2014 Gage Awards

Reference #	7491940
Status	Complete
Name of hospital or health system	UW Medicine
Name of project	Edward Thomas House Expanded Medical Respite Program
CEO name	Johnese Spisso
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
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Within which of the two categories does your application best align?	Population Health

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	People living in shelters and on the streets are three to four times more likely to suffer premature death than people who are housed. They also have a higher incidence of hospitalization than the general public with longer inpatient stays. However, the lack of a stable home environment diminishes the effectiveness of their hospital care, and they endure more complications and an increased probability of rehospitalization after discharge. The Edward Thomas House Expanded Medical Respite program meets the needs of homeless people by providing a safe place for medical care and improving access to primary care, eligibility funding, mental health and chemical dependence counseling, and housing after a hospitalization. As a community partnership, it was developed by a broad coalition of homeless and housing advocates including UW Medicine and other local hospitals, Seattle/King County Public Health, and Healthcare for the Homeless Network. The Respite program serves homeless individuals with acute illness or injury who are too sick for a shelter setting, but not ill enough to remain in the hospital. While patients are in the program, we work to improve their housing status and link them to services to achieve long-term medical and social stabilization. We admitted our first client on September 11, 2011. The Edward Thomas House is managed by Harborview Medical Center, the safety net hospital for Seattle and King County. During our first year of operation, we served 456 homeless persons with complex needs, acute and chronic medical issues, and a high incidence (74%) of chemical dependency and/or mental health diagnoses. The most common admitting medical diagnoses were abscesses, post-op recovery, cellulitis/diabetes and fractures. Patient demographics were 78% male, 22% female, 64% Caucasian, 22% African American, 7% Hispanic, 4% American Indian, 1% Asian/Pacific Islander, 1% Multi-racial and 1% unknown. The program's goals include medical healing, mental health/chemical dependency treatment, and linkage to public benefit programs, primary care and housing. Patients average a 2-3 week length of stay and are frequently connected to case management services prior to discharge. The results indicate that for the average respite patient with a 19-day length of stay, considerable inpatient costs are avoided and access to mental health and substance abuse services leads to longer term stability.
1A. Attachment, if applicable (Applicable examples include a peer reviewed journal article, other content published in the literature, or a presentation at a national meeting)	2014GageAward_EdwardThomasHouseRespiteAdmissionCriteria.pdf (327k)

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	In 2007, Seattle/King County Public Health brought together hospital providers, housing, respite and social service representatives, and policy experts to develop a new approach for managing homeless hospital patients requiring medical follow-up. At the time, these patients were kept in acute care beds because the patients were too behaviorally complex to be accepted by Skilled Nursing Facilities, and the shelter system did not have the capacity to manage their medical issues. Compounding the problem, the existing shelter-based respite program could accommodate only about half of the referrals received and was unable to take higher acuity patients such as those requiring IV antibiotics or complex wound care. The Edward Thomas House Expanded Medical Respite Program provides care for up to 34 patients on a floor unit leased from Seattle Housing Authority. Patients with higher acuity, including stable patients needing extended IV therapy and those with complex wounds, are accepted and cared for by an experienced nursing team and medical director. The free-standing facility and augmented nursing and ARNP staff allow the new program to care for these high acuity patients. Patients are referred for primary care during their stay to establish a medical home for long-term health management. The program also has a robust mental health team (four mental health practitioners and a psychiatrist) to assess patient needs around mental health, case management, benefits and housing, and to initiate appropriate referrals. The enhanced mental health team allows the program to successfully care for very behaviorally complex patients that could not be managed in most other settings. Timeline: -- 1996: Seattle/King County respite service is established with 17 beds in shelters. -- 1997: Respite beds were increased to 22 due to high demand -- 2007: Seattle/King County Public Health organizes workgroup to consider options for meeting increased demand. -- 2008: Jefferson Terrace, a facility owned and operated by the Seattle Housing Authority, is selected as a free-standing site where one floor can be converted to respite care. -- 2009: American Recovery and Reinvestment Act capital grant secured for Jefferson Terrace remodel. Financial support is secured from community and federal partners. A year-long environmental assessment is conducted for residents of Jefferson Terrace -- 2010: ARRA funds are released, allowing Jefferson Terrace remodel design and construction to begin. -- 2011: Harborview Medical Center is selected to operate the program, which is located across the street from the hospital. First patient is admitted in September.

3. Describe the results of the project. What data was used to support improvement results?	The Edward Thomas House has adopted a "Harm Reduction" approach to care. We accept the patients "where they are at" with regard to their chemical dependency and mental health issues and help them reduce the harm from their lifestyle choices. While patients are not allowed to use drugs on the unit, they are not discharged for using drugs or alcohol off site. Rather, interventions are utilized to prevent their behavior from interfering with their medical care, their safety or the safety of others. Our low-barrier admission philosophy and highly skilled approach to care has allowed respite to care for homeless patients that would not be accepted into Skilled Nursing Facilities, assisted-living programs or other levels of community care. The Harm Reduction philosophy allows for engagement and motivational interviewing to facilitate healthy behavioral changes and limit the harmful consequences to patients and their community. The Edward Thomas House has seen a significant increase in referrals and admissions of both homeless men and women over the past 18 months: -- 83% of all patients were connected to primary care prior to discharge -- 25% were discharged to permanent and transitional housing -- 32% were discharged to shelters with services -- 15% were discharged to the hospital for additional planned care -- 14% left AMA -- 8% had other placements (family, friends) -- 6% returned to the streets The enhanced medical respite program has been able to serve more than 100 additional patients per year since it opened. The new facility and increase in staffing have made women feel safer and more comfortable utilizing respite services, resulting in an increase in more than 40 women patients per year in the program. A utilization review comparison was conducted of 62 patients referred and admitted by Harborview Medical Center to show utilization six months prior to respite compared to six months post-respite. Review findings are listed below: -- 56% reduction in inpatient hospital visits -- 70% reduction in total inpatient hospital days -- 10% reduction in Emergency Department visits -- 67% reduction in surgeries and procedures six months post respite. This data does not take into account the cost avoidance achieved by hospitals being able to significantly reduce patients' length of stay, especially for those receiving IV antibiotics. Between January 1, 2013 and September 30, 2013, our medical respite program provided 904 days of IV antibiotics that would otherwise have been provided in a hospital setting.

4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	The Edward Thomas House provides a national model for improving respite care. It demonstrates that a free-standing location based on a “Harm Reduction” approach to care can serve more patients, including those with very complex medical needs, than shelter-based programs. When the health service utilization improvements and improvements in the patients’ outcome data are combined, the benefits to both patients and the community are substantial and significant. There is high potential to create tighter partnerships between healthcare providers and insurers to facilitate the achievement of the Triple Aim of better health, lower costs, and a better healthcare experience for all patients. The Edward Thomas House model can be duplicated readily by other organizations. The program's Medical Director, in concert with the National Health Care for the Homeless Council, participates in providing on-site technical assistance to other areas working to develop respite programs. This assistance has been provided in many states including Kansas, California, Alaska, and Washington. Our respite program leadership team also provides consultation on an on-going basis for organizations developing respite programs. The Medical Director of Edward Thomas House is working with the National Healthcare for the Homeless Council—Respite Care Providers Network Standards Task Force to develop national standards for medical respite programs. We are hopeful that respite care will become a viable reimbursable service within CMS, which will help more homeless people get the transitional care they need while assuring the financial viability of respite centers.

5. Describe how patients, families, and if appropriate, community was included in the work.	The vision and planning for the Edward Thomas House was accomplished by a respite and housing community collaboration. Governance is provided by a Medical Respite Steering Group, which includes the participating hospitals, Seattle/King County Public Health, and King County Mental Health, Chemical Abuse and Dependency Service representation. The Steering Group provides guidance and feedback on performance of the program and assures that the program is meeting its goals in a safe, effective and efficient manner. It has recently expanded to include managed care organizations. Program outcomes are regularly presented at meetings of the Medical Respite Steering Group to help guide program development. As the program operator, Harborview Medical Center reports to the Steering Group on a monthly basis, providing data on admissions, patient demographics, patient outcomes and budget reports. Hospitals participating in the Steering Committee help to fund the project. Regular community meetings are held with the respite patients to discuss the challenges they face and receive input on the program from their perspective. Monthly meetings are also held with the residents of Jefferson Terrace to address any concerns they have with respite patients and problem-solve solutions and future plans. The model and outcomes of the Edward Thomas House have been presented at National Health Care for the Homeless Council annual conferences. The Washington State Hospital Association named the Edward Thomas House as the co-winner of its Community Health Leadership Award in October 2013.
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