



Advice from Medical Respite Program Coordinators: Survey on Relationships with Hospitals

2021

In Spring 2008, a Research Task Force of the Respite Care Providers' Network developed and conducted a survey of known medical respite programs across the United States to develop a profile of if/how those programs were relating with hospitals in their communities. This survey resulted in the foundational resource [Medical Respite Programs for Homeless Persons: Survey on Relationships with Hospitals](#). As part of the survey, respite program coordinators from 8 medical respite settings were asked to describe what the ideal working relationship between their respite program and a referring hospital would look like. This updated document provides an overview of the providers' responses related to key areas of hospital relationships to guide developing and current programs in navigating these relationships in their communities.

What would be an ideal working relationship between your respite program and a referring hospital?

Formal Agreement

- Includes a plan for funding.
- Includes mutually agreed upon guidelines.
- May be inclusive of several public and/or private hospitals to ensure enough funding for the program. The amount of funding would be based on the number of beds, services, and staffing (such as 24 hour coverage). This would allow the program to provide services to most of the patients referred by hospitals and remove many of the limitations of the current program.
- Identifies a discharge plan for patients experiencing homelessness that is co-created with the respite program staff.
- Identifies discharge procedures to the medical respite program.
- Education to hospital staff regarding the needs of their patients experiencing homelessness.
- Onsite relationship between hospital and respite staff.
- Medical support from the hospital.

- Agreement for the hospital to provide follow-up outpatient care for patients they refer. Detailing a mechanism to readmit the patient to the referring hospital if the patients' condition becomes unstable and beyond the scope of care medical respite can provide.
- They should have written agreements regarding medications, primary care and follow-up specialty care.
- Include HIPAA-compliant agreements to share patient data from the hospitals. Have patients sign HIPAA releases upon admission to allow data sharing. Gather data periodically (annually) to demonstrate that respite patients are not being readmitted to the hospital (or shorter stays). This is important to get continued funding.

Funding

- Long-term funding plan for all medical costs related to the facility (i.e. medical staff, medical program costs, related administrative costs).
- Funding plan is included in the formal agreement.
- Enough funding to ensure adequate staffing to manage all referrals.
- Enough funding to cover 24 hour staffing.
- Help the hospital recognize the vast amount of savings medical respite programs to support the hospital funding a portion of the program.
- A formal agreement with hospital funding and strong communication as well as an onsite relationship between hospital and respite staff.

Communication

- Early frequent verbal communication. The operational relationship is just as important as the written agreement.
- Fostering a positive relationship with area hospitals that refer. As a stand-alone entity, that allows the program more flexibility.
- Having a respite program staff liaison at the hospital/on-staff at the hospital. This helps with discharge planning, accepting/denying referrals, and coordinating transfer of care/readmission.
- Develop an online referral process if possible which eases the process.
- Access to the hospital's EMR to allow ease of reviewing medical and patient information.

What advice would you give to a new/developing respite program about relating well with hospitals?

Engaging the hospital for funding and support

- Begin with a true spirit of collaboration.
- Get in there early. Sell respite program as a means to alleviate their problem.
- Enlist the support of a key advocate (person or organization) with influence among hospital executives (e.g. HMO conversion foundation; collaborative health care membership organization; sympathetic public official; health commissioner).
- Make contact with the social workers. Most meet monthly as a group and you can attend a meeting to introduce your staff and services.
 - Set up regular meetings/in-services at the hospital with discharge planners, social workers, case managers, ER physicians
 - Try to get hospital administrators present at these meetings or separately.
 - Be a general resource re. homeless issues/requests for services, etc. for hospital staff
 - Make sure they are able to contact you – case managers, physicians, social workers – via phone and/or e-mail, particularly ER physicians
 - Provide your clinic’s hours of operations, scope of services and liaisons with other homeless service providers
 - Let them know that you are trying to prevent unnecessary ER visits by homeless patients and instead, get them into your primary care
 - Discuss cost savings for hospital
- Enlist the help of a sympathetic health educator, preferably a physician who teaches at a medical school or teaching hospital.
- Be sure you have hospital support before beginning project unless you have adequate money to care for very sick patients. Set up a community or interagency advisory committee before you do anything else.
- Discuss efficacy of treatment outcomes with addition of respite care for homeless in your community
- Enlist the help of a data analyst or financial analyst.
- Enlist the help of someone who speaks “hospital” and/or speaks “business”.
- Conduct an Internal Review Board (IRB) approved study at the hospital that treats the majority of homeless people. Captures information on the rate of hospitalizations and ER visits from people who are homeless. The work may be done with the help of students. It can be involved

(manually pull a sample of patient records), but a quicker, easier approach is to request a computerized data file (have analyst help design the data request).

- Get free American Hospital Association data on hospital costs by region (med school library). For a subscription fee you can get hospital specific data through online services.
- Analyze the approximate financial impact of unreimbursed hospital costs for homeless people.
- Key advocate invites all hospitals (and some key government officials) to a joint meeting to discuss the results.
- Present the data in a professional business-style manner (e.g. PowerPoint) including financial impact.
 - A knowledgeable physician should present the medical need. Financial analyst presents the data and financial impact.
 - Business / hospital professional closes the presentation with the ask.
 - Present the need from the perspective of the audience (i.e. brief focus on the patients' unmet needs, but a greater focus on the hospital's need to discharge sooner or prevent repeat visits to the hospital due to lack of healing – sounds cold and heartless but is necessary for success).
 - Close with a folder including the slides from the presentation and a concise (one page) written bullet- point summary that ends with a call to action (hand this out at the end and discuss). The people sent from the hospitals to attend the meeting will probably not be the decision-makers. They will take this back to their executives.
- Be sure to suggest that the funding might come from the hospitals' "Community Benefit" budget. The IRS and state/city governments have been challenging the tax-exempt status of hospitals around the country. Tax-exempt hospitals look too much like for-profit hospitals (high executive salaries and some charity care. They must demonstrate that they provide community benefit significant enough to justify continuing the status (tax-exempt status means no property taxes as well as no income taxes). Hospitals have set up new budget line items and even whole departments, called "community benefit". Homeless respite care should be highly consistent with the mission of most hospitals (and it saves them money). Even if a hospital has a separate foundation they will not want to pay you from the foundation. The money has to come from the hospital budget to count for this purpose.
- If possible, get a challenge matching grant from the HMO conversion foundation or other key local foundation sympathetic to homeless health issues. The challenge is to the hospitals to provide funding.
- Do not get discouraged and keep soliciting them for funding. Continue to communicate with the appropriate staff and build good working relationships. Make sure to be clear on referral guidelines and stay consistent. It is important that they know your face and that you advocate for the client at all times.

- Don't forget public officials and the business community. The community benefits from homeless respite care in many ways, including financial. When a homeless person is treated at a hospital and cannot pay, the unreimbursed costs are ultimately spread across all customers. Everyone pays more for health care when some cannot pay. So unnecessary hospitalizations of people with no pay source drive up costs for everyone.
- Include HIPAA-compliant agreements to share patient data from the hospitals. Have patients sign HIPAA releases upon admission to allow data sharing. Gather data periodically (annually) to demonstrate that respite patients are not being readmitted to the hospital (or shorter stays). This is important to get continued funding.
- Publicly thank hospital funders for being heroes.
- Stick with it, hospital attorneys will make this as difficult as possible, get sympathetic physician-champion.
- Hospital funders are mostly concerned with shortened hospital stays and reduction in repeat ER visits but hospital staff see our biggest assets as ease of accessibility to the program, making their day and job easier.
- Continue throughout with a true spirit of collaboration.

Continue to Engage Stakeholders

- Convene a committee of stakeholders that include folks involved in homeless healthcare (medical, substance use, psych, etc.) AND folks from institutions or agencies that haven't yet developed expertise in issues around homelessness. Encourage people to bring their concerns & questions to the table early. Ask each of the stakeholders what they need and what they're willing to give. Start meeting early & meet often.
- Once the respite facility is up and running, reconvene the meetings semi-regularly to update your stakeholders on your successes and your challenges. Start collecting data from the moment you open your doors – demographics, length of stay, discharge venues, etc.
- To consistently keep the dialogue open on the Administrative level: Having a consistent person that you are in contact with who will follow-up on issues of concern and work within the program guidelines would be great.
- Follow through with the collaboration. Allow all funders to have seats on your board or on an advisory committee.
- With hospital funding and board members, it's sometimes difficult to walk that line between the needs of the clients and the hospitals' need to "save money". It feels slimy to talk about saving hospitals money when there are people dying on the streets, but it's necessary to get the attention and support of the hospitals. Never compromise your mission to help people who are homeless. This must always be the first priority. But at times you will have to continue to demonstrate the financial benefit to the community and to the hospitals to receive ongoing

support. Work to bring the right people from the hospitals onto your board (i.e. ones who believe in the mission, not just look out for their money).

Develop and maintain the relationship with hospital staff

- Make connections with case managers and MDs, keep detailed notes of case studies and cases which went well, hold frequent meetings with hospitals and constantly work on relationship building and education of hospital staff re. homelessness and issues related to homelessness
- Get to know the discharge staff.
- Frequent contact with social work, ER staff is helpful to ensure the understanding of homeless patients and the program options to support patients at discharge.
- Find out who does the placement and speak directly to them.
- Initially meeting with hospital staff most directly responsible for discharge planning is key. Through presentations on the nuts and bolts of respite, who is and who is not appropriate, and the expectations of patients leaving the hospital can set a tone for clear and on-going communication.
- Giving those directly responsible for discharging a tour of the respite facility also helps because they are able to see first-hand the staffing, the living quarters, and the degree a patient is responsible for providing self-care.
- Be flexible, be clear, have good boundaries. Because of staff turnover in social services at referring agencies, periodic in-services need to be done.

Develop Clear Guidelines and Boundaries for Admission

- Highest priority is to meet the needs of the patients. Though a referral may be made which is outside the scope of what should be accepted, do what is right and best for the patient.
- Develop clear MOU's before accepting patients; it's much easier to create a culture than to change a culture. Do not back down around things that are important. For example, for us several issues were deal breakers. Any hospital that could not commit to adhering to our referral process (including involving clinicians in the referral), to sending patients with a week's supply of meds, in hand, and to sending patients with a discharge summary, would not have access to respite. Many of the hospitals complained that they would never be able to convince their inpatient pharmacies to comply with the medications, but when push came to shove, they did.
- First establish the limitations of the program with the hospitals with explanations for the limitations. Attend staff meetings periodically to go over the program with the discharge planners and social workers. This provides you with an opportunity to refresh experienced staff and introduce the program to new employees while putting a face and name with the program.

When accepting or declining a referral, always speak with the discharge planner. Provide explanations for declining a referral and alternative solutions. Many discharge planners are not aware of the conditions of the shelter systems, both good and bad. Helping them be more aware would allow them to better serve the patient and understand the needs, limitations, and gaps in the homeless care system. Be flexible and accommodating without compromising the program. Remember that making an exception may mislead the discharge planners to believe the exception has become the rule.

- Maintaining consistency with the admission requirements and educating hospital staff on what cannot be safely managed in the respite program is critical. I have found that discussing our limitations is as important as reviewing our available services.
- If someone is inappropriately or prematurely discharged, it is important to contact the facility and case manager (if available) to discuss the reason a patient is being returned to the emergency department. A small percentage of the time, this is a difficult conversation but I have found that a majority of the time it was a lack of understanding as to what the respite team is able to safely provide.

Information adapted from:

Respite Care Providers Network. (2008). *Medical Respite Programs for Homeless Persons: Survey on Relationships with Hospitals*. National Health Care for the Homeless Council & National Institute for Medical Respite Care. <https://nhchc.org/wp-content/uploads/2019/08/HospitalSurveyfinalReport-1.pdf>