Nominee:

Edward Thomas House Expanded Medical Respite Center

Washington State Hospital Association
Community Health Leadership Award
2013 Nomination

Organization Nominated: **Edward Thomas House Expanded Medical Respite**
Seattle, WA

Name: Brian Giddens, Director, Social Work & Care Coordination, University of Washington Medical Center; Julie Jones, MSW/LICSW, Manager, Social Services, Virginia Mason Medical Center; Rachel Dieleman, Supervisor, Case Management, Swedish Medical Center

Phone: Brian Giddens: 206 598-7910
Email: bgiddens@uw.edu

1. How did your organization, or the one you nominate, identify your community's health needs as the foundation for establishing this new "above and beyond" project and/or program within the last five years?

The Edward Thomas House Expanded Medical Respite program admitted its first client September 12, 2011, but the need for such a program was identified by hospitals several years prior to the opening of Thomas House. In 2007, Public Health – Seattle & King County convened a meeting of hospital providers, housing, respite and social service representatives, and policy experts to begin to problem-solve solutions for management of hospital patients requiring medical follow-up. Prior to that meeting, discussions had occurred between hospitals and Public Health in hopes of finding assistance to deal with a growing population of homeless patients, often with ETOH/Drug and/or behavioral issues that needed a medical care transition that was not available in the community at that time. Hospitals were keeping these patients in acute care beds because Skilled Nursing Facilities would not accept patients seen as "high-risk", and the shelter system did not have the capacity to manage the medical issues. At the same time, Public Health was concerned because the respite program at the time could accommodate only about half of the referrals received. To better quantify the need for post-hospital respite, in mid-2007 four King County hospitals (UW Medical Center, Harborview, Swedish Medical Center and Virginia Mason) tracked the number of homeless patients needing a discharge placement over a six week period, finding that 76% of these patients had significant barriers to discharge. Prior to this collaborative hospital study, the UWMC conducted a review of 31 patients over an 18 month period on their Medicine services who were homeless, substance-users, and/or with mental health issues, without discharge options for their medical care. This segment of the UWMC patient population alone totaled 578 overstay days.

Based on this data, planning proceeded to identify the funding and infrastructure for some form of expanded medical respite. In 2008, the Seattle Housing Authority expressed interest in re-purposing some of the Jefferson Terrace public housing units, and additional public funding for the project became available. Hospitals agreed to contribute significantly to the cost based on anticipated number of referrals, and the project moved towards reality.

2. What innovative actions did the organization take to address those identified needs-i.e: what is the resulting project?

Public Health of Seattle/King County began the process of developing the site at Jefferson Terrace to be able to provide medical respite care for up to 34 patients. Remodeling was completed and a RFP was released for an operator. Harborview Medical Center was chosen as the operator and staff began planning for a 2011 start date. It was clear in discussions with all the hospitals that it was important for respite to be able to provide a higher level of acute care than the previous shelter respite model. Hospitals identified homeless patients with infections and intravenous antibiotic therapy as patients that could particularly benefit from admission. This necessitated a higher level of nursing care to manage this population and expanded hours to cover intravenous dosing. Public Health and the participating hospitals also felt that the program needed to be able to manage patients with acute behavioral challenges related to chemical dependency and mental illness as this is common in the homeless population. This called for a robust, skilled mental health team to help behaviorally manage the patients and provide linkages for funding, housing and case management.

To be able to accept these more acute and behaviorally challenging patients, a Harm Reduction approach to care was adopted. This meant that staff accept the patients "where they are at" with regard to their illness and help them reduce the harm they would experience during treatment especially with regard to addictions. Patients were not discharged while using drugs or alcohol, rather an intervention was conducted when their behavior began to interfere with their medical care, their safety or the safety of others. However, patients are not allowed to use on the unit or have drugs in their possession. Care plans were developed and patients were monitored for medical and behavioral compliance with the program. This low admission barrier and highly skilled approach to care has allowed respite to care for patients that would not be accepted into Skilled Nursing Facilities, assisted-living programs or other levels of community care.

3. Who were the other community collaborators essential to creating this new project/program?

There were several community collaborators who served in creating the vision for the program as well as participating in the development of the finished product. Initially, hospitals participating included Harborview, UW Medical Center, Swedish Medical Center and Virginia Mason. By the time that the Edward Thomas House had opened, the list had grown to include St. Francis Hospital, Evergreen Medical Center, and Valley Medical, and soon after, Northwest Hospital joined the group. Besides the consistently strong presence of Public Health – Seattle & King County , the respite and housing community, Downtown Emergency Services Center, the Committee to End Homelessness, Seattle Housing Authority and King County Mental Health, Chemical Abuse and Dependency Services (MHCADS) also assisted in the identification of need process and the various stages of planning and development.

4. How were members of the Governing Board of a WSHA member organization involved in a meaningful way in establishing this project/program? (i.e. design, approval, implementation, etc....)

Besides bringing the initial concerns to the attention of public health and participating in the planning and development process, hospitals participate in a "Medical Respite Steering Group" which was founded upon the opening of Edward Thomas House in 2011. Harborview was chosen to run the operations of Edward Thomas House, and reports to the Steering Group on a monthly basis, providing data on admissions, demographics of patients being referred, patient outcomes information and budget reports. Hospitals participating in the Steering Committee are those that are helping to fund the project, and the committee's role is to provide guidance and feedback on performance of the program, and assure that the program is meeting its goals in a safe, effective and efficient manner. The group has

expanded to include managed care organizations, and continues to have King County Mental Health, Chemical Abuse and Dependency Service representation as well as the ongoing presence of Seattle-King County Department of Public Health..

5. What results are you seeing with this new project and/or program?

The Edward Thomas House has seen a significant increase in referrals and admission of both homeless men and women over the past 18 months. During the first year of operation, respite served 456 homeless persons living on the street or in shelters with complex needs, acute and chronic medical issues and 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.
During the first year of the Edward Thomas House 83% of all patients were connected to primary care prior to discharge, 25% were discharged to permanent and transitional housing, 32% to shelters with services, 15% to the hospital for more care, 14% unknown [left AMA], 8% other [family, friends] and 6% to the streets. The demographics of admission included 78% male, 22% female and 64% Caucasian, 22% African American, 7% Hispanic, 4% American Indian, 1% Asian/Pacific Islander, 1% Multi-racial and 1% unknown.

A utilization review was conducted of 62 patients referred and admitted in the first 6 months of operations by Harborview Medical Center to show utilization 6 months prior to respite compared to 6 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
- 6 month post Emergency Department data showed 50% reduction in inpatient admission
- 67% reduction in surgeries and procedures 6 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.

Medical Respite has specific goals for homeless patients that 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.

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 the health care providers and insurers to facilitate the achievement of the triple aim of better health, lower costs, and a better health care experience for all patients.

PP-28 Attachment A
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COMPLIANCE

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SOCIAL WORK AND CARE COORDINATION
1959 NE Pacific Street, Box 356125
Seattle, WA 98195-6125

Facsimile Cover Sheet

To:	Deborah Swets, VP Membership	From:	Brian Giddens
Organization:	WSHA	Phone:	206-598-4370
Phone:		Fax:	206-598-6333
Fax:	206-577-1900	Email:	bgiddens@uw.edu
Date:	8/27/2013	Pages:	4 (including this cover page)

Comments:

Please accept this nomination for the WSHA Community Health Leadership Award.

Thank you,

Brian Giddens, Director, Social Work & Care Coordination, UWMC