ES 12b BP 71 Hospital Re-entry Respite Beds

Existing MIDD Program/Strategy Review X☐ MIDD I Strategy Number ___12b_____ (Attach MIDD I pages)

New Concept X ☐ (Attach New Concept Form)

Type of category: Existing Program/Strategy EXPANSION

SUMMARY: Under MIDD strategy 12 b, the Edward Thomas House Medical Respite Program provides comprehensive recuperative care after an acute hospital stay for people who are living homeless, focusing particularly on those with disabling substance use and mental health conditions. This recuperative care is a critical intervention for a segment of the homeless population with high rates of emergency room and hospital utilization as well as involvement in the criminal justice system. In addition to intensive medical and mental health care, patients at Edward Thomas House (ETH) receive intensive case management services to help them transition from their stay to ongoing behavioral health treatment, housing, social services, and primary care. Thus, it promotes recovery by providing a full continuum of services. This paper includes a concept to support and expand the program at higher MIDD funding levels than budgeted under MIDD I.

Collaborators:

Name	**Department**
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Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	**Role**	**Organization**
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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

Under MIDD strategy 12 b, the Edward Thomas House Medical Respite Program provides comprehensive recuperative care after an acute hospital stay for people who are living homeless,

focusing particularly on those with disabling substance use and mental health conditions. This recuperative care is a critical intervention for a segment of the homeless population with high rates of emergency room and hospital utilization as well as involvement in the criminal justice system. In addition to intensive medical and mental health care, patients at Edward Thomas House (ETH) receive intensive case management services to help them transition from their stay to ongoing behavioral health treatment, housing, social services, and primary care. Thus, it promotes recovery by providing a full continuum of services.

The program's ability to effectively address such a wide array of needs immediately following hospital discharge dramatically reduces the probability that its patients will fail to recuperate from their current acute illness and need to be re-admitted to the hospital. At the same time, by integrating comprehensive behavioral health and medical interventions, the program creates an extremely effective platform for addressing the root causes of patients' homelessness and their challenges to accessing and maintaining linkages to ongoing care and services outside of the hospital. In this way, it reduces its patients' risk for *future* acute behavioral health and medical crises and thus reduces the likelihood of common and costly problems among the mentally ill and substance using homeless populations such as frequent emergency medical services and emergency room utilization and arrests.

ETH has not only been recognized as a leader in a national movement to provide post-discharge respite treatment to hospitalized homeless patients, but it has been singled out specifically for its emphasis on serving those whose disabling behavioral health conditions make them among the most complex to serve, in particular, injection drug users with chronic mental health conditions. ETH is currently one of five respite programs nationally taking part in a study funded by the federal Center for Medicare & Medicaid Innovation (CMMI) to document evidence of the improved outcomes and lower overall costs of communities providing respite care to vulnerable homeless individuals post-discharge from acute care medical stays.

Since the program expanded in 2011 it has steadily increased its capacity to serve such patients by dramatically increasing not only the size of its clinical team, but also the hours that mental health, substance use, and nursing staff are available to provide onsite care. For example, nursing care has increased from 8 to 12 hours per day, and mental health support staff are on site 24 hours a day. This year after year increase in behavioral health capacity has been critical to meeting the needs of the program's target population, which has been significantly impacted by the heroin epidemic that is sweeping through King County, as it is in many other communities in America. As of 2016, well over 75% of ETS admissions are injection drug using patients.

ETH is operated by Harborview Medical Center (HMC) and occupies the entire 7th floor of the Seattle Housing Authority's Jefferson Terrace Building, directly across the street from the HMC Emergency Room. The program is managed collaboratively by HMC and Public Health-Seattle & King County, with financial and program support from five other hospitals operating within King County. Patients stay at ETH, receiving 24/7 care. The average length of stay for 2015 (through Quarter 3) is 24 days.

The program's overarching goal is to improve health outcomes and reduce community costs in the health, human services, and housing arenas. Within that broad goal, it seeks to stabilize the medical and behavioral health conditions of its patients and effectively link them to (1) ongoing substance use and/or mental health services in the community, (2) an ongoing medical home, (3) social services, and (4) stable, appropriate housing. It strives to ensure that patients leave the program with identified case

management provided by partnering agencies in the community that will help them make these linkages.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   X **Crisis Diversion** ☐ **Prevention and Early Intervention**

   X **Recovery and Re-entry** ☐ **System Improvements**

   Please describe the basis for the determination(s).

Patients enter ETH in the throes of crisis, and they have a high risk for future crisis: They live homeless and often unsheltered, have been hospitalized for an acute illness or injury, and, in most cases, struggle with substance use and mental health conditions. Statistically they are far less likely than the average hospital inpatient with the same diagnoses to recover and far more likely to require re-admission to the hospital, often through the emergency room. ETH not only helps them recuperate in a safe and stable environment, but it also provides behavioral health services and linkages to ongoing care and housing that are critical to averting the next crisis.

In terms of recovery, ETH leverages the relationships its clinical team forms with its patients as well as the safety and security its patients experience during their stay to guide people toward a path of recovery. For example, there are many cases of patients establishing linkages to case management during their stay that result in immediate entry upon discharge into methadone treatment at a nearby clinic.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

High rates of mental illness and substance use among the homeless population, particularly among those classified as chronically homeless, are well documented by medical and public health researchers.[1, 2] Moreover, research also indicates the critical importance of adapting clinical practice guidelines to respond to the complex behavioral health, medical, and psycho-social needs that commonly represent significant impediments to recovery among homeless patients. For example, the National Health Care for the Homeless Council cited that:

> Two-thirds of homeless adults report a substance use and/or mental health problem, and about one in four meets criteria for a serious mental illness, compared to one in 17 adults in the general U.S. population. Approximately 30% of persons experiencing homelessness have substance dependence/ abuse, compared to 9% of the general population. The incidence of these disorders is considerably higher among people who have been homeless on a long-term basis. Substance use disorders, in particular, increase risk of exposure to infectious diseases and can cause or exacerbate diseases of the cardiovascular

[1] Ellen L. Bassuk, M.D., Lenore Rubin, Ph.D., and Alison Lauriat, M.A. *Is Homelessness a Mental Health Problem?* American Journal of Psychiatry Vol. 141, No.12: 1546-50, 1984.

[2] Buchanan, D., Doblin, B., Sai, T. & Garcia, P. *The Effects of Respite Care for Homeless Patients: A Cohort Study* American Journal of Public Health Vol. 96, No. 7: 1278-1281, 2006.

system and liver. Behavioral disorders and cognitive impairments associated with them can interfere with treatment adherence.[3]

Research has also shown that people who live homeless with these conditions struggle to establish and/or maintain appropriate treatment within the mainstream health care system[4]. Many people experiencing these problems are caught up in cycles of crisis and lack the family and other social supports as well as the income and other material resources that might help them break these cycles. They are extremely challenging for behavioral health and medical providers to locate and engage, let alone establish in an ongoing plan of treatment. Their chronic behavioral health and medical conditions worsen, their likelihood of involvement with the criminal justice system escalates, and, in many cases, they begin to cycle in and out of emergency rooms, inpatient hospital stays, and jail.

These dynamics help explain the significantly higher risk of hospital readmission for homeless patients that has been established in numerous research studies.[5] This increased risk relates to the scarcity of places in which homeless patients can safely rest and obtain the support they need to fully recuperate. It also relates to behavioral health disorders that can lead to behaviors that complicate or undermine recuperation.[6] Because of this risk, hospitals often delay discharge of homeless patients past the point at which they would discharge a person with housing and other necessary supports for recuperation and thus past the point that is medically indicated.[7] Their experience has shown that when a person's living situation makes it impossible to adequately rest, keep from walking or putting weight on a joint, or keep a surgical site clean, the hospital is much more likely to see the person return for infections or other problems that necessitate readmission. The experience of HMC and other local hospitals has also shown that discharging inpatients with histories of injection drug use before they finish the intravenous antibiotic treatment that is commonly prescribed post-surgery *significantly* elevates the risk of drug overdoses, secondary infections, and other adverse outcomes that often result in readmission and can even result in the patient's death.[8] Absent the respite care option ETH provides, these hospitals often must face the difficult dilemma of either keeping the patient in the hospital solely to continue IV antibiotic treatment or releasing the patient to the streets with the knowledge that the risk of a poor outcome is extremely high.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

[3] Bonin E, Brehove T, Carlson C, Downing M, Hoeft J, Kalinowski A, Solomon-Bame J, Post P. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*, 50 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2010.

[4] Bonin E, Brehove T, Carlson C, Downing M, Hoeft J, Kalinowski A, Solomon-Bame J, Post P. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*, 50 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2010.

[5] Buchanan, D., Doblin, B., Sai, T. & Garcia, P. *The Effects of Respite Care for Homeless Patients: A Cohort Study* American Journal of Public Health Vol. 96, No. 7: 1278-1281, 2006.

[6] Thompson, SJ, Bender KA, Lewis CM, Watkins R. *Shelter-based Convalescence for Homeless Adults*. Canadian Journal of Public Health, Vol. 97, Issue 5: 379-383, 2006.

[7] Gundlapalli A, Hanks M, Stevens SM, Geroso AM, Viavant CR, McCall Y, Lang P, Bovos M, Branscomb NT, Ainsworth AD.. *It takes a village: a multidisciplinary model for the acute illness aftercare of individuals experiencing homelessness*. Journal of Health Care for the Poor and Underserved. Vol. 16 Issue 2:257-72, 2005.

[8] Edward Dwyer-O'Connor, Senior Manager for Downtown Programs, Harborview Medical Center, Seattle, WA. Interview January 7, 2016.

Medical respite care is defined as 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 stay in a hospital. Respite programs such as ETH provide a cost-effective discharge alternative for hospitals and provide patients with a place to receive ongoing post-hospital care while working on their health and housing goals[9]. ETH specifically targets people who, without respite program services, would be discharged from the hospital into homelessness and who have a high risk of poor health and social outcomes because of their substance use, mental health, and/or other debilitating condition. It provides a safe place where these patients can stay 24 hours per day while they rest and recover. It also provides comprehensive clinical services, including nursing and mental health services that are accessible 24/7 to ensure that they not only recuperate from the specific illness or injury that led to the original hospitalization, but that they gain a greater level of stability to begin to tackle underlying substance use, mental health, and other issues. Services received while at ETH thus often include intensive case management and on-site behavioral health treatment. They also include establishing, prior to discharge from ETH, linkages to case managers in mental health, substance use, housing, and other programs that can serve the patient after they exit the respite program.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Several research studies have demonstrated that programs like ETH that provide a respite care option for homeless patients immediately following hospital discharge reduce future hospitalizations. For example, a 2006 Chicago study found that homeless patients discharged into respite care required less than one-half of the hospital days within the 12 months following their hospital discharge than homeless patients who had similar demographic characteristics, admitting diagnoses, and patterns of medical care but who were denied admission to respite because beds were unavailable when they were discharged from the hospital.[10] Another Chicago study documented a 60% reduction in hospital utilization during the 12 months following a respite program stay as compared to hospital utilization in the 12 months immediately preceding the respite stay for a cohort of 161 homeless patients. The absolute reduction in hospital days was 4.9 days per person after controlling for gender, race, diagnosis, and prior utilization of services. A control group that was similar in terms of gender, race, diagnoses, and prior utilization of health services but that was denied admission to respite care because beds were not available showed no such reduction in hospital utilization.[11] Other studies have documented a strong correlation between respite stays and a significant reduction in the risk of hospital readmission.[12]

In addition, researchers have demonstrated the effectiveness of programs combining residential recuperative medical care with psychiatric treatment in stabilizing and linking to housing and other needed services homeless patients with mental illness or substance use disorders. A Canadian study of

[9] National Health Care for the Homeless Council (www.nhchc.org/2014/07/16439/)

[10] Buchanan, D., Doblin, B., Sai, T. & Garcia, P. *The Effects of Respite Care for Homeless Patients: A Cohort Study* American Journal of Public Health Vol. 96, No. 7: 1278-1281, 2006.

[11] D Buchanan, D., Doblin, B., MD, & Garcia, P. April 2003 *Respite Care for Homeless Patients Reduces Future Hospitalizations*. Journal of General Internal Medicine v. 18 (S1) .

[12] Kertesz SG, Posner MA, O'Connell JJ, Swain S, Mullins AN, Shwartz M, Ash AS. *Post-hospital medical respite care and hospital readmission of homeless persons*. Journal of Prevention and Intervention in the Community. Vol. 37, No 2: 129-42, 2009.

a one such program that accepted patients post-hospital discharge, as well as shelter residents too ill to remain in shelter, documented significant success in linking patients to housing, for example; 60% of patients applied for housing and 24.3% obtained housing during their stay.[13]
Reflecting evidence of respite program effectiveness in other cities, ETH outcome data indicate significant improvements in hospital utilization and success in linking patients not only to intensive case management but also to ongoing services and supports post-respite program discharge. The following represents a sampling of that outcome data:

- In 2012, a study of hospital utilization for ETH patients conducted for a University of Washington research project found a significant reduction in utilization post-respite program discharge compared to pre-respite program admission. The study focused on 69 unduplicated respite patients who entered ETH after discharge from an inpatient stay at HMC. It compared total HMC inpatient days for these patients for the 180 days *after* successful completion of these patients' stays at ETH to total inpatient days for these patients for the 180 days *prior* to ETH admission and found:
    - 70% reduction in HMC total inpatient hospital days
    - 50% reduction in HMC inpatient admissions from the emergency department
    - 67% reduction in HMC surgeries and procedures[14]
- 94% of ETH patients treated in 2015 (347/369) completed a psycho-social assessment for mental health care, substance use treatment, housing, and other needs and then established at least one self-management goal
- 24% of ETH patients treated in 2015 (88/369) were formally enrolled in a methadone treatment program[15]
- 17% of ETH patients treated in 2015 (63/369) were linked prior to discharge to intensive case management provided by Evergreen Treatment Service's REACH Program, an ETH partner specializing in outreach and intensive case management of people experiencing homelessness and addiction. This case management focused on linking patients to substance use treatment, shelter, housing, and other services, including assistance in applying for Medicaid. All of these patients had a substance use disorder (SUD), 50% had a mental health diagnosis, and 50% had a physical impairment. Outcomes of this case management included:
    - 38% accessed some kind of SUD Treatment: inpatient, outpatient, methadone, or recovery support
    - 30% moved from the street into shelter or housing
    - 14% moved into permanent supportive housing[16]

4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/anPromising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

Medical respite care for homeless populations is considered promising practice that combines and integrates numerous evidence-based practices in a way that is specifically tailored to meet the acute

[13] Thompson, SJ, Bender KA, Lewis CM, Watkins R. *Shelter-based Convalescence for Homeless Adults*. Canadian Journal of Public Health, Vol. 97, Issue 5: 379-383, 2006.
[14] Marshall D *Edward Thomas House Medical Respite Report: Health Care Utlization (180 Days Per/Post Respite)*. Reseach report presented to Public Health-Seattle and King County by University of Washington Master's in Public Health candidate DeAnna Marshall, 2012.
[15] Edward Thomas House Respite Program outcome data submitted by Harborview Medical Center to Public Health- Seattle and King County, December 2015.
[16] REACH Program outcome data submitted to Public Health- Seattle and King County, December 22, 2015.

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 stay in a hospital.[17]
Incorporated evidence based practices include transitional care, patient centered self-management goal setting, motivational interviewing, and case management to address socio-economic and other factors affecting health outcomes and access to timely and appropriate care.[18]
The federal Centers for Medicare and Medicaid Services (CMS) has recognized the potential of programs providing respite care in communities around the country as a way to provide a cost-effective discharge alternative for hospitals and provide patients with a place to receive ongoing post-hospital care while working on their health and housing goals. In 2014 CMS's Center for Medicare and Medicaid Innovation (CMMI) awarded a grant to the National Health Care for the Homeless Council (NHCHC) to work with ETH and four other medical respite programs around the nation to collect data supporting CMS investment in respite care as a method to reduce costs and improve outcomes for homeless Medicare and/or Medicaid beneficiaries.
In coordination with NHCHC, the national Respite Care Providers Network (RCPN) in 2015 completed proposed standards to improve quality and consistency across a range of U.S. respite programs and to improve opportunities for research and federal funding for medical respite care. This work reflected the input and active participation of ETH managers, who have played a leadership role in RCPN. RCPN is a national membership organization that supports the development of new and existing medical respite programs through education, client advocacy, networking and research, training, and comprehensive respite resources and information. Having standards in place is an important component of the case being made for respite becoming a recognized set of reimbursable services at the federal level.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Outcome	Indicator	Data Source
Reduction in future hospital utilization for hospitalized homeless patients with mental health and/or substance use disorders	Hospital inpatient days post-respite program discharge versus pre-respite program admission	• Local hospitals referring patients to the respite program
Successful medical recuperation of hospitalized homeless patients with mental health and/or substance use disorders	Percentage of respite program patients who complete their treatment and are discharged after medical providers confirm they are medically ready to leave	• Respite program medical records
Engagement in treatment by hospitalized homeless patients with mental health and/or substance use disorders	Percentage of respite program patients who complete a psycho-social assessment and then establish a self-management goal	• Respite program medical records
Entry into case management of	Percentage of respite	• Respite program medical

[17] National Health Care for the Homeless Council (www.nhchc.org/2014/07/16439/)
[18] National Health Care for the Homeless Council (www.nhchc.org/2014/07/16439/)

hospitalized homeless patients with mental health and/or substance use disorders	program patients who, during their respite program stay, enter a case management program that continues to provide service post-respite program discharge	records • Partnering case management program records
Successful linkage of hospitalized homeless patients with mental health and/or substance use disorders to shelter, housing, and behavioral health treatment services provided outside the respite program	Percentage of respite program patients who obtain shelter, housing, mental health care, or substance use treatment from partnering agencies following discharge from respite care	Outcome reports submitted to Public Health Seattle and King County by HMC and the REACH Program

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐	**All children/youth 18 or under**	X	**Racial-Ethnic minority (any)**
☐	**Children 0-5**	☐	**Black/African-American**
☐	**Children 6-12**	☐	**Hispanic/Latino**
☐	**Teens 13-18**	☐	**Asian/Pacific Islander**
☐	**Transition age youth 18-25**	☐	**First Nations/American Indian/Native American**
X	**Adults**	X	**Immigrant/Refugee**
X	**Older Adults**	X	**Veteran/US Military**
☐	**Families**	X	**Homeless**
☐	**Anyone**	☐	**GLBT**
X	**Offenders/Ex-offenders/Justice-involved**	☐	**Women**
☐	**Other – Please Specify:**		

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.
The ETH Medical Respite Program serves homeless adults who are being discharged from inpatient hospital stays and prioritizes people with substance use and mental health disorders.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**:
County-wide

ETH accepts referrals from hospitals throughout King County.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities,**

law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.

Since its inception ETH has depended on strong partnerships and active collaboration among multiple agencies for its success. The program is managed as a long-standing partnership between HMC and Public Health- Seattle and King County's Health Care for the Homeless Network. While HMC manages day-to-day operations, it is guided in this management by a very active steering committee that includes Public Health as well as six hospitals and seven other community partners. Steering Committee membership is as follows:

Harborview Medical Center
Northwest Hospital Medical Center
Swedish Medical Center
University of Washington Medical Center
Valley Medical Center
Virginia Mason Medical Center
Amerigroup
Coordinated Care Corporation
Molina Health Plan of Washington
United Health Care Community Plan
King County Department of Community and Human Services
Public Health- Seattle and King County
Seattle Housing Authority.

The success of the ETH model of care depends not only on regular input from Steering Committee partners, but on a host of collaborative partnerships with community agencies providing health care, housing, and other services to the homeless population. Many of these partners, such as Evergreen Treatment Services' REACH Program and Neighborcare Health's homeless health programs, are existing Health Care for the Homeless Network providers. Such long-established partnerships have been instrumental in helping ETH patients transition directly from ETH to methadone and other treatment. Other partnerships with housing providers Plymouth Housing, Compass Housing Alliance, and Downtown Emergency Services Center (DESC) have proved invaluable in helping ETH patients enter shelter and transitional or permanent supportive housing after their respite stays. Mental health provider partnerships that facilitate expedited access to mental health care following respite stays include DESC, HMC's Downtown Mental Health program, and Sound Mental Health. In terms of substance use treatment and harm reduction, ETH's partnerships with the Evergreen Treatment Services Methadone Clinic and the King County Needle Exchange have been critical.

In addition, both HMC and Public Health/HCHN continue to actively participate in broader community collaborations that impact our collective capacity to stabilize and assist people struggling with chronic homelessness, chronic behavioral health conditions, and other obstacles to maintaining health, personal safety, and self-sufficiency. These collaborations include the Familiar Faces Initiative and various initiatives of All Home (formerly Committee to End Homelessness), including Coordinated Entry and Assessment.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Health care reform, particularly the expansion of Medicaid eligibility, has been an important facilitator of the expansion of ETH services by increasing both Medicaid revenue to the program and Medicaid managed care organization investment in ETH's success. The State of Washington is now entering the next phase of reform and seeking to build partnerships among Medicaid managed care organizations and local providers serving beneficiaries at high risk for future hospitalization. Public Health and HMC will participate in planning for these partnerships and work to ensure that the importance of ETH services is widely appreciated among all potential partners. As King County develops its Accountable Community of Health, with direction provided by State health care reform policy, ETH may be able to take advantage of new opportunities to support its integrated services and enhance its capacity to link patients to integrated services and intensive care coordination at discharge. Public Health and HMC do not anticipate that health care reform initiatives will obviate the need for ETH to any degree, however. Nor do they anticipate that future reform initiatives will reduce the feasibility or sustainability of the program.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

ETH has been successfully implemented, and it has employed MIDD and other funding streams to expand its capacity to address disabling mental health and substance use disorders within its target population. Unfortunately, in 2016 the federal government made a change in eligibility for funding that had been critical to the program's expansion and this change has resulted in a significant decrease in federal revenue.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

ETH has been successfully implemented.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

   While ETH has expanded its capacity to address disabling mental health and substance use disorders within its target population, it is currently able to only meet a fraction of the demand. ETH's ability to maintain and continue to expand this behavioral health capacity depends on significantly increasing local funding above current levels.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Realistically, the two alternatives to providing respite services to homeless hospital patients who do not require hospital-level medical care but who have a high risk for poor outcomes and/or readmission if discharged are as follows:

- **a.** Keep the patient in the hospital and attempt to provide bedside case management services and linkages to external primary care, mental health, substance use treatment, housing, and social services
- **b.** Discharge the patient back to homelessness with or without any case management or established linkages to external services.

Option A has proven ineffective and far more costly than respite care; Option B has proven to result in poor health outcomes and a hospital readmission rate significantly higher than that experienced by the general population.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the VETH and Human Services Levy or any other County policy work?**

Respite care represents a critical transitional step within the continuum of care, bridging the care patients receive in the inpatient hospital setting with the primary care, behavioral health treatment, and social services they can receive on an outpatient basis. The program's design reflects its priority to provide the level of intensive support that has proven critical to helping its highly vulnerable population succeed in making this transition. In as much as this support entails care that completely integrates mental health and chemical dependency treatment with medical treatment, the program represents a leading example of how behavioral health integration (BHI) can succeed in our community and thus aligns extremely well with the County's BHI initiative.

The program also provides an excellent example of how the county's Public Health Department and its Department of Community and Human Services (DCHS) can coordinate efforts in an extremely effective manner in the pursuit of Health and Human Services Transformation goals. ETH stands directly at the crossroads of efforts to improve the physical health, behavioral health, housing, and socio-economic status of a segment of the county population that is among the most affected by disparities. Virtually 100% of ETH patients require intensive assistance and ongoing support with problems in all of these areas, and thus virtually all ETH program initiatives directly relate to other initiatives undertaken by both Public Health and DCHS. Over the years, the quality of ETH services and its partnerships with other agencies providing services to ETH patients has been greatly enhanced by longstanding and ongoing collaboration among Public Health's Health Care for the Homeless team and DCHS's King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and All Home staff.

Finally, ETH collaborates closely and coordinates care with numerous programs and services funded through the King County Veterans and Human Services Levy, such as Evergreen Treatment Services' REACH Program.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

ETH's clinical model is grounded in best practices that directly flow from the principles of recovery, resiliency, and trauma-informed care. For example, its intensive case management and transitional care services utilize a harm reduction approach and tools such as motivational interviewing to assist patients in investing in their own recovery and setting recovery-oriented goals. In addition, the clinical team receives trauma-informed care training to help ensure that treatment and case management plans take into account the much higher rates of trauma history among the homeless population compared to the general population.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

The ETH target population represents a segment of the broader homeless population that experiences an extremely high level of risk for poor health outcomes, frequent criminal justice system involvement, and social disenfranchisement. Once people with unmet substance use and mental health treatment needs become acutely ill enough to be hospitalized, their capacity to independently access community resources to exit homelessness and connect to ongoing care tends to be at an extremely low level. As a result, chances for increasingly poor outcomes increase dramatically. Respite care represents a critical intervention that directly impacts the patient's chances of stabilizing enough to make the needed linkages to ongoing care and treatment that will improve their health, reduce the chances for future criminal justice system involvement, improve their housing situation, and generally improve their social wellbeing. Thus ETH directly addresses the health outcome disparities experienced by the homeless population as compared with the general population.

Further, African Americans and American Indian/Alaska Natives represent a higher percentage of ETH patients than they represent of the King County population. African Americans make up 15% of ETH patients, compared with 6.7% of the county population, and American Indian/Alaska Natives make up 6%, compared with 1.1% of the county population. This overrepresentation mirrors the significant overrepresentation of people of color within the *overall* homeless population, both in King County and in many other areas of the country. To the extent that ETH services help stabilize patients' health and connect them to services they need to *exit* homelessness, the program contributes to broader countywide efforts to reduce this disparity in the rate of homelessness. It also contributes to efforts to reduce chronic disease health outcome disparities experienced by people of color in our community.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

ETH has been successfully implemented; it is sustaining high quality services and has expanded its capacity to address disabling mental health and substance use disorders among its target population. Yet the program is currently able to only meet a fraction of the demand. There are many more homeless hospital patients with disabling behavioral health conditions who need respite care than ETS can accept.

At the same time as demand is increasing, the program is experiencing significant cuts in federal revenues that threaten the program's ability to serve its mental health and substance use disorder clients. The program has worked diligently to increase other revenue to make up for this decrease by, for example, working with the Medicaid Managed Care Organizations (MCO) to maximize Medicaid reimbursement for respite stays for those patients enrolled in these MCOs' plans. In light of the federal cuts, however, increases in Medicaid and other revenue are not keeping pace with the cost of maintaining the level of behavioral health capacity that can effectively respond to the ever increasing level of demand. Without a significant increase in local revenue, the program would need to change its model and admit a much lower percentage of patients with disabling opiate addiction and other behavioral health conditions.

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

ETH is requesting MIDD funding in the amount of $1.5 Million per year. From ETH's first receipt of MIDD funding in 2011 to the present, ETH has continually expanded to provide providing comprehensive,

integrated care to people challenged by disabling substance use and/or mental health conditions in addition to their homelessness. In fact, as Seattle and King County have experienced a growing epidemic in heroin use, ETH has increased its focus on working with the injection drug using population. MIDD funding, at the annual level of $508,500, along with revenue from other sources, has allowed ETH to expand its behavioral health clinical capacity and make other required changes to help stabilize patients during their respite program stay and create a platform for successful linkages to substance use and/or mental health treatment upon discharge from the program. Annual MIDD funding of $1.5 Million will allow ETH to maintain its ability to effectively serve patients with disabling behavioral health conditions despite significant federal cuts. It will also allow the program to continue, albeit at a lower level, the trend it has established over the past 5 years to steadily increase behavioral health staff capacity.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

The respite program is supported by several revenue sources in addition to MIDD. Six local hospitals' community benefit programs currently contribute over $950,000 per year to the program. In addition, Public Health - Seattle & King County contributes over $321,000 in federal Health Care for the Homeless grant funds. Medicaid also contributes to the program in the form of reimbursement for Medicaid-enrollees' respite services.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Attachment 1. MIDD Strategy 12b Final, 2008

Strategy Title: Expand Re-entry Programs

Strategy No: 12b – Hospital Re-entry to the Community Respite Beds

County Policy Goal Addressed

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Homeless people with mental illness and/or chemical dependency often stay in local hospitals longer than medically necessary due to the challenges hospitals face in finding placement options to meet the complex needs of these individuals. Current programs do not meet these needs. A recent survey conducted by four local hospitals over a six- week period identified 333 homeless people who needed housing upon discharge. These people spent a total of 244 days in the hospital due solely to the lack of a safe placement, representing an estimated annual cost of three million dollars. The existing Medical Respite Program, a collaborative project between Health Care for the Homeless Network (HCHN) and Harborview Medical Center's Pioneer Square Clinic, is at capacity and provides recuperation options for some types of patients, but is not able to serve those with more complex medical and behavioral health needs. In addition, the network of boarding and nursing homes is challenged to serve individuals with current substance abuse and/or mental illness.

◊ *B. Reason for Inclusion of the Strategy*

There is a pressing need for hospital beds, and particularly psychiatric beds, in King County. About one out of every four individuals detained under the mental illness involuntary commitment law has had to be held in emergency rooms and hospitals. These facilities are not licensed for involuntary treatment services due to unavailability of psychiatric in-patient beds. This practice, which is a national problem, is called "boarding". Freeing up capacity on psychiatric units by discharging individuals when they no longer require a hospital level of care would reduce the incidence of boarding, reduce hospital costs, and assist individuals in their recovery. Individuals with mental illness and/or chemical dependency, along with ongoing medical needs, also are often kept longer than necessary on inpatient medical units and in the emergency department. These individuals also need a new recuperative care resource, including medical and psychiatric monitoring and intensive case management, to help them re-enter the community and begin their recovery.

◊ *C. Service Components/Design*

The proposed service model being considered by the Respite Expansion/ Hospital Discharge Project planning group includes one or more facilities equipped to accept individuals being discharged from hospitals and staffed by health care professionals, mental health and chemical dependency professionals, and discharge planners. Services would include case management, medical (including medication) management, transportation to appointments and housing options, and the provision of basic needs (food, hygiene, laundry, etc.) while in the program. Case management will be focused on linking homeless people to more stable housing and ongoing medical and mental health care and substance abuse treatment.

◊ *D. Target Population*

Homeless persons with mental illness and/or chemical dependency who require short-term medical care upon discharge from hospitals.

◊ *E. Program Goal*

Develop expanded respite care options for homeless individuals with mental illness and/or chemical dependency being discharged from hospitals. Provide case management services to help these individuals access permanent supported housing, if needed.

◊ *F. Outputs/Outcomes*

Estimated 350-500 individuals served per year, depending on the final service model.

Reduce the length of hospital stay for the target population. This will reduce public costs for these individuals, free up capacity for those in need of a hospital level of care, and reduce the boarding of involuntarily detained individuals in emergency rooms and on medical units.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
April-Sept 2008	Continued planning under auspices of Medical Respite Expansion Project	
Sept-December 2008	Hire consultant/facilitator to complete planning	$20,000
	Total Funds 2008	**$20,000**
Jan–March 2009	Find facility and finalize design.	$15,000

	(retain consultant)	
March-June 2009	RFP and contracting process	
June-Aug 2009	Start-up : Hire and train staff; buy medical equipment, furniture, supplies, etc.	$85,000
Sept-Dec 2009	Services begin	$190,000
	Total Funds 2009	**$290,000**
Ongoing Annual	**Total Funds**	**$565,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and Type of Providers (and where possible FTE capacity added via this strategy)*

To be determined

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

To be determined

◊ *C. Partnership/Linkages*

In June 2007, Public Health-Seattle and King County convened a workgroup to address the issues of recuperative care needs and hospital discharge of homeless patients and the need for a system-wide approach to developing and managing placement options. Participants in this workgroup have included representatives from Harborview, Swedish, University of Washington, and Virginia Mason Medical Centers; the Committee to End Homelessness in King County; King County Mental Health, Chemical Abuse and Dependency Services Division; Life Care Centers; Downtown Emergency Service Center; City of Seattle Human Services Department, King County Office of Management and Budget; and United Way. The planning group is continuing to meet, and this planning process includes potential use of the MIDD Sales Tax Funds for the component of the hospital discharge plan that would provide the critical mental health and chemical dependency services for the individuals in the respite program.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Development of recommendations for model	Nov. 2007-June 2008
Develop agreements among stakeholders regarding financing, responsibilities, policies	July -December 2008
Find facility, complete specifics for plan	Sept.-Dec. 2008
RFP/contracting process	March –June 2009

◊ *B. Procurement of Providers*

RFP process (if needed under final plan) for mental health and chemical dependency services component of plan	March-June 2009

◊ *C. Contracting of Services*

Complete contracts	June 2009

◊ *D. Services Start Date(s)*

Hire and train staff	June-Aug 2009
Open for services	September 2009

71 Working Title of Concept: Medical Respite Program

Name of Person Submitting Concept: Jennifer DeYoung
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

The Medical Respite Program cares for homeless persons needing a safe place to recuperate after an acute hospital stay; provides case management to transition patients to housing, social services, and ongoing primary care; and addresses both acute and chronic behavioral health needs, including mental health and substance use disorders. The purpose of the program is to improve health outcomes and reduce costs in the health, human services and housing arenas, while improving the patient's experience. The program expanded dramatically in 2011 with the support of seven local hospitals and the willingness of Seattle Housing Authority to lease space at Jefferson Terrace apartments for this purpose. The hospitals identified the need for a respite model that could accept their homeless patients with more serious behavioral health issues; specifically injection drug users hospitalized for serious infections that required post discharge IV antibiotic treatment and/or daily or twice daily wound care. Additionally they needed a discharge destination for behaviorally challenging homeless patients with mental health problems. The program fist began receiving MIDD funds when it expanded in 2011. In the years since then, these MIDD funds have helped the program expand its capacity to serve people with a greater acuity of mental health and substance use needs. The MIDD funds have been leveraged with funds from other sources to expand the hours that mental health clinicians and nursing staff were present from 8 hours per day to 24 hours per day as well as significantly expand the overall size of the clinical team. While the program has added significant new revenue from Medicaid and other sources

to support this higher level of care and added capacity, it will require additional funds to sustain its ability to meet patient needs relating directly to behavioral health disorders.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

People living homeless with serious mental illness and substance use disorders, particularly injection drug users, experience tremendous difficulty in recuperating after a hospital stay compared to people with stable and suitable housing. National studies have shown that this population has a significantly higher hospital readmission rate than the general population. Approximately 80% of Medical Respite Program patients have substance use disorders. As the program has developed it has determined that increased levels of overall behavioral health clinical capacity as well as greater clinical capacity overall proved critical to stabilizing patients with these disorders, often co-occurring with serious mental illness. Without the intensive and 27/7 services that this expanded capacity enables, patients would be more likely to leave before it is medically advisable or would need to remain in respite longer, thus taking up scarce bed space and preventing new patients from entering care.

3. How would your concept address the need?
Please be specific.

An increase in MIDD funding will ensure the Respite Program's ability to maintain its current expanded capacity to meet the recuperative needs of people with significant behavioral health challenges and will allow it to continue serving a population with extremely high risk for increasing hospital stays and criminal justice involvement and the associated costs to the community of these increases.

4. Who would benefit? Please describe potential program participants.

Homeless persons needing a safe place to recuperate after an acute hospital stay, the Respite Program's general target population would benefit. In particular, people in this group with behavioral health treatment needs would benefit from the continuation of the program's robust behavioral health component. In addition, the tax payers would benefit from the savings related to avoided jail stays , first responder usage, and other costs associated with this population's lack of access to needed services.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

All Respite Program patients receive a psycho-social assessment within 48 hours of admission. This assessment allows the clinical team to determine the specific services the client needs while in respite as well as the linkages to community programs needed at discharge. Specific outcome measures include: the % of respite clients who are discharged to a more stable housing situation, the % of respite clients who are linked to at least one of the areas identified as a needed service for that client, and the % of clients who have completed their recommended respite stay and resolved their present medical problem(s) to a level where they are no longer in need of the services offered by respite. A utilization review was conducted of 62 clients after the first 6 months of the expanded program at Jefferson Terrace showed

- 70% reduction in total inpatient hospital days
- 10% reduction in Emergency Department visits
- 6 month post Emergency Department data showed 50% reduction in inpatient admissions
- 67% reduction in surgeries and procedures 6 months post respite

A recent analysis of respite data shows that in 2014 the Respite program provided 760 visits to 29 patients who were identified as Familiar Faces (individuals who had four or more jail admissions in a year and a behavioral health issue)

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

The Respite Program's population represents a segment of the homeless population that experiences an extremely high level of risk for poor health outcomes, frequent criminal justice system involvement, and social disenfranchisement. Once people with unmet substance use and mental health treatment needs become hospitalized, their capacity to independently access community resources to exit homelessness and connect to ongoing care tends to be at an extremely low level and the chances for increasingly poor outcomes increase dramatically. Respite care represents a critical intervention that directly impacts the patient's chances of stabilizing enough to make the needed linkages to ongoing care and treatment that will improve their health, reduce the chances for future criminal justice system involvement, improve their housing situation, and generally improve their social wellbeing.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

The Respite program collaborates with local hospitals, behavioral health providers, housing and other homeless services providers, and programs like REACH that provide outreach and case management for a variety of behavioral health and social needs post-program discharge.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$ 1,500,000 per year, serving 500 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.