted

Mechanism: Longer-term investments for high performing organizations providing essential services

- 3 – 5 year grant cycle with mid-way continuation application
  - One application for CCSF and CMHF funds
  - Prioritize integrated family services models
- Separate regional braided fund with St. Louis County Children's Service Fund
  - Explore leveraging Medicaid for specialized services

saint louis mhb

Flexible Funding for High Quality Prevention Services

Purpose: Increase the availability of high-quality prevention programs

- **FOCUS ON YOUNG PEOPLE -** Intervene early to prevent or lessen the severity of mental health or substance use disorders

Mechanism: Shorter-investments from 1 – 3 years designed to help organizations launch or expand evidence-based programs

- Early Childhood Facility Improvement Fund
  - Improves physical environment to better position childcare providers to successfully implement SEL curriculum [Done in tandem with existing CCSF EC program]
- Out of School Time Initiative
  - Increase access to year-round prevention programs for children and youth
  - Leverage investments from the City of St. Louis and St. Louis Public School District
- Unallocated Fund
  - Invests unallocated funds from completed CCSF or CMHF application cycles to address unmet MHB goals and priorities

Flexible Funding for High Quality Services Across the Lifespan

Purpose: Increase the availability of high-quality programs for youth and adults

- **EXPAND ACCESS TO THE FULL RANGE OF WHAT WORKS -** Increase availability of effective evidence-based care in clinical settings and evidence-based/promising practices in non-clinical settings

Mechanism: Shorter-investments designed to help organizations launch or expand evidence-based programs

- Traditional 3-Year Competitive Cycle
  - Funding for programs and services that address MHB funding priorities
  - Focus on projects that remove barriers to service delivery and increase access
- Emerging Needs Fund – Staff Directed Open Timeline
  - Responsive fund to address unanticipated needs in the community, with priority given to projects that align with MHB's funding priorities

saint louis mhb

Community Building

Purpose: Support community-driven programs and initiatives that can effectively reach underserved populations

Transform the Landscape - Fund innovation and higher risk efforts to create transformative change

Mechanism: Smaller grants paired with dedicated technical assistance

- Two-year grant cycle with two cycle limit
  - Community-driven needs assessment to set funding priorities
  - Grants under $100,000
  - Categories: piloting/launching an innovative concept, expanding or enhancing an existing program, maintaining a successful program

	FY23	FY24	FY25	FY26	FY27
EC Facility Fund Grants Awarded • Launch Q3 FY23 • Integrate into EC CCSF FY 23 – 25 award period with ongoing quarterly distributions					
Out of School Time Initiative Grants Awarded • Launch Q4 FY23 • Year-round programming spring 2023 – summer 2026					
Emerging Needs/Unspent CCSF Allocation • Launch Q2 FY23 (internal process) • Integrate into EC CCSF FY 23-25 award period with delayed start of January 2023					
Community Building Grants Awarded • Launch Q1 FY24 community driven priority setting • 2-year project periods up to two cycles					
CCSF FY25 One-Year Extension					
Core Funding for Essential Services Grants Awarded					
High Quality Services Initiative Grants Awarded					

Trustee Discussion and Decision Points for Retreat

1. Establish Core Funding for Essential Programs with 5-year funding cycle at approximately 35% - 40% of annual budget
2. Extend CCSF FY23-25 cohort by one year to end in FY24
3. Establish one CCSF and CMHF application process to support essential programs
4. Authorize Early childhood Facility improvement fund
5. Authorize special meeting to allocate unspent CCSF funding for 2 ½ year grants as a part of the CCSF FY23-25 cohort
6. Establish Community Building Fund at approximately 5% - 10% of annual budget

saint louis mhb