



Bronx Medical Respite Needs Assessment

Summary of Findings

Background

The Bronx Health & Housing Consortium (“the Consortium”) has undertaken several studies of the “medically homeless” population in the Bronx, defined as those whose housing needs are directly related to their health conditions, to explore how a medical respite program may provide an innovative solution to improve people’s health, avoid unnecessary and expensive hospital stays, and help transition people who are homeless into stable housing. The Consortium intends to develop a service model initiative in the Bronx with the potential of replicating it across New York City. The first step in developing a program was to conduct needs assessments in hospitals to better understand the volume and scope of respite services needed in the Bronx. This study, conducted in June of 2017 and February of 2018, was done in partnership with the Office of the Bronx Borough President, the Bronx Partners for Healthy Communities PPS, and the Bronx Health Access PPS, in association with the Coalition for Housing and Health.

Context

The National Health Care for the Homeless Council defines medical respite 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 be in a hospital.” If this group had an appropriate home, they would be discharged there and necessary services, like wound care, physical therapy, etc. could be delivered in the home.

We have learned from experience with patients in the Bronx as well as from experts in the field that there is a Hospital-Homeless cycle of homeless patients. When people are ready for discharge, if they are not provided appropriate shelter they often end up on the street, where their medical condition does not improve. They then go to the Emergency Department and may be readmitted, which starts the cycle again. Only if we change where they are discharged to—what we sometimes call a respite facility, and ultimately a home—can we address their medical and social needs to break this vicious and expensive cycle.

Methodology

This needs assessment was conducted in Bronx hospitals on June 7, 2017 and February 28, 2018. The stakeholders wanted to get data from a warmer and colder month to ensure the samples represented different times of year. All six acute Bronx hospitals—Montefiore Medical Center, BronxCare Health System (formerly Bronx-Lebanon Hospital Center), St. Barnabas Health System, and New York City Health + Hospitals North Central Bronx, Lincoln and Jacobi—participated in June and all but Lincoln Hospital participated in February. This was a point-in-time study, covering a full day (8:30am to 5pm) at each point in order to avoid duplications.

A questionnaire was developed collaboratively by staff from hospitals, Performing Provider Systems (PPS) and homeless services providers, and then pre-tested with two hospitals. The questionnaire was used by the Social Work Department of each hospital to identify people who were ‘stuck’ (medically

cleared for discharge but lacking a safe discharge plan due to absence of appropriate housing) in their hospital and potentially eligible for respite services. Questions were about patients' health care utilization, diagnoses, housing situation, income, days beyond medically cleared discharge, and post-hospital supports needed. The questionnaire used in February 2018 included additional questions. The surveys were completed through interviews with the patients, staff knowledge, and patient medical records. All surveys were anonymous.

To gain additional understanding of the scope of need beyond the point-in-time study, we asked each hospital's Social Work Department to complete an additional survey, estimating in a typical month the number of people who are homeless (e.g. street) and the number who are unstably housed (e.g. couch surfing) and could be discharged to a respite program that offered basic acute and post-acute medical services on-site. Hospitals were urged to include only those patients who could function well in their Activities of Daily Living (ADL), as this is a standard requirement in respite programs around the country. Respite programs are typically staffed to support people who do not require 24/7 care, but support they would receive at home if they had an appropriate home where they could be safely discharged from the hospital.

Returned questionnaires were reviewed by two independent reviewers, both with experience in respite programs. They reviewed information about the health needs and potential housing placement after respite, using all available information from the questionnaires, and identified those who seem to be eligible for respite, those determined not to be eligible, and those who *may* be eligible. This 'maybe' group was difficult to place because there was not enough information in the questionnaire to make a determination of their eligibility. The reviewers discussed and agreed on these findings.

Results

A total of 36 questionnaires were returned in June 2017 from six hospitals and 14 people were deemed potentially eligible for a medical respite service and four people who were 'maybe'. Eighteen were deemed ineligible, usually because their medical needs were too great and/or they were undocumented and therefore ineligible for housing afterwards. We recognize that people who are undocumented would need to agree to go to the shelter system after respite and one of the follow-up steps to these studies is discussing how that transition process could work with the Department of Homeless Services.

In February 2018, 15 questionnaires were returned from six hospitals and seven people were deemed potentially eligible for a medical respite service. Four were deemed ineligible, usually because their medical needs were too great. There were an additional four who were 'maybe'. If we assume that half the 'maybe' population could meet the criteria with more information, 16 people in June and nine people in February were good candidates for respite programs on two given days. However, we report data and analysis only for the 'eligible' group below.

	June 2017	February 2018	Total/Average
Respite Eligible	14	7	21
Respite Maybe	4	4	8
Respite Eligible per hospital on one day	2.3	1.4	1.9
Range of 'Eligibles' per hospital	0-7	0-5	0-6
% Male	64%	42%	48%
Age 18-30	43%	0%	29%
Age 31-60	43%	86%	57%
Age 60+	14%	14%	14%

% with Medicaid/Medicare	93%	100%	95%
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Respite Needs Assessment Findings: General Description

Based on this sample, we understand that the respite program needs to address people in many age brackets and women as well as men, and that most people will have Medicaid, Medicare, or both. On the two days surveyed, hospitals had an average of 0-6 people who potentially could have been discharged to a respite program.

Because hospital staff were concerned that the two point-in-time days may not be typical, in February 2018 hospitals were asked specifically to estimate the number of people who are homeless (street, shelter) and the number who are unstably housed (couch surfing, living with friends or relatives) that they would propose for a respite program monthly. Eligible patients would have functioning ADLs, and needs that respite provides such as medication management, case management, IV and visiting nurse services. Four hospitals responded and estimated a total of 11 homeless people and 15 unstably housed patients would meet these criteria. If we extrapolate from these data, each acute hospital would require over 6 respite patient beds per month.

The New York Legal Assistance Group (NYLAG) conducted a citywide assessment of the need for respite services about two years ago. They found that hospitals identified 0-3 people at any time who would qualify for respite services. Overall, we are confident that 0-5 is a good planning number for respite program planning and development.

Medical and Behavioral Health Conditions

The medical conditions of respite eligible on both days included post-surgical care, hypertension, stroke, kidney disease (many requiring dialysis), obesity, withdrawal, heart failure, sickle cell disease, diabetes, asthma, COPD, cystic fibrosis, pancreatitis, Grave's disease, seizure disorder, GI bleed, anemia, and sleep apnea. Their behavioral health conditions include alcoholism, depression, anxiety, schizophrenia, schizoaffective disorder, and bipolar disease.

The services that the hospital staff indicated these people would need post-discharge included: IV antibiotics, making appointments, food preparation, medications management, transportation to appointments, and case management for income and housing. One patient who had a new ostomy had been couch surfing and had no current housing option. At that point, she required support and teaching before being housed or moving into the shelter system. There were a few cases of people who seemed to require IV or physical therapy before being shelter eligible. Specialized services such as IV antibiotics are needed by some patients and could be arranged using off-site providers, like the Visiting Nurse Service of New York, or by on-site clinicians.

Housing Situations

The housing situation of the eligible group prior to hospitalization included living on the street, in shelter, or staying with families or friends who would not take them back.

We also reviewed the potential candidates for respite care for the housing they may be eligible for post-respite, based on the information about their income, clinical diagnoses, and follow-up needs. Of course, this is very preliminary, as an interview and more detailed information are required to make an accurate assessment of housing options. From the available information, it seems that some people would move from respite to shelter, some to supportive or transitional housing or assisted living, and others to a form of general subsidized housing. Few, if any, would be prioritized for supportive housing because they do

not have current substance use disorders or serious and persistent mental illness, although they have other serious medical conditions, along with the required homeless chronicity.

The range of long-term support services seems to run from light to heavy touch support required over time. People who are undocumented are not currently eligible for government housing programs and would have to be discharged to the shelter system. People in this cohort who do not meet the homeless chronicity requirements of many housing programs would most likely stay in the respite program until they are stable, enter a shelter until they are homeless for 12 months, and then move into supportive housing.

Financial Implications

We asked hospital social work staff to report the number of days each patient will be in the hospital beyond the day that s/he would be medically discharged to home. In June and February, there were several people who had already stayed weeks beyond this point. The 21 people we found potentially respite-eligible had a combined number of days beyond medical clearance of 955 days. This means an average of 45 days/person. Using a daily Medicaid reimbursement of \$2000 (which is low), that translates to over \$1.9 million revenue lost to the hospitals. Another way to think about this is that if an average hospital stay is 5 days for a medical bed (which included all of the 21 eligible individuals) that means an average of 9 additional patients could have used the bed for needed services (45 days over divided by 5 days per stay).

Cost Implications from Combined Point in Time Respite Needs Assessment			
<i>Potentially Eligible for Respite</i>	<i>Number of nights in hospitals past medical clearance</i>	<i>Est. Medicaid cost/night</i>	<i>Unnecessary Medicaid Spending</i>
21 patients	950 days	\$2,000	\$ 1.9 Million

Timely and appropriate patient discharge frees hospital beds for people who require them. Respite services would not only increase revenue, but would improve staff morale and make current systems more efficient and effective. Importantly, it also decreases the risk of hospital-acquired infections. Many of these patients are probably immunocompromised as well and would improve more effectively in non-hospital settings once they are medically cleared.

The Other ‘Stuck’ Patients

There were some hospital inpatients identified by this study that were clearly not eligible for respite services, primarily because their health needs are too major and/or they are undocumented and would not be able to be housed afterwards. Although they are not the focus of this respite work, we should better understand them and address their needs as they are practically living in hospitals (some for years) and hospitals are not appropriate for housing people. Many of these patients require nursing home level care or other institutional care. The sample of 18 patients in June who we deemed ineligible for respite accounted for a total of 3,681 non-medically necessary days or an average of 204.5 days per patient. The inability of hospitals to safely discharge them to more appropriate settings is costly to hospital systems and to patients alike—those who are ‘stuck’ in hospital beds and do not require that level of care, and those with medical needs who have no access to those beds.