NATIONAL INSTITUTE for MEDICAL RESPITE CARE

Promising Practices: Providing Behavioral Health Care in a Medical Respite Setting

November 2nd, 2022

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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HRSA Acknowledgement & Disclaimer

Acknowledgement

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Key Definitions

Behavioral health:

- "…the promotion of mental health, resilience, and wellbeing;
- the treatment of mental and substance use disorders;
- the support of those who experience and/or are in recovery from these conditions." [1]

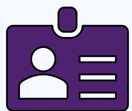
Medical respite care *(MRC) is post-acute care for people experiencing homelessness who are too ill or frail to recover from an illness or injury on the street or in shelter, but who do not require hospital level care. MRC programs offer short-term residential care that allows people experiencing homelessness (PEH) the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services.*

Method: Identifying Promising Practices

Series of listening sessions

Stakeholder interviews

Review of relevant research


Subject matter expert review

REPORT

NATIONAL INSTITUTE *for* MEDICAL RESPITE CARE

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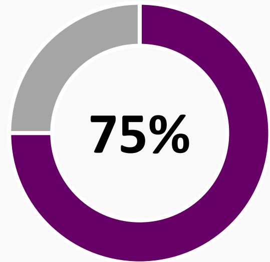
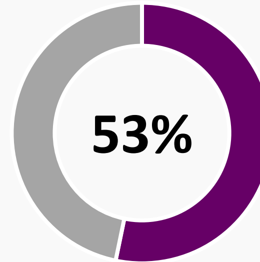
August 2022

Behavioral Health Stigma

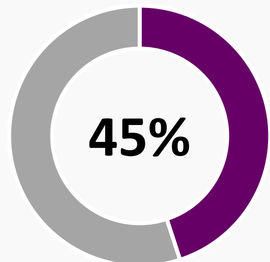
A 2021 survey of a representative sample of nearly 8,000 U.S. residents found that: [2]



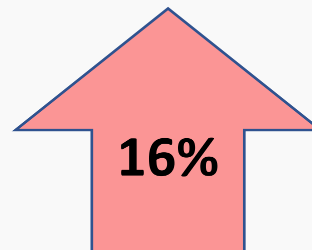
Do not believe that people with SUD are experiencing a chronic medical condition



Believe that SUD is caused by a person's bad character



Of **health care professionals** believe that prescribing medications for opioid use disorder is substituting one drug/addiction for another



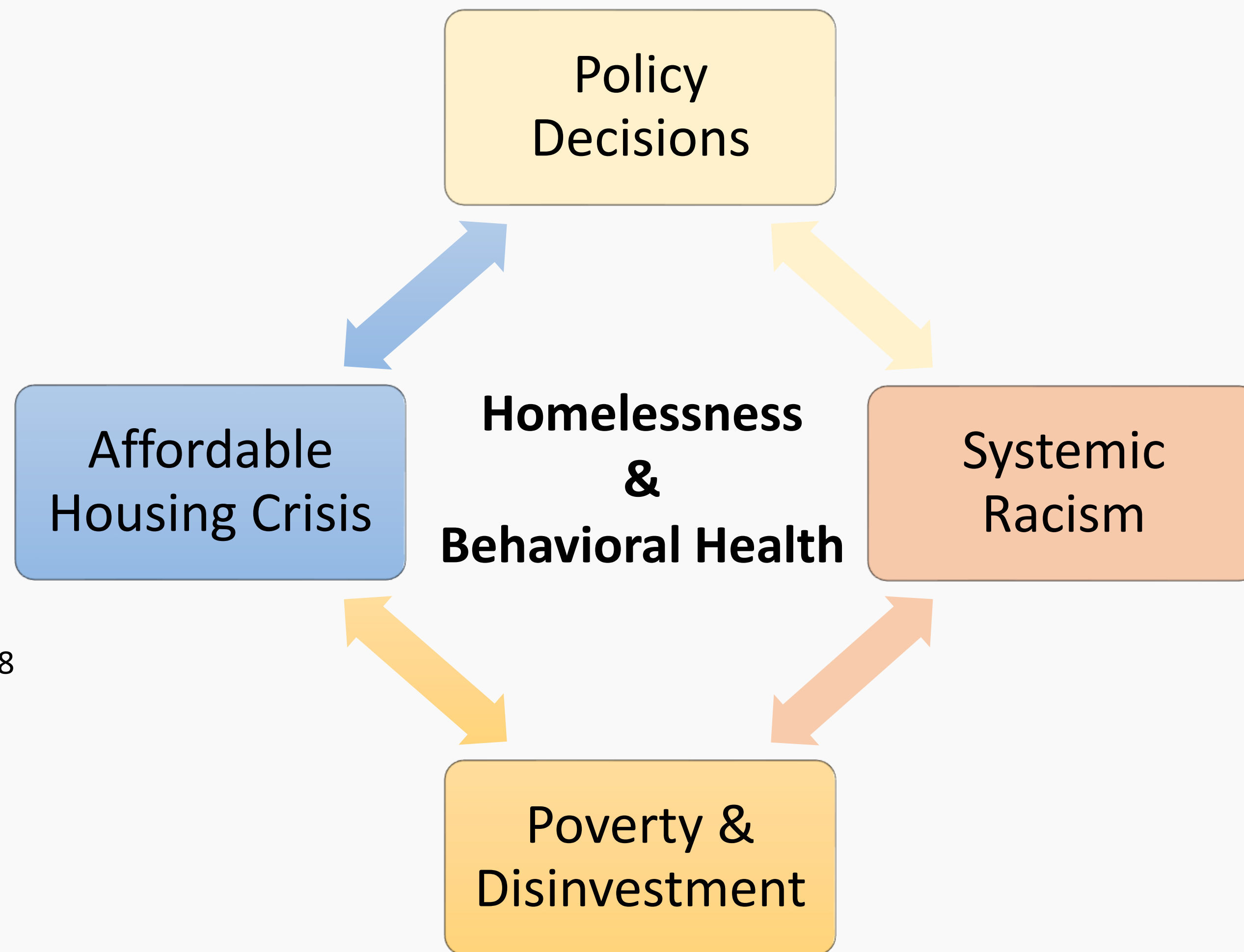
Increased belief that people with schizophrenia are dangerous (from 1996 to 2018) [3]

Behavioral Health & Homelessness: Relationship

Myth: [4]

Mental illness and substance use are the primary causes of homelessness.

Structural Context: [5,6,7,8]

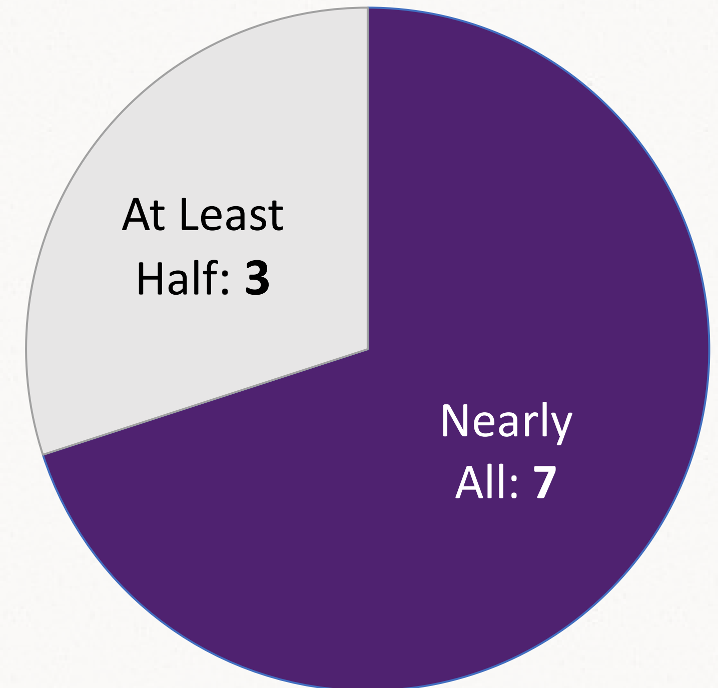


Behavioral Health & Homelessness: Prevalence

Behavioral health conditions: risk factor for homelessness *and* created/exacerbated by homelessness.

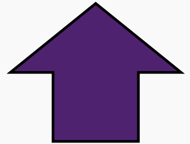
	Current (past 12-months) prevalence among PEH: [9]	Current (past 12-months) prevalence among U.S. population: [10,11,12]
Any current mental disorder	76.2%	21%
Schizophrenia spectrum disorders	12.4%	0.25 - 0.64%
Major depression	12.6%	8.4%
Bipolar disorder	4.1%	2.8%
Alcohol use disorder	36.7%	10.2%
Drug use disorders	21.7%	6.6%

How many of your MRC clients have behavioral health conditions?



*Of 10 MRC programs polled during this project

Behavioral Health & Homelessness: Mortality



A 2022 systematic review found that standardized mortality rates among PEH were **8.6 to 16.1 times** greater than non-homeless comparison groups. [13]

Overdose was the leading cause of death among PEH in numerous mortality studies (Boston, San Francisco, Los Angeles, and Alameda County). [14,15,16,17]

- Deaths from complications of chronic alcohol use were also significant.

Suicide was one of the leading causes of death among PEH in several mortality studies.

Suicide rates among PEH compared with the general population: [13,16,17,18]

- **7.7 times** higher (Los Angeles, CA)
- **14.1 times** higher (Alameda County, CA)

Note: Elevated risk for suicide and fatal overdose following discharge from inpatient settings. [19,20]

Barriers to Behavioral Health Care

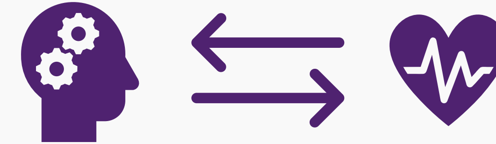
For decades, behavioral health services have been siloed and delivered in contexts that are *"geographically, financially, culturally, and organizationally separate from mainstream health care,"* resulting in:[21,22]

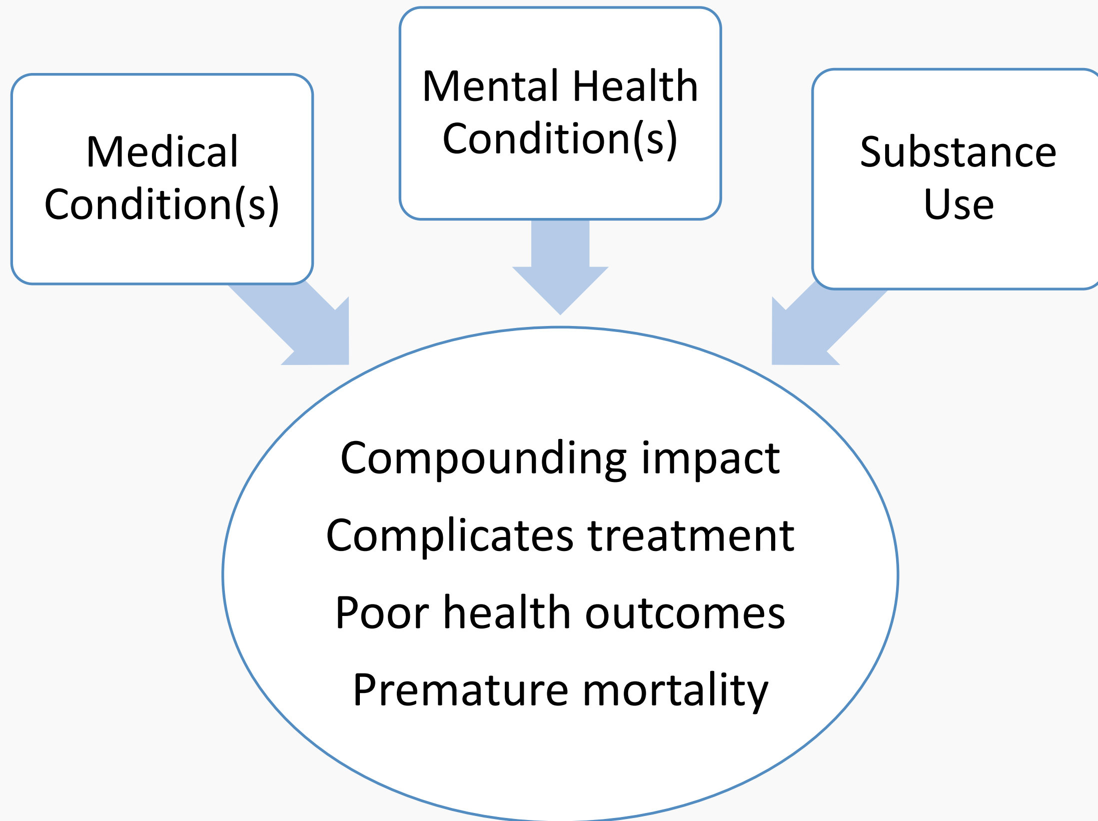
- Workforce shortages
- Poor coordination among providers
- Difficulty enforcing parity laws

Disparities in access: Racial and ethnic minorities are less likely to receive behavioral health care than Whites.[23]	
Asian	- 46%
Black	- 40%
Hispanic	- 36%
Native Hawaiian or Other Pacific Islander	- 31%
Native American or Alaskan Native	- 28%

Heath Implications for Medical Respite Clients

PEH in MRC programs are likely to have **co-occurring** behavioral health and acute/chronic medical conditions. [24,25]





Integrated primary and behavioral health care: Most effective approach for this population. Opportunity for MRC programs to have a profound impact. [26,27]

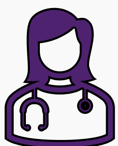
"Probably 85-90% of our folks have behavioral health concerns, and it just affects everything. And usually, those are what's leading them to getting into a medical situation where they need medical respite – behavioral health is driving that."
-MRC Program Clinician/Administrator

Implications for Community & Programmatic Goals

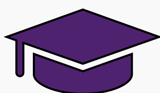
Aligning with community priorities (hospitals, payers, local government, etc.)

Hospitalizations, ED use, emergency services, and law enforcement encounters. [28]

- Ontario, Canada: PEH with behavioral health conditions were nearly twice as likely to have healthcare costs in the top 5% of the whole city. [29]
- Camden, NJ: 82% of high-utilizers had a behavioral health condition (n=681). These patients had 30,000 hospital visits costing $260 million (only $31 million reimbursed). [30]



Connection to outpatient care can mitigate these costs and improve health outcomes. [31,32]

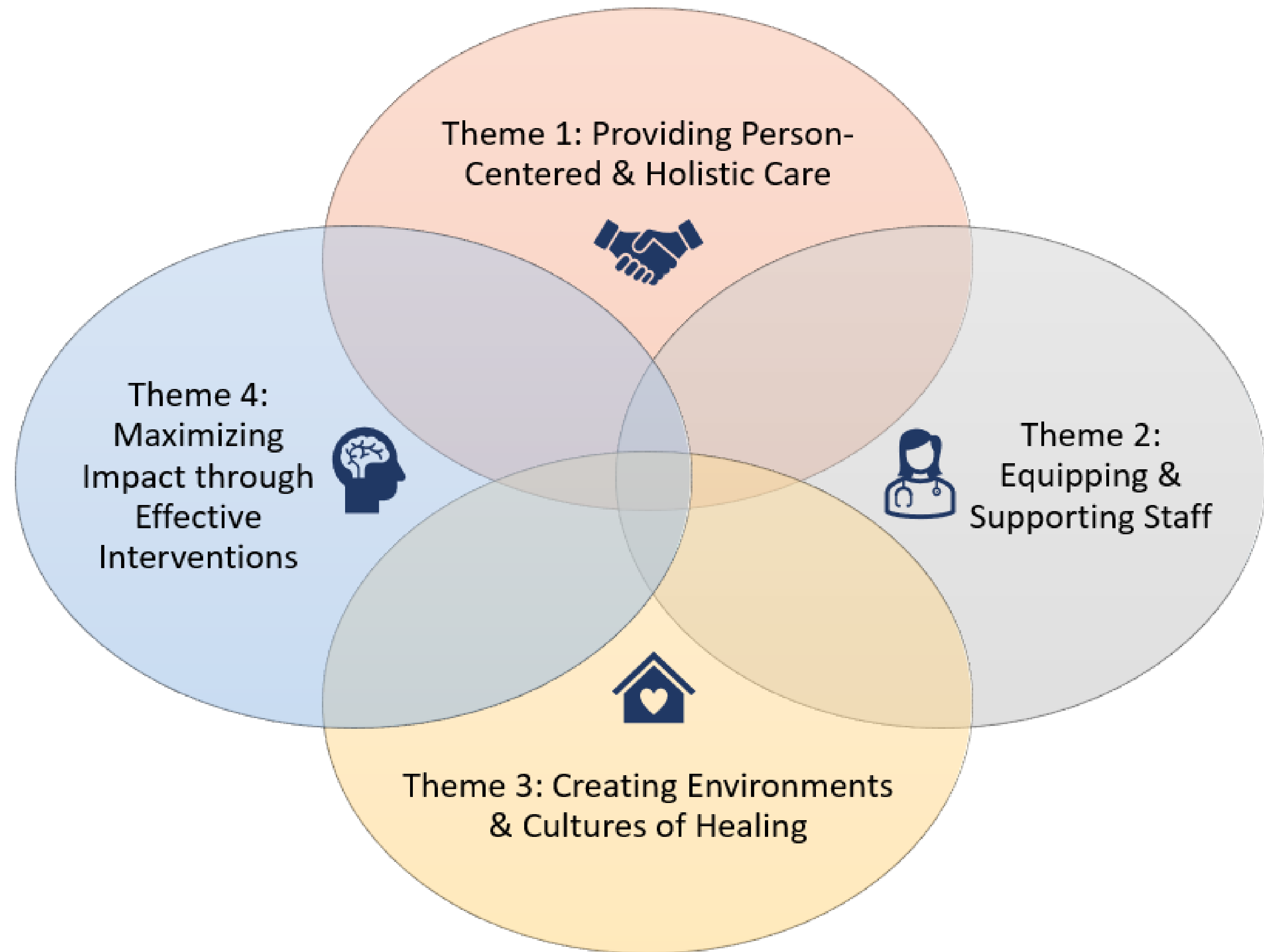


Behavioral health integration in MRC programs helps to: [33,34]

- Engage and retain clients
- Prevent unplanned discharges and returns to the hospital
- Complete care plans and social objectives

Findings: Promising Practices

Nineteen promising practices within four themes:



BHCHP

Respite Behavioral Health Services

Boston health care for the Homeless program

Our mission is to provide or assure access to the highest quality health care for all homeless men, women, and children in the greater Boston area.

Medical Respite: Behavioral health services

Georgia Thomas- Diaz, M.Ed.; LMHC, LADC1; CTS

Agenda

Respite history

Teams

Prevalence of Behavioral health/stigma

Population

Impact of polysubstance in respite

Case study (1)

Behavioral health services

Major psychiatric illnesses

Depression screening process

Community partners

BHCHP’s Respite history

- 1985—Shattuck shelter in Jamaica plain with 25 beds
- 1993-The Barbara McInnis House opens for medical respite care, the first facility of its kind in the country, providing effective, dignified, around-the-clock respite care for patients too sick for shelter or the streets but not sick enough to occupy an acute care bed in one of Boston’s hospitals.
- Our first location was 461 walnut avenue, Jamaica plain, Mass with only 90 beds, and now at the current location 780 Albany street with 104 beds since 2008, operated by an interdisciplinary team around the clock.
- The Stacy Kirkpatrick House (May 2016)-named after a beloved nurse practitioner (1964-2016) who was known for her infectious positivity and her unwavering compassion for our patients—offers 20 medical respite beds and runs by BHCHP nurses, case managers, and operations staff.

It is a BHCHP’s step-down model that allows for medically frail patients to transition from round-the-clock care at the Barbara McInnis House to low-risk care at the Stacy Kirkpatrick House to long-term housing facilitated by our case managers.

Respite’s Interdisciplinary team

Medical providers

Physician assistants/Nurse Practitioners

Nurses

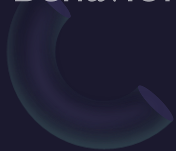
Case managers

Treatment program specialist

Respite aids

Unit secretaries

Behavioral health clinicians



Psychiatrists

Recovery coach

AmeriCorps members

Spiritual support

Nursing and behavioral health students

Prevalence of behavioral health conditions/mortality rate and stigma in medical respite

- According to the 2020 Annual Homeless Assessment Report (AHAR) to Congress, on a single night in 2020, there were approximately 580,000 individuals experiencing homelessness in the United States.

- Many experiencing homelessness have high rates of chronic and co-occurring health conditions and mental and substance use disorders.

- Individuals who are homeless also may be dealing with multiple traumas, and children experiencing homelessness are at risk for emotional and behavioral problems, which often interfere with learning

- Additionally, research has shown that individuals who are homeless have a risk of mortality that is 1.5 to 11.5 times greater than the general population

Stigma

- Within the health care system, stigma toward a person living with a specific disease (HIV, mental health, Cancer, TB) undermines access to diagnosis, treatment, and successful health outcomes.

- Teaching participants about the condition itself or stigma, its manifestations, and its effect on health

- "Structural" or "policy change" approaches included changing policies, providing clinical materials, redress systems, and training around trauma-informed care.

Respite clients

Addiction, job loss, and mental health issues ranked as the top three responses.

Housing--eviction, job loss, sickness

Lack of support—rejections due to drug use or going through transitions

Incarceration—struggling to reintegrate into society

Undocumented and too sick to be discharged to the streets or shelters

Women and men who are both homeless and ill face difficult challenges to ambulate or provide for providing upon discharge from the hospital in need of a secure, supportive place to recuperate.

The needs fall across the spectrum of illnesses. Chemotherapy can be exhausting. Broken bones require attentive care. Burns need careful and frequent dressing changes.

Patients who are facing a terminal illness benefit from palliative care. These and other serious medical problems place Boston's homeless men and women at risk of worsening their conditions.

The impact of polysubstance use in respite

The new data show that overdose deaths involving opioids increased from an estimated 70,029 in 2020 to 80,816 in 2021. Overdose deaths from synthetic opioids (primarily fentanyl), psychostimulants such as methamphetamine, and cocaine also continued to increase in 2021 compared to 2020

- Respite environment is not abstinence free of drugs
- Clients struggle with sobriety in respite vs. those who are struggling to stay sober, sharing the same room
- Safety in the environment
- Sharps containers are in every room, hallway, and bathrooms
- Two bathrooms in respite with motion censors, and two more will be installed soon
- Clinicians are well trauma-informed to meet with clients where they are and use the multi-pathways to recovery to assess readiness
- Recovery coach is a significant asset in the respite milieu-commonalities are shared, and trust building has been established

Case study

- Celine is 57 yrs. Old, AA, unhoused for many years, living on the streets/shelters. She presents a history of chronic PTSD/anxiety/depression/intimate partner violence/regular polysubstance use. Celine spends most of her time as a high utilizer in emergency rooms and respite. She often has multiple stays in peace. She shares that her longest sobriety time was four months with family support in a structured program where she attended groups supported by other women and minimal family support. Celine's respite stay has always been a turmoil for staff, her roommates, and others in the milieu due to her constant use., which often resulted in an abrupt discharge to the ER or a detox. The respite medical team always does an extraordinary job with a non-judgmental approach to address overdoses, and patients' safety is their priority. Celine met with this writer to discuss a plan to go to detox, but instead, she asked if it was possible to go to the WILLOWS next door. Ct and this writer went over the logistics of the program. Celine agreed to go to (WILLOWS) where she can come and use at her leisure; and return to be monitored by well-trained staff, including recovery coaches. She has been in the program for over seven months and has not been in respite since then. She comes to the outpatient clinic to see her PCP and her therapist.

Behavioral health referrals

- Referrals are made by the medical team, case managers, and nurses via epic
- BH team huddles every day to go through the referrals and each clinic is assigned to a task for the day around meeting client's needs, or group coverage.
- Referrals are screened within 24 hours by the Behavioral health clinicians
- Psychiatry referrals are also screened in a timely manner comparable to other facilities that often have an opening in 6 months to a year.
- Behavioral health telehealth is also offered for clients with an established psychiatrist. Clinician assists with virtual visits

The recovery coach is an integral part of the team

- Clinicians are well knowledgeable to address the disease of addiction with the clients in applying stages of change to assess the client's readiness to enter treatment.

Psychiatry screening process from admission

- Admission RN refers any patients with major psychiatric illness to the Behavioral Health team for review before admission
- Patients with multiple psychiatric admissions in the past 6 months to a year, frequent suicidal ideations including homicidal, and multiple suicidal attempts
- Behavioral health therapist reviews the client's chart, sometimes with the client's assigned psychiatrist or BHCHP's chief psychiatrist to create a safety plan in place for the client.
- BH therapist also works closely with the charge nurse to make sure that the client is in a room close to the nurse's station for frequent check-ins.
- A comprehensive suicidal risk assessment is completed with the client to assure safety during respite stay and a follow-up plan with internal or external BH services.

Behavioral health comprehensive core services

1994--BH services started with just one psychiatrist and a social worker. As the years went by, the increase for mental health needs increased tremendously, and the respite team has grown exponentially to a full, well-knowledgeable team of clinicians/prescribers:

- Psychiatry and Individual psychotherapy services
- Arts and crafts groups daily
- Recovery groups 5 days a week
- Women's groups 2 days a week
- Providing support in the milieu around behavioral issues
- Referrals to detoxification and rehabilitation programs
- Substance use disorders services
- Recovery coach support

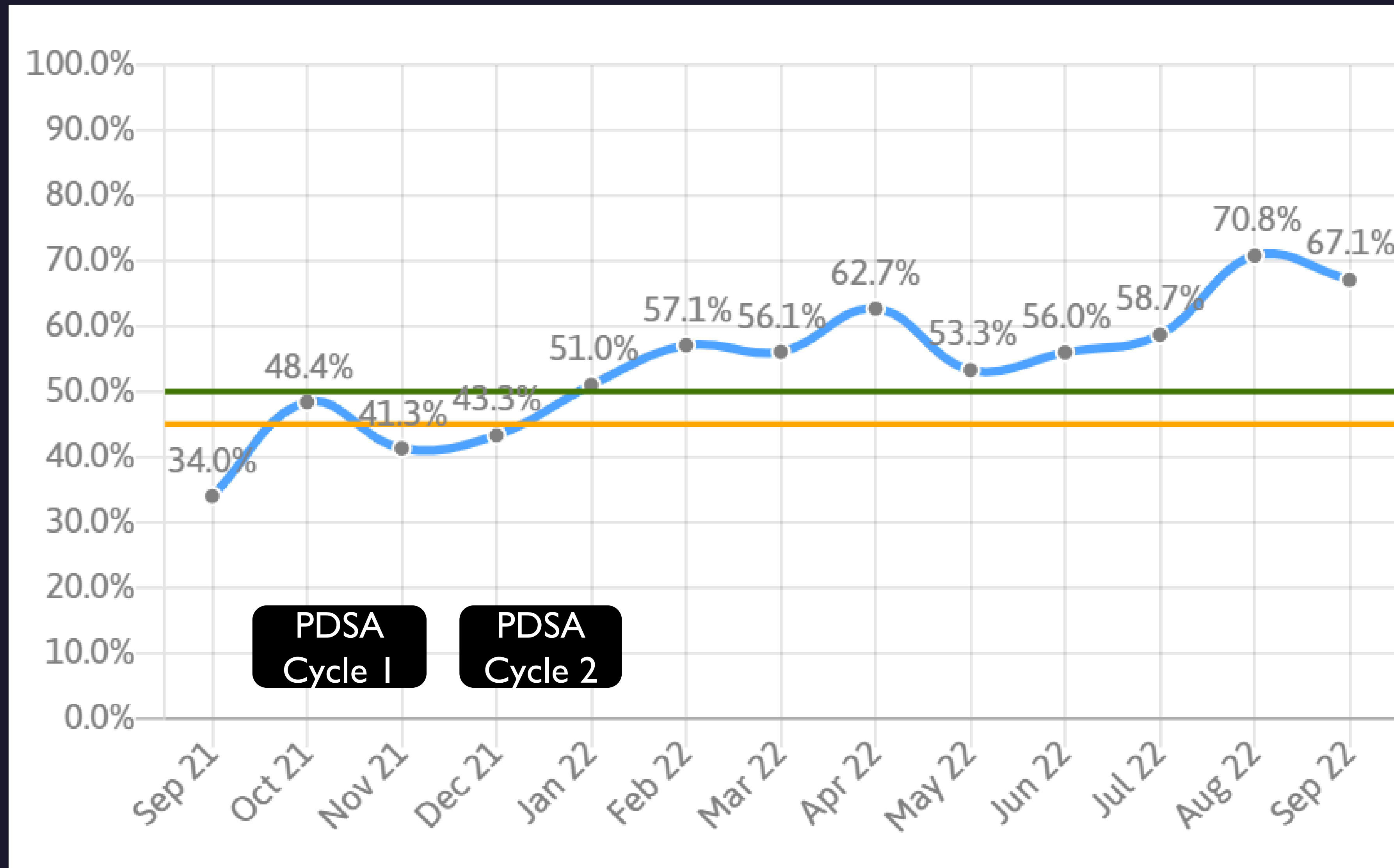
Major psychiatric illnesses

- Major depressive disorder
- Anxiety
- Bipolar disorder
- Schizophrenia
- Complex PTSD
- Alcohol and drug dependence
- ADHD
- Schizoaffective disorder
- Borderline personality disorders
- Alzheimer's/dementia
- Traumatic brain injuries
- Co-occurring disorders

Depression Screening

- Depression screening in respite is highly encouraged by clinicians and Behavioral health students to complete within 24 hours upon admission.
- It is also a quick opportunity to educate and assess the need for referral to a psychiatrist or a psychotherapist.
- The data team creates a weekly report with all the patients admitted the previous week with an overdue PHQ9.

Depression Screening and Follow-up Monthly Trend at BMH



Respite Behavioral Health team

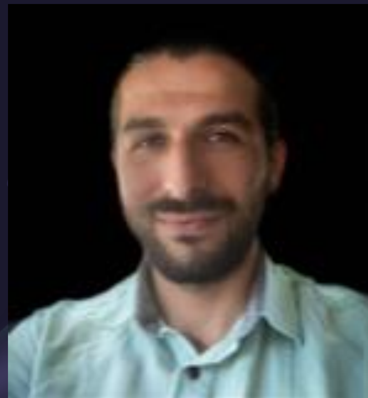
Georgia Thomas-Diaz, LMHC Behavioral health, Director

Nicole Columbare, LISCW

EJ Huston, MHC

David Rachlin, LISCW

Jessica Mowatt, MHC



Hasim Senel, MHC

Rachel Gannon, LISCW

Demetrius Dunston, Recovery Coach

Community partners

- BMC—Boston medical center (special procedures, SANE examination, etc.)
- Willows--- (BPHC/SFH) 2021—Women who are living in the encampment at the Mass and Cass. These women have incredibly complex lives—actively using drugs, living with multiple complicated medical and mental health conditions, struggling with trauma and daily re-traumatization, and experiencing exploitation and abuse in their life on the streets.
- Round House—Pine Street Inn and Roundhouse for unhoused individuals (mini spot)
- Treatment programs-CSS/TSS/residential/sober homes
- MGH—homeless clinic
- PAATHS---(Providing Access to Addictions Treatment, Hope, and Support) program helps individuals, families, community partners, and other treatment providers.
- Project assert---embedded at BMC-referrals to detox/treatment programs
- Faster paths---Faster Paths to Treatment is BMC's substance use disorder urgent care program.

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Thank You

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FIREHOUSE
MINISTRIES

FIREHOUSE RESPITE PROGRAM: A BEHAVIORAL HEALTH CASE STUDY

ANNE RYGIEL, 2022

MEET JOHN

John is a 40 year old Black male who was dropped off by the Birmingham Police Department late one afternoon. John was appropriately dressed but presented with a flat affect and although he was oriented, was unable to provide details as to why he needed a shelter bed other than he had high blood pressure. John had received day services at the shelter several weeks before, but had no other notable interactions documented in HMIS. John had no belongings with him, and his hospital discharge paperwork included patient information for insomnia, musculoskeletal pain, and suicide prevention.

Shelter intake staff realized that John needed to be assessed by Respite, and so the Respite worker (Abby, who was walking out the door) decided to stay late to do an assessment. John told Abby that he "was slow" and would not go back to his primary caregiver, his mother. Although John did not fit the criteria for acute medical crisis, the decision was made to place him in a respite bed and investigate further the next day.

THEME 1: PROVIDING PERSON CENTERED & HOLISTIC CARE FROM THE START

- Respite Standard 4: Medical respite program administers high quality post-acute clinical care

- Although John's chief complaint (high blood pressure) was not severe enough to warrant a respite bed in normal circumstances, the intake process, which took place in a supportive, conversational format, provided enough information to ascertain that John was in crisis, and would benefit from the respite program. From the beginning, Abby prioritized John's concerns as part of the client centered case plan.

- Respite care must be flexible and holistic when possible. Using Trauma Informed Care as a model is helpful when assessing and developing a collaborative treatment plan as many people will present in crisis.

JOHN'S FIRST WEEK IN RESPITE

The first barrier in determining the best place for John was lack of ability to self report and lack of medical records. After releases were signed, the hospital reported that John had been in and out of the hospital for weeks, but was never admitted. John's primary concern was high blood pressure, but every time he presented, his blood pressure was normal. John's medical history at the hospital started in 2018 and included the following diagnoses: Herpes; Intellectual Functioning Disability; Mild Asthma; Anxiety; Hypertension; Alcohol Dependence. Even with history of anxiety and substance use, he was never seen by the hospital psychiatrist, and was discharged the same day.

John was not thriving in the congregate respite setting. He was giving away his money and peer contact was increasing his anxiety, resulting in multiple 911 calls, refusal to participate in any group activities or directives, and behavioral disruptions. Instead of dismissing John from the program, Abby decided to move him into a private room (a converted medical office) and advocate for his continued participation in the program. Due to John's global delays, Abby used therapeutic listening techniques to help John understand respite and develop goals.

THEME 2: EQUIPPING AND SUPPORTING STAFF

- Respite clients that present with behavioral health needs can be especially challenging and additional training and support for ancillary staff may be needed. Additional training may include: harm reduction strategies, de-escalation techniques, and a crisis management plan. All staff that interfaces with the client should participate in the trainings, as behavioral health events don't follow a 9-5 schedule.
- If clients are in a congregate setting, having resident guided rules and regular meetings to discuss shared impact can be helpful if it is purpose driven. Care should be taken to moderate these meetings so that they stay productive and keep clients and staff on the same, solutions based page.

JOHN'S FIRST MONTH

Over the first month, Abby worked with agency partners to get John an accurate diagnosis of Schizoaffective disorder, bipolar type, Anxiety, and Polysubstance use disorder. John continued to reside in the private room, and was partnered with a peer specialist who helped him find a meaningful way to participate- folding laundry. On days John had access to his peer advocate and his task, he didn't call 911. John declined group activities such as yoga and art class, but he worked on breathing exercises one on one with Abby and the LPN. The LPN also assisted him with medication monitoring and symptom management.

John also consented to contact with his former support team, who reported that due to working in a grocery store, John had lost his benefits. Unfortunately, John lost his job due to substance use on property, so Abby worked to get his disability benefits reinstated and connected him with a payee program.

THEME 3: CREATING ENVIRONMENTS & CULTURES OF HEALING

- Remember- once size doesn't fit all when it comes to environment or therapeutic treatment! Consider easy ways of adapting spaces to be a more comfortable for your client. Removable screens, white noise machines, and decompression spaces with tactile/sensory objects are all options for an adaptive environment.
- If you have limited staffing and a client who may have different needs, partnering with other agencies for one on one care or allowing clients to Zoom in and just observe on rec events can be inclusive and less stimulating.
- Make sure clients, especially those with behavioral health considerations, have the physical tools they need to be successful. Amnesty boxes, needle disposal, and easy access to safe outdoor space can head off many behavioral conflicts before they happen and improve programmatic outcomes.

JOHN'S DISCHARGE

Unfortunately, John ultimately needed a higher level of care than respite was able to provide. On weekends, John called 911 multiple times per day, engaged in behaviors that were harmful to the rest of the program, and threatened evening staff. John refused support and did not return to the shelter after his last 911 call. John stayed in the respite program approximately 6 weeks, during which time he:

- Received a full medical exam and was linked to a PCP who had access to his medical history
- Received an accurate diagnosis and medication regime
- Was linked to services in the community, including charity care, a payee program, recovery resources and a benefit specialist
- Was given tools to use to help manage his anxiety

THEME 4: MAXIMIZING IMPACT THROUGH EFFECTIVE INTERVENTIONS

- Respite is a short term intervention- starting at intake, focus on community supports your client will need after discharge to help manage their behavioral health. This may include day centers, family or friends, recovery groups, or spiritual resources. Talk early on about where they would like to discharge to and focus your efforts on that location.
- Don't lose sight of the reason they are in respite. Behavioral health issues may be distracting, but if they are in the program for an acute healthcare need, make sure that they have the information and space to heal and make informed decisions about their health.
- Successful interventions are evidenced based and, most importantly, have client engagement and buy in. Maximize your time by listening to the client during the initial assessment and focusing on what the client has identified as being highest priority.

LESSONS LEARNED- MOVING FORWARD WITH BEHAVIORAL HEALTH IN RESPITE

- If respite is about wellness, providers must look at the whole person, not just the obvious malady. Behavioral health concerns are valid, but can be mitigated with the appropriate interventions.
- Learn the difference between “Unusual and Unsafe” and make sure all staff is on the safe page with program expectations and goals.
- Flexibility and expeditiousness is key- respite as an intervention is short, so every day matters. Using respite as an onramp to supportive housing keeps the focus on the future whilst building a medical framework to help maintain the positive momentum and healing.
- Not every client will end in a successful discharge, but every day in respite is a day with dignity.

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Questions?

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