



April 7, 2023; 8:30am-10:00am

Virtual Meeting

<https://us02web.zoom.us/j/82062544065?pwd=ZHJvd2JuZUJyQ0wvQTNHaHczaVpYZz09>

1.669.900.6833

Meeting ID: 820 6254 4065#

Passcode: 787646#

8:30 - 8:50	Welcome & Introductions, Review & Context Setting
8:50 - 9:20	Request for Support <ul style="list-style-type: none"><li>• Medical Respite – Cynthia Maree</li></ul>
9:20 - 9:30	Initial Operations Development (Continued) <ul style="list-style-type: none"><li>• Evaluation of the Request for Support Form</li></ul>
9:30 - 9:55	Development of Prioritization Guidelines (Continued)
9:55 - 10:00	Wrap-Up and Next Steps



## **Operations Council**

### **Guiding Principles**

#### **Shared Focus**

We come together to improve the health and well-being of individuals living in various and diverse communities throughout Central Oregon region. We develop agreed-upon actions to solve the issues and keep the needs of our communities as the main focus.

#### **Shared Metrics**

We measure progress, process, and outcomes through a shared lens. Success is defined by the issue, those most impacted, and those closest to the work.

#### **Partner with Priority Populations**

The individuals living in our diverse Central Oregon communities are the center of our work. We make every effort to include people from every part of the region in our discussions, processes, and decisions.

#### **Collaborate to Solve Complex Issues**

Inviting diverse perspectives from throughout the Central Oregon region deepens our shared understanding of complex issues and propels us toward better progress and outcomes. We practice frequent, structured, open communication to build trust, assure shared objectives, and create common motivation. We respect the privacy and sensitivity of information partners share.

#### **Coordinate Collective Efforts**

We are made up of diverse partner organizations and individuals with unique strengths, skills, and resources. We coordinate our efforts and use our unique strengths and skills to meet our shared goals.

#### **Learn and Adapt Together**

We embrace shared learning and a growth mindset. We create a space that allows for mistakes, failures, second chances, and a celebration of brave attempts. We adjust and apply our learnings to the complex and changing landscape of health and well-being in Central Oregon.



## **CHARTER: Central Oregon Health Council Operations Council**

The Central Oregon Health Council was created to improve the well-being of all residents across Central Oregon.

The Operations Council serves as a place to coordinate collective efforts among the Central Oregon Health Council's community partners, committees, workgroups, community members and the Board of Directors.

The Operations Council will:

- Assists to strategize and operationalize the Central Oregon Health Council strategic plan as directed by the Board of Directors
- Support and address regional issues escalated from the committees, workgroups, and community partners
- Addresses broad, regional initiatives and cross-sectional work to decide feasibility, develop a strategy and operationalize the strategy

Partners include:

- Organizational leaders who have delegated authority to make operational decisions
- Impacted community members and leaders who have influence to impact change

Partners Roles and Responsibilities:

- Communicate information within their organization, partner organizations and communities
- Provide individual, community and organizational support of agreed upon initiatives and workplans

### ***Definitions:***

#### **Partner, Community Partner, Partner Organization. Terms may be interchanged.**

Individuals and organizations who purposefully work together within the Central Oregon Health Council (COHC) structure to share information, resources, services and other types of support to understand and address the regional priorities identified by communities throughout the Central Oregon region.

**Community** can be defined by describing the social and political networks that link individuals, community organizations, and leaders. Some communities fall within geographically mapped physical locations. Some communities are made of social groups or groups that interact in an organized way either in person or using technology. A community can be made up of people with shared qualities such as age, economics, gender, and beliefs.

There are multiple communities that may be important for any one person and include families, workplace, social, religious and political. People have their own sense of community and may feel

belonging to multiple communities based on different parts of their identity. Their sense of membership to communities can change over time and impact their participation.

(Adapted from Principles of Community Engagement, second edition; CDC, 1997)

**Sector:** A sector is a grouping of organizations that share the same or related activity, program, or service.

**Multi-sector:** Two or more sectors coming together to leverage expertise, knowledge, skills, resources and reach through the combined input and strengths of participating partners working towards a shared goal (e.g. improving health outcomes) from problem identification, solution creation and decision making, implementation, assessment and adjustment cycle.

DRAFT



## COHC Operations Council Request for Support

<b>Your Name</b>	Cynthia Maree
<b>Contact Email</b>	clmaree@stcharleshealthcare.org
<b>Contact Phone</b>	310-913-3193
<b>Organization</b>	Medicine Section Chair Medical Director: Infectious Disease, Infection Prevention, Caregiver Health, and Antimicrobial Stewardship St. Charles Health Care
<b>Date of Request</b>	3.7.23

### Short, concise summary of issue.

Patients are discharging from the hospital but SDoH challenges make it hard to get the care they need. Medical respite is collective-community approach to providing housing and medical care to folks who would otherwise not be able to receive care because of insufficient or absence of stable housing.

### What efforts have been made to address this issue?

I have met with many of the stakeholders to determine the scope of need and resources available in the community.

### What are you requesting from the Operations Council?

Funds and space are available. The immediate question for community partners is: "If the organizing folks provided money and space, is there any organization here that would be interested in taking this on? Or do we need to find an outside entity to do it?"

### How does this relate to the priorities of the Operations Council?

- ☐ Address Poverty & Enhance Self-Sufficiency
- ☐ Behavioral Health: Increase Access & Coordination
- X ☐ Promote Enhanced Physical Health Across Communities
- X ☐ Stable Housing & Supports
- ☐ Substance & Alcohol Misuse: Prevention & Treatment
- ☐ Upstream Prevention: Promotion of Individual Well-Being
- X ☐ Creating Aligned Partnerships for Innovation between Payers, Delivery Systems, and Patients
- ☐ Demonstrating Effective Governance
- ☐ Engaging Regulators for Informed Decision-Making
- X ☐ Identifying and Addressing Inequities
- ☐ Incentivizing Better Outcomes

☐ **Investing In and Developing Data Infrastructure to Support Continuous Performance Improvement**

**Please describe how this issue relates to the priorities you selected above:**

Physical Health -improving health outcomes for those living with chronic conditions.  
Housing and Poverty – providing ppl in crisis with housing.  
Behavioral Health and Substance and Alcohol Misuse – will have services embedded in the program,  
  
It will also improve hospital bed availability, reduce wait times in the emergency department.  
This is a problem that can only be solved through multi-sector, community partnership.

**Sectors: Which sectors does this impact? Which sectors are already engaged in addressing this issue?**

*Note from requestor- the names mentioned below are organizations that have been part of community conversations about developing a Medical Respite program and site.*

X☐ **Health** (i.e., hospital, primary care, behavioral health, dental, surgeons, pharmacy, public health)

Mosaic, Summit Medical, SCHS, BestCare, Deschutes County Public Health, Partners in Care

☐ **Media** (i.e., TV, radio, newspaper)

☐ **Education** (i.e., K-12, early learning, post-secondary, community)

X☐ **Infrastructure** (i.e., public works, transportation, utilities, housing)

☐ **Justice** (i.e., law enforcement, jail, parole, lawyers)

X☐ **Government** (i.e., elected officials, tribal, county, city, and state offices)

City of Bend

☐ **Spirituality/Religious** (i.e., churches, missions)

☐ **Business & Manufacturing** (i.e., information technology (IT), web-based, brick and mortar, research & development, agriculture, retail)

X☐ **Community Support Services** (i.e., food bank, shelters)

NeighborImpact

☐ Finance (i.e., banks, funders)

☐ Civic Volunteer Groups (i.e., Rotary, Kiwanis, neighborhood associations, social justice groups)

**Which geographic areas are impacted?**

X☐ Crook County

X☐ Deschutes County

X☐ Jefferson County

X☐ Northern Klamath County

**Specific  
Communities  
Impacted:**

Site would live in Bend, but folks would be referred from across the central Oregon Region. There is a higher need rate for medical respite by people with behavioral health, substance misuse, medical needs and veterans, older adults, the aging houseless folks, folks aging into Medicare. 45-65yo is the biggest age bracket.

**What age group(s) are affected?**

0-5

☐

6-17

☐

18-34

☐

35-54

X☐

55-64

X☐

65+

X☐

**Level of urgency**

High Urgency

X☐

Urgent

☐

Neutral

☐

Low Urgency

☐

Not at All Urgent

☐

**Please explain the urgency of the request and rationale.**

There are 2302 funds available. However, programs have to spend funds by Jan 2024. Lack of bed capacity in ED (gurneys are bumper to bumper). Time urgent because of housing funding from governor. Lots of bonds and moneys that are available but are also time limited.

**What is the level of severity for this issue?**

Extreme

☐

Major

☐

Moderate

☐

Minor

☐

None

☐

**Please explain the severity of this issue.**

"This feels crushing." A quote from a person trying to provide services to people with needs for medical respite.

# Brief Summary of Medical Respite Proposal for Central Oregon

**What is Medical Respite:** Medical respite care is acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from an illness or injury on the streets or in a shelter, but who do not require hospital-level care. Unlike “respite” for caregivers, “medical respite” is short-term residential care that allows individuals experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services. Medical respite care is offered in a variety of settings including freestanding facilities, homeless shelters, motels, and transitional housing

**What is the current situation:** Unhoused community members are leaving against medical advice or being discharged without a safe place to recover from illness or injury. This leads to poor health outcomes, increased utilization of medical services and undue burden to our shelter systems attempting to provide support without funding or sufficient resources.

## What model of medical respite are we proposing:

Coordinated Clinical Care Model:

The Coordinated Clinical Care Model focuses on individualized case management and provides basic onsite medical services. Additional services are offered through community connections and partnerships.

Services provided include but not limited to:

- Transportation to and from appointments
- On-site wound care, physical therapy, and other services contracted via home health
- Daily safety checks
- Permanent housing solutions options
- Coordination with behavioral health and addiction services
- Three meals a day
- Safe storage of medications and valuables
- Social work services

## Who would be eligible for respite care:

Example Criteria for admission:

1. The individual is Literally Homeless (per HUD definition) and requires shelter services.
2. The individual has a medical need, which requires further medical services deliverable at our facility or offsite.

3. Referred individuals must be able to complete the following tasks with limited support (skills training, coaching, reminders) from staff:
  - a. Safely exit the facility in case of an emergency
  - b. Contact appropriate support in an emergency
  - c. Safely regulate emotions and behaviors
  - d. Engage in program services specific to coordinating medical services.
    - i. Sign up with PCP, attend appointments
    - ii. Receive in home or outpatient services

**Where would the respite be located:** Within one of our permanent shelter or transitional housing facilities to be determined.

**How will the respite be funded:** Expect funding to come from multiple sources including health systems, managed Medicaid CCOs, private funds, state/county/federal grants.

**Example budget for ShelterCare in Eugene for 18 beds:**

<b>ShelterCare</b>	
<b>SMR Budget Summary Report</b>	
<b>FY 7/1/22 - 6/30/23</b>	
<b>Account Name</b>	<b>FY23 Budget</b>
<b>Revenue</b>	
COVID Emergency Beds	\$ 52,568.00
Homeless Medical Respite-Trillium	\$315,000.00
Homeless Medical Respite-PacificSource	\$332,640.00
	<b>#####</b>
<b>Expense</b>	
Staffing & Benefits	\$322,455.80
Admin:Prof Svcs, Legal, Insurance, Alloc	\$146,690.05
Life Skills and Client Assistance	\$ 12,030.76
Maintenance	\$ 62,603.09
Food	\$ 35,000.00
Office & Operations	\$ 17,282.86
Utilities	\$ 29,161.87
Vehicle	\$ 450.00
	<b>#####</b>
<b>Net Result</b>	<b>\$ 74,533.57</b>

## Who is interested in being part of a planning group for this initiative?

FQHC/Mosaic: ElaineKnobbs-Seasholtz  
 Lighthouse Shelter: Randy Jacobs, John Ryan  
 St Charles: Gregg Cohan/Cynthia Maree  
 Deschutes County/City of Bend: Cheyenne Purrington  
 Pacificsource: Ed McEachern  
 COHC: Carmen Madrid  
 Behavioral Health County: Colleen Thomas  
 City of Bend: Amy Fralay  
 Bethlehem INN: Gwen Wysling  
 Neighbor Impact:Molly Heiss/Autumn Rackley  
 Partners in Care: Greg Hagfors  
 Summit Health: Molly Tilley

Potential adds not yet contacted:

BestCare  
 COIC  
 Fuse  
 Housing Works

Creating America's healthiest community, together.



## Central Oregon Medical Respite

Cynthia Maree, MD

Data and Financial Analysis by Bobby Bangs and Kristy Edwards

February 2023

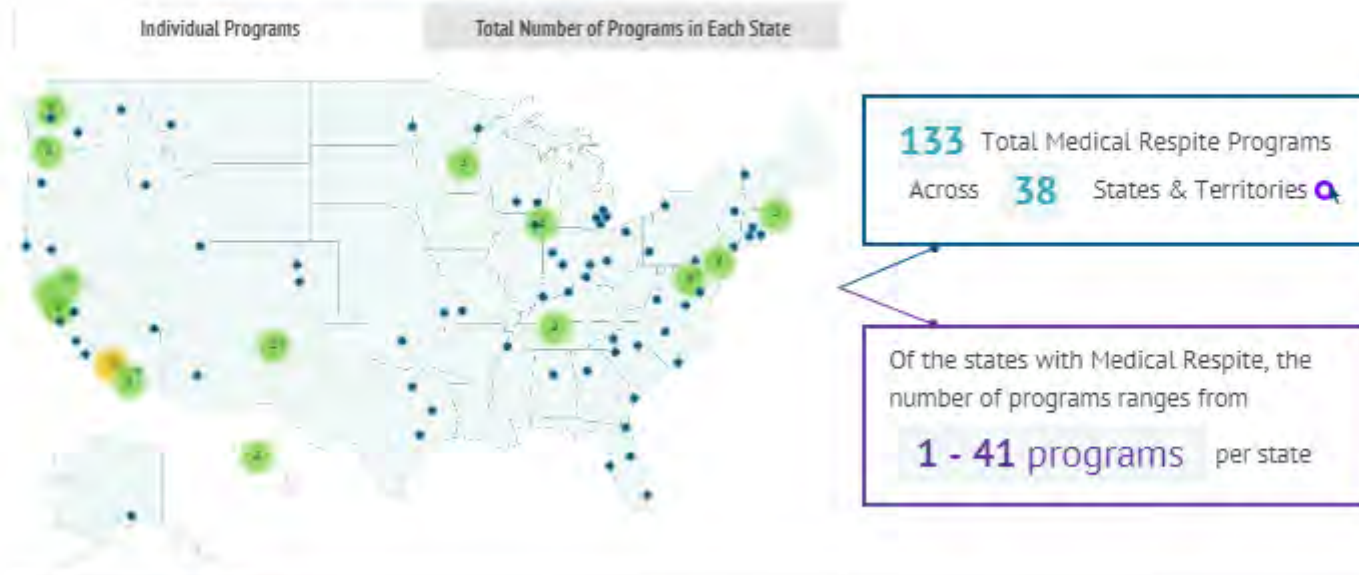
## What is a Medical Respite?

- Medical respite care is defined as acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital

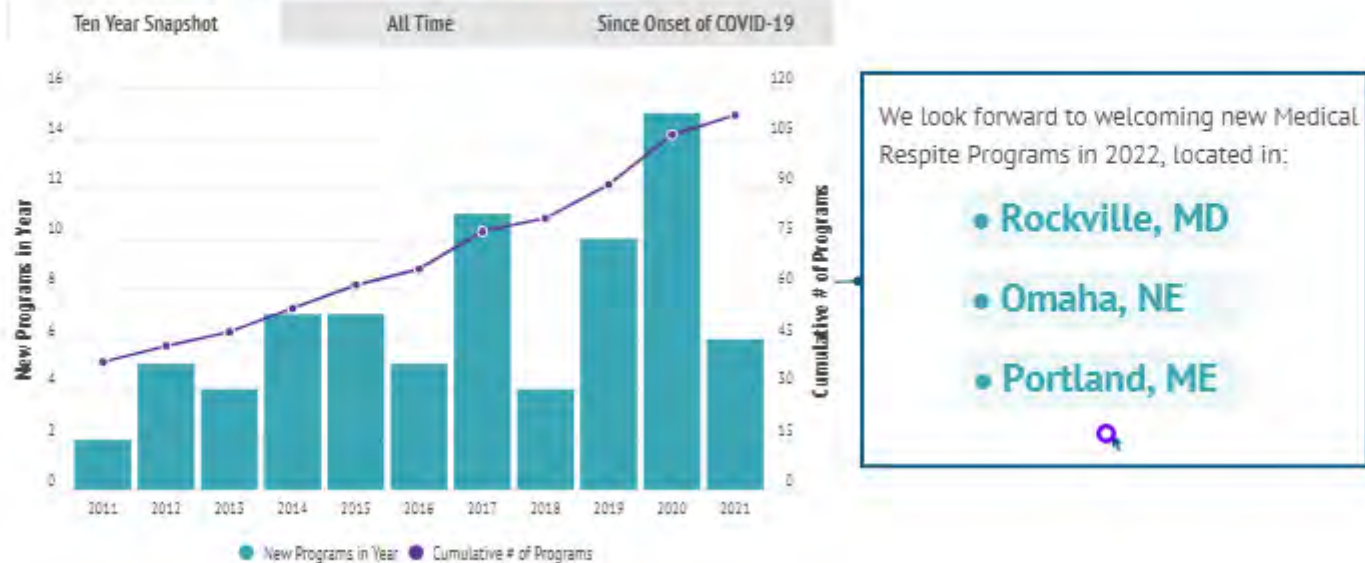
# What is a Medical Respite?

- Criteria for admission:
  1. The individual is Literally Homeless (per HUD definition) and requires shelter services.
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  3. Referred individuals must be able to complete the following tasks with limited support (skills training, coaching, reminders) from staff:
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    - c. Safely regulate emotions and behaviors
    - d. Engage in program services specific to coordinating medical services.\
      - i. Sign up with PCP, attend appointments
      - ii. Receive in home or outpatient services
    - a. Manage and self-administer own medication
    - b. Provide basic self care; use the bathroom facilities and bathe
    - c. Pick up meals and supplies daily, and as needed
    - d. Participate in discharge planning or obtain housing independently


## Location of Medical Respite Programs



## Growth of Medical Respite Care Over Time



## How Do Medical Respite Programs Operate?

 [Hover over for more information](#)



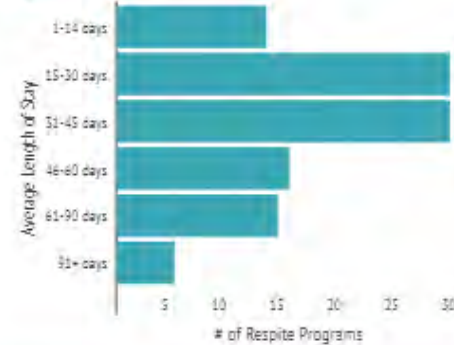
### Bed Capacity

Medical Respite Programs vary in bed capacity,  
ranging from **3 - 210 beds**

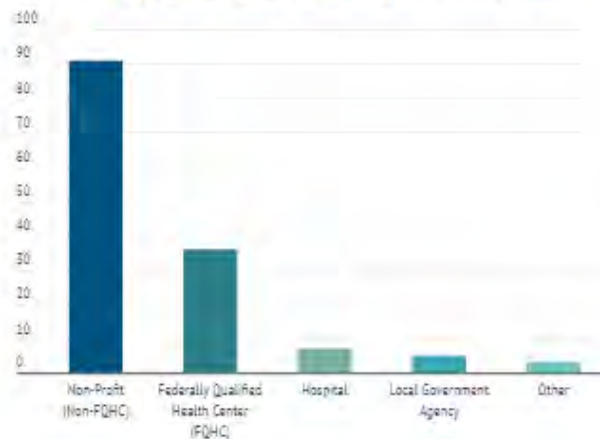
*Median Program Capacity:* **17 beds**



### Length of Stay

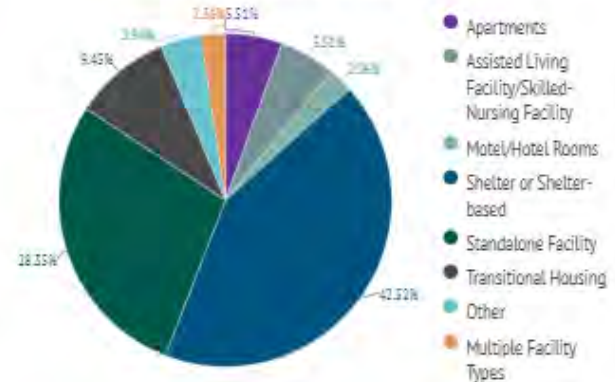


### Type of Agency Operating Respite Program



### Type of Medical Respite Facility

*Where are beds and services located?*



### Medical Respite Program Funding



### 80 programs (or 72%)

reported multiple sources of funding. Medical respite programs commonly manage numerous private and public grants, contracts, and other revenue streams to sustain their services.

### Who Provides Clinical Care at Medical Respite Programs?



**65 programs**

Onsite medical respite staff provide clinical care



**33 programs**

Consumers receive clinical care offsite at a nearby FQHC while in the program



**27 programs**

Hospital staff provide clinical care during the Medical Respite program stay



**35 programs**

FQHC staff provide clinical care onsite at the Medical Respite program



**31 programs**

Home Health Agency provides clinical care at the Medical Respite program



**14 programs**

Another contracted agency provides clinical care



**54 programs (or 47%)**

reported multiple sources for clinical care. Medical Respite programs provide care in a wide range of ways and often form partnerships with other organizations to meet the complex needs of their consumers.

#### Emerging Practices and Services in Medical Respite



I.V. Antibiotics 



**25 programs (or 20%)**  
support I.V. antibiotic treatment



Palliative and End of Life Care 



**19 programs (or 15%)**  
provide palliative and end of life care



Peer Support 



**53 programs (or 42%)**  
provide peer support



Accommodations for Families 



**14 programs (or 13%)**  
provide accommodations for families

## Key Components of all Medical Respite Programs

 Hover over for more information

Although each program and model of Medical Respite Care may differ, **all programs should include...**



24-hour access to a bed



3 meals per day



Transportation to any/all medical appointments



 Care Coordination



Safe space to store personal items

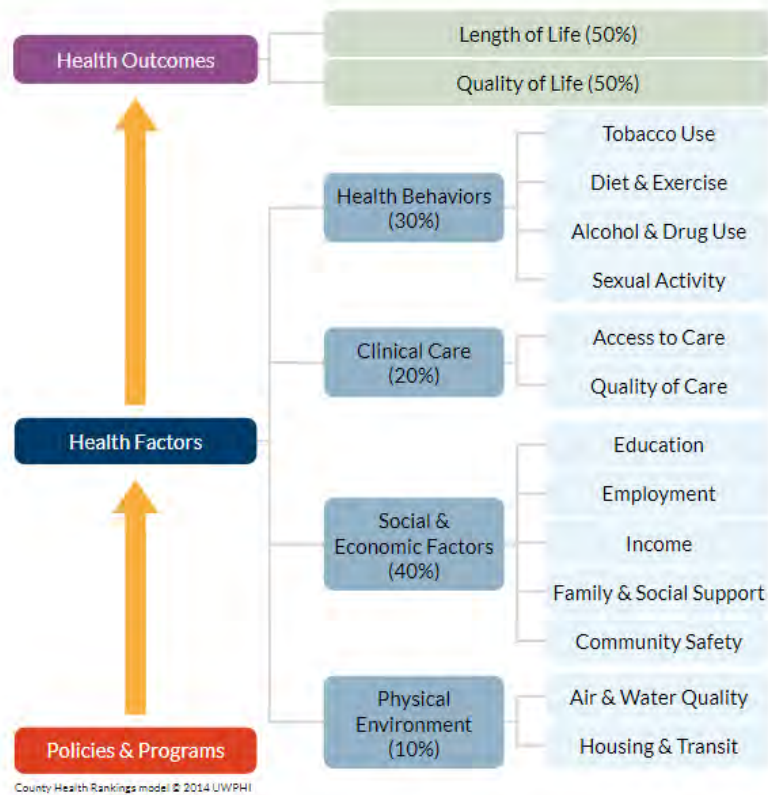


Access to a phone for telehealth and/or communications related to medical needs



Wellness check at least once every 24 hours by medical respite staff (clinical or non-clinical)

# Social Determinants of Health Outcomes



# Triple AIM Goals through Respite Care



# Literature Review on Outcomes

Comprehensive review of 45 studies published between 2010-2020 can be summarized below when addressing outcomes

## Outcomes of Medical Respite

(Table 3 p. 20)

- MRC admissions decreased time spent in the hospital, ED use, and re-admission rates, resulting in cost savings for hospitals.
- MRC can improve health-related quality of life and health management for consumers.
- MRC can reduce gaps in services and increase connection and use of benefits and outpatient primary and mental health care.

# Model Proposal with Budget Estimate

- Coordinated Clinical Care Model:

The Coordinated Clinical Care Model focuses on individualized case management and provides basic onsite medical services. Additional services are offered through community connections and partnerships.

## SMR Summary Budget

Revenue:	
Revenue at full capacity (avg. 15 clients/month)	612,000.00
Revenue at COVID-19 capacity (10 clients)	408,000.00
Total Program Revenue:	408,000.00

The average client stay is four weeks at a rate of \$3400 per week  
With social distancing, only 10 clients can be safely housed

Expenses at COVID-19 capacity:	
Staff Wages including benefits	346,910.00
Office Supplies & Equipment (copiers, computers, etc.)	8,020.00
Electronic Health Record (HIPAA-compliant)	6,500.00
Insurance	2,000.00
Facility Utilities (including phone lines in each room)	24,050.00
Facility Maintenance (including bio-hazard cleaning)	35,345.00
Client Supplies during residency (food, medical, household)	5,800.00
Client Transportation (taxi and bus pass for medical appointments)	4,000.00
Client Funds for transition to permanent housing	2,000.00
Client Food	27,000.00
ShelterCare Admin Expense	121,000.00
Total Expenses	582,625.00

Fixed - 8.3 FTE including cook, custodian and community healthworkers who staff the facility seven days/week during daytime hours to provide case management and on-site support  
Fixed  
Fixed  
Fixed  
Fixed  
Fixed - This is an older building, and clients in crisis can cause substantial damage, some infections will also require post-stay sanitization  
Adjusted for fewer clients - pays for supplementary food, medical items and household supplies  
Adjusted - Clients are provided taxi vouchers or bus passes to go to medical appointments and on housing searches if appropriate  
Adjusted - Used to help clients obtain identification and pay application fees  
Adjusted - SMR clients receive three prepared meals per day  
Fixed costs of program support such as medical billing, clinical oversight and supervision

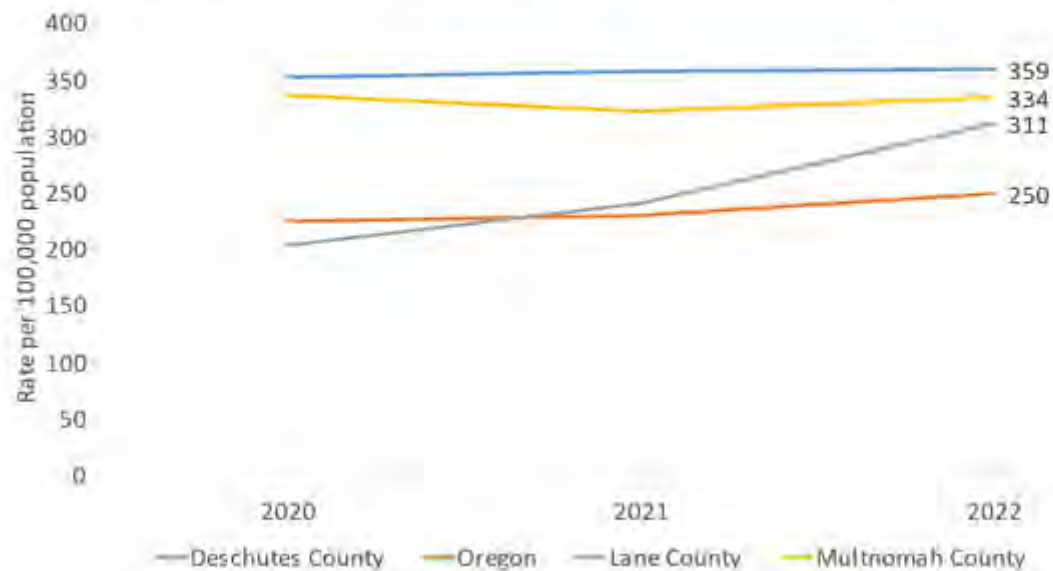
Program Results: (174,625.00)

# Latest post-COVID Budget

<b>ShelterCare</b>	
<b>SMR Budget Summary Report</b>	
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	<b>\$ 625,674.43</b>
<b>Net Result</b>	<b>\$ 74,533.57</b>

# The Need

Rate of Emergency Department visits that reported houselessness as part of the reason for the visit



Graph from Deschutes Public Health

# ED and Inpatient Encounters

## Findings

### *ED*

- Houseless tend to have more of a clustered visit pattern, resulting in a series of visits that are relatively less days apart when compared to the Housed.
- Houseless patients have significantly more ED visits than the Housed.
- Houseless patients have significantly longer lengths of stay in the ED than the Housed.
- The Houseless population has a significantly greater proportion of psych patients than the Housed.
- Houseless psych patients have significantly higher utilization measures than the Housed.
- The Houseless population have a significantly greater proportion of patients with substance abuse conditions.
- Houseless patients have higher risk of hospital visit or ed visit than the Housed.

### *Admits*

- Houseless tend to have more of a clustered admit pattern where they have a series of admits that relatively less days apart when compared to the Housed.
- Houseless patients have significantly more Admits than the Housed.
- Houseless patients have significantly longer lengths of stay than the Housed.
- Houseless psych patients have significantly higher utilization measures than the Housed.
- Houseless patients tend to have a lower severity and weight per admit than the Housed.

# ED and Inpatient Encounters

- Need over past 3 years:
  - Number of patients seen: 504 per year.
  - Number of encounters: 2,204 per year
  - Encounters by Medicaid Managed Care Patients: 60 % (1,307)
  - Cost per year: \$10,104,789 per year
- Summary of encounter data Housed vs Unhoused Patients
  - Average ED visits 7 vs 22
  - Days between ED visits 315 vs 14
  - Readmission rates 2 X Housed in 30 days for Unhoused
  - LOS 30% longer if Unhoused

## Cost of care for unhoused vs housed

Patient Populations: Not Houseless Population

Service Date - Fiscal Year: FY2022

	Not Houseless			Houseless			Houseless	
	Cases	Direct Cost	Cost Per Case	Cost Per Case	Difference		Cases	Potential Savings
<b>1 - Commercial</b>	240,498	\$123,741,466	\$515	\$ 4,724	\$ (4,210)		28	\$ (117,877)
<b>104 - Medicaid Managed Care</b>	112,412	\$78,907,836	\$702	\$ 4,496	\$ (3,795)		186	\$ (705,781)
<b>105 - Government Programs</b>	28,448	\$31,230,915	\$1,098	\$ 3,018	\$ (1,920)		14	\$ (26,883)
<b>106 - Medicare Advantage</b>	157,972	\$120,338,985	\$762	\$ 4,048	\$ (3,287)		34	\$ (111,744)
<b>107 - Work Comp-MVA</b>	8,422	\$9,387,271	\$1,115	\$ 11,205	\$ (10,090)		10	\$ (100,903)
<b>2 - Medicare</b>	29,886	\$27,431,388	\$918	\$ 7,129	\$ (6,212)		44	\$ (273,308)
<b>3 - Medicaid</b>	17,986	\$17,722,331	\$985	\$ 3,926	\$ (2,941)		55	\$ (161,759)
<b>4 - Self-Pay</b>	21,977	\$11,213,147	\$510	\$ 2,342	\$ (1,832)		67	\$ (122,732)
							438	\$ (1,620,987)

## Community Partners

NeighborImpact  
PacificSource  
Deschutes County Mental Health  
BestCare  
Central Oregon Health Counsel  
Partner in Care  
Mosaic Medical  
Central Oregon Fuse  
Coordinated Houseless Response office  
Shepard Ministries/Lighthouse Shelter  
Bethlehem Inn  
City of Bend  
Summit Health

Questions?

Link for Medical Respite

<https://nimrc.org/wp-content/uploads/2020/08/WorkBook.pdf>