December 2019

Convalescent Care Program

Expansion Planning Report for the Community Health Partnership of Baltimore (CHPB)

HEALTH CARE for the HOMELESS

Contents

Executive Summary

Current Program

Impact

People come to us having experienced serious medical conditions while living on the streets. Many times, they also struggle with severe behavioral health problems. Our Convalescent Care Program (CCP) offers a safe place to heal with access to medical, behavioral and case management services. We also connect clients to primary care, community resources and, when possible, housing. To the best of our ability, we help clients transition to healthy and stable environments, rather than return to hospitals or the streets.

- 148 people recuperated at CCP (Jan.-Oct. 2019)
    - 80% were discharged to a community program, shelter or housing
- 94% agreed or strongly agreed that "my health is improving here"[1] (2018)
- 79% of clients with hypertension reached controlled blood pressure (Oct. 2018-Sept 2019)
- 72% of clients saw a medical provider within seven days of discharge (Oct. 2018-Sept 2019)

Limits

We turn away more people than we accept because we don't have enough beds, we do not have the resources to care for certain health needs, or we cannot accommodate hospital discharge timelines. We also do not have sufficient funding to pay for all the services that we provide. In the first 10 months of 2019:

- 75% of denials are because no beds were available or we couldn't connect with the hospital
- 80% of the time we meet our 24-hour referral response time
- Only 25% of all visits were reimbursable through Medicaid and Medicare

Community Experience

Approximately half of all Health Care for the Homeless clients—3,702—visited a hospital in 2018 within a six month period. And the overwhelming majority of CCP clients are referred by a local hospital.

- 76% of CCP referrals come from local hospitals (Jan.-Oct. 2019)
- Hospital charges decreased by $2,895,193 for CCP clients three months after they were admitted compared to the three months before (2018)
- 12% of all Health Care for the Homeless clients seen at any of our clinics were admitted or kept for observation at a hospital within a six month period, accounting for 1,724 visits (2018)

Future Opportunities

CCP is a one of a kind program in the Baltimore region that needs to grow to meet demand. With additional funding, we would expand the CCP program to better meet the needs of partner hospitals and individuals experiencing homelessness by:

- Increasing the number of people we serve with 30 additional beds at a new site;
- Improving how fast we can admit referred clients into the program after hospital discharge; and

[1] Of 36 clients surveyed

- Adding services that hospitals indicate are needed for their clients post-discharge, such as oxygen and the ability to accommodate isolation needs with private rooms.

To expand our program, we are exploring a range of financing strategies and models.

Methodology

This report is based on input from hospital partners, Health Care for the Homeless staff members and CCP clients. We have also analyzed data from the CRISP Reporting Services platform and the Health Care for the Homeless Electronic Medical Record.

Interviews

From August to December 2019, we interviewed community members who refer, work or stay at CCP. During these one-on-one conversations, we asked for on-the-ground experience to help improve care. We interviewed:

- 11 staff members in case management and social work at six local hospitals
  - Johns Hopkins Hospital
  - Johns Hopkins Bayview Medical Center
  - Mercy Medical Center
  - Sinai Hospital
  - Ascension Saint Agnes Hospital
  - University of Maryland Medical Center (UMMC)
- 13 CCP clients
- Five CCP staff members
- The Emergency Services Coordinator at the Mayor's Office of Homeless Services

We asked a series of interview questions that included the following:

- What services are most needed?
- How can we improve the referral process?
- What is the demand for convalescent care?
- Where should a new program be located?
- What amenities would you like to see at a new program?
- How do you think the program should be staffed?

Additional Client Feedback

We collected 36 surveys from CCP clients between October 2018 and April 2019. We also asked for feedback during two client meetings in October 2019.

CRISP Utilization

We reviewed the before and after hospital utilization charges of clients who entered CCP in 2018 using the CRISP Reporting Services platform. We compared costs at three, six and twelve months. There were 181 individuals served during this period.

- 173 clients were included in the three-month and six-month analysis
- 140 clients were included in the 12-month analysis

Health Care for the Homeless Client Data

We reviewed EHR data for all Health Care for the Homeless clients, as well as CCP clients:

- CCP referrals, discharges and denials (Jan.-Oct. 2019)
- CCP client screenings and health outcomes (Sep. 2018 –Oct. 2019)
- CCP total expenses and Medicaid/Medicare reimbursements (Jan.-Oct. 2019)
- Rate that Health Care for the Homeless clients visit hospitals (2018)

Introduction

When we leave the hospital we are told to "follow doctor's orders"—rest, stay off our feet, eat right, keep our wounds clean. Without a safe place to recover, people experiencing homelessness cannot possibly follow those orders. They are in the hospital more often, stay longer and are twice as likely to have had an emergency department visit in the past year as people who have housing.[2]

Health Resources and Services Administration (HRSA) defines recuperative care as "short term care and case management provided to individuals recovering from an acute illness or injury that generally does not necessitate hospitalization, but would be exacerbated by their living conditions (e.g., street, shelter or other unsuitable places)."[3] There are over 80 recuperative care programs in the U.S., which vary by services, facility, size and allowed length of stay.

The Triple Aim

The Institute for Healthcare Improvement recommends a three-pronged approach to optimizing health care: improving population health, improving experience of care and reducing costs. When serving people experiencing homelessness, hospitals and health systems face unique challenges in meeting the Triple Aim. According to the National Health Care for the Homeless Council, recuperative care programs address the "gaps in community services such as a shortage of affordable housing and a lack of safe hospital discharge options."[4]

Convalescent Care Program (CCP)

Health Care for the Homeless provides the only place in Baltimore where people without homes can recuperate after an acute hospital stay. We operate a 25-bed Convalescent Care Program (CCP) in the city's largest shelter, the Weinberg Housing and Resource Center (WHRC). Our staff provide medical,

[2] National Health Care for the Homeless Council and UnitedHealthcare. *Managed Care and Homeless Populations: Linking the HCH Community and MCO Partners*. https://nhchc.org/wp-content/uploads/2019/08/mco-hch-policy-brief.pdf (accessed Nov. 27, 2019).

[3] The terms "medical respite care" and "recuperative care" are used interchangeably. The National Health Care for the Homeless Council's Respite Care Providers' Network prefers "medical respite care," which they defines 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." National Health Care for the Homeless Council. *Standards for Medical Respite Programs*. https://www.nhchc.org/standards-for-medical-respite-programs/ (accessed Nov. 27, 2019).

[4] National Health Care for the Homeless Council. *Medical Respite Care Programs & the IHI Triple Aim Framework,* https://nhchc.org/wp-content/uploads/2019/08/policy-brief-medical-respite-triple-aim-1.pdf (accessed Nov. 18, 2019).

behavioral health and case management services to hundreds of clients each year. Yet, many still can't access our services. In the first ten months of 2019, we were forced to turn away 75% of potentially eligible clients because we did not have beds or the capacity to connect to the referral source in time.

CHPB Planning Grant

In June 2019, CHPB awarded us a grant to plan for expansion, based around the following questions:

- How many beds are needed to meet both the demand of the four CHPB partner hospitals and of all Baltimore area hospitals?
- Where should these beds be located in the Baltimore metro area?
- What type of facility infrastructure (shelter, nursing home, private rooms, etc.) would provide the appropriate space for expansion?
- What mix of acute versus step-down beds are required?
- Will a dedicated Referral Screener allow us to decrease wait times, fill beds during staffing shortages and provide better customer service?
- What are sustainable funding sources beyond CHPB?
- What other funding sources, such as hospital reimbursement or Medicaid MCO payments, could be used in addition to CHPB funding in order to meet the demand for respite services?
- What is the roadmap to advocate for a state Medicaid waiver to fund these services?
- What are the costs, opportunities and challenges of continuing to partner with another organization to provide shelter/housing and 24/7 operations?
- What are the costs, opportunities and challenges if we provide services and operations?

As a result of this funding, we are providing:

- This Expansion Planning Report (December 2019)
- A proposed timeline for implementation of report findings (December 2019)
- Results of referral screener pilot (June 2020)

Should we secure additional funding for expansion, we will also provide an update on the first phase of expansion in 2020.

"A second CCP location would open up so many opportunities to care for more people."

Ann, CCP Nurse

Current Program

Overview

CCP is a recuperative care program that provides people experiencing homelessness with a safe place to heal from an acute illness. Clients often experience cognitive impairment, chronic behavioral health illnesses and substance use. In 2018, 88% of CCP clients had a behavioral health diagnosis. Our program provides behavioral, medical and supportive services through a harm reduction approach:

- Nurses provide health education, care coordination, wound care and other outpatient services seven days a week, ten hours per day.
- A physician or nurse practitioner provides primary care on-site 16 hours per week.
- Licensed clinical social workers assist with referrals to housing resources, applications for identification and benefits and behavioral health and substance use treatment.
- A community health worker coordinates transportation and provides support for clients as they access health and housing services in the community.
- A psychiatric occupational therapist address mobility and cognitive impairments that interfere with clients' ability to manage their health care.

Our current CCP program is located above a shelter and just a few blocks from our downtown health clinic. It includes 7 beds for women and 18 beds for men. Staff create treatment plans within one week of each client's entry based on standards set by the National Health Care for the Homeless Respite Care Providers' Network,[5] which include accommodations and environmental services, care coordination and care transitions, clinical care and quality improvement.

Eligibility

Clients come to us without homes, health care and other vital supports. In order to be eligible for our services, they must be:

- Experiencing homelessness
- At least 18 years old
- Recovering from a post-acute medical issue
- Able to independently manage activities of daily living (ADLs) and self-administer medication
- Able to stay in a group living environment

We do not have the capacity to accept clients who:

- Require oxygen, unless the referral facility is able to provide an oxygen concentrator
- Require IV medications

For the safety of other clients, we do not accept clients who have been banned from CCP or WHRC.

[5] National Health Care for the Homeless Council. *Standards for Medical Respite Programs*. https://www.nhchc.org/standards-for-medical-respite-programs/ (accessed Nov. 27, 2019).

Staffing

CCP is staffed by the equivalent of nine full-time employees (FTE), including:

- 3 FTE weekday registered nurses
- 1 FTE weekday certified nursing assistant
- 2 FTE therapist case managers
- 1 FTE community health worker
- .5 FTE weekend registered nurse
- .5 FTE weekend certified nursing assistant
- .4 FTE medical provider
- .2 FTE clinical director
- .5 FTE client access associate

Impact

In the first 10 months of 2019, CCP helped 148 clients recover and return to their communities, healthy and stable. From October 2018 to September 2019, seventy-nine percent (79%) of clients who were diagnosed with hypertension reached controlled blood pressure during their stay at CCP. Forty-six percent (46%) of clients had a colorectal cancer screening and 75% had an HIV screening. Both of these rates are higher than the national and statewide rates for clients at federally qualified health centers (FQHCs) and the general population.[6]

Of the 36 clients who completed a client satisfaction survey in the past year, 94% agreed or strongly agreed that "my health is improving here," and 100% agreed or strongly agreed that "my care team is working together to come up with a plan to meet my needs." Clients also told us they like being close to resources like the shelter and other homeless services. They find the size of the program easily navigable and appreciate one-on-one support from providers.

We try to transition clients to stable environments—not to the streets or hospitals. We aim to provide clients with the support they need to live happy and healthy lives once they leave CCP.

Clients are discharged when they:

- Are medically stable
- Are connected to primary care
- Have transportation to scheduled appointments
- Understand their care plan as best they can
- Have been referred to housing
- Are connected to mental health care, case management, substance use treatment, a community health worker and nursing care coordination (when appropriate)

Discharges: Jan-Oct. 2019	Clients	Percent
Shelter	**78**	**53%**
Friend/Family	**19**	**13%**
Street	12	8%
Permanently Housed	11	7%
Unknown	11	7%
Transitional housing	4	3%
Hospital	5	3%
Substance use program	3	2%
Nursing home/rehab	3	2%
Other	2	1%
Total	**148**	

[6] HRSA, *2018 National Health Center Data*, https://bphc.hrsa.gov/uds/datacenter.aspx (accessed Nov. 18, 2019);
HRSA, *2018* Maryland *National Health Center Data*, https://bphc.hrsa.gov/uds/datacenter.aspx?year=2018&state=MD (accessed Nov. 18, 2019);
Kaiser Family Foundation, *HIV Testing in the United States*, https://www.kff.org/hivaids/fact-sheet/hiv-testing-in-the-united-states/ (accessed Nov. 18, 2019).

We help clients apply for housing through the Baltimore City Coordinated Access Program, assisted living facilities and transitional housing programs. Many clients are discharged to the shelter while they await housing (53%). We keep clients connected to care throughout the often lengthy process. Between September 2018 and October 2019, a medical provider saw 72% of CCP clients within seven days of discharge, a key measure of a successful care transition.

Finances

Thanks to a partnership with CHPB, we doubled our capacity to 25 beds in 2016. From January to October 2019, total expenses for clinical services for 25 beds was $883,000. Personnel costs accounted for $835,000 and supplies and other overhead amounted to $48,000. We are funded by public and private grants; 25% of our services are reimbursable through Medicaid and Medicare. Baltimore City funds operating costs (facility costs, food, linens, etc.) as the facility owner and operator.

Medicaid and Medicare

Out of the 143 clients we saw in the first ten months of 2019, 104 were insured through Medicaid, 20 through Medicare and 19 didn't have insurance. Only 25% of our CCP visits during this time were billable through Medicaid or Medicare.

Managed Care Organizations	# of Referrals
Priority Partners	26
Maryland Physicians Care	20
JAI Medical	12
No MCO selected	12
United Health Care	10
Amerigroup	9
University of Maryland Health Partners	6
MedStar Family Choice	5
Aetna Better Health of Maryland	3
Kaiser Permanente	1

BILLABLE VISITS

Clients: 164
Billable Visits: 935
Non-billable Visits: 3,746

Allowed Payments:
$204,838

Jan.-Oct. 2019

Limits

We simply can't care for everyone who needs our services. From January to October 2019, 75% of our denials were because we either didn't have beds or we were not able to connect with the hospital in time to complete the referral.

Our standard response time is within 24 hours. Eighty percent (80%) of the time we are meeting that goal. Still, hospitals have told us that this isn't fast enough for clients getting discharged from the emergency department. Some hospital dischargers also need to make referrals late in the evening, which we can't currently accommodate.

Referral Denials*	Total	Percent
No beds available	**240**	**51%**
Bed no longer needed or no follow-up from hospital	**112**	**24%**
No acute need	40	8%
Unable to perform ADLs	46	10%
Risk of violence or disruptive	14	3%
Banned from CCP or WHRC	7	1.5%
Suicidal in last 30 days	4	1%
Requires isolation	4	1%
Requires oxygen	3	.5%
Other	3	.5%
Total	**473**	

Clients also told us they are dissatisfied with some aspects of their environment of care. For instance, only 42% agreed or strongly agreed that "the food here meets my dietary needs." They also noted that the beds and bedding are not good quality and there isn't much privacy.

Being located within a shelter is helpful when discharging clients who don't have a place to stay; however, it means most facility amenities—food service, bedding, cleaning and security—are outside of our control.

**Referral sources familiar with our admission criteria don't typically make referrals for clients we cannot accommodate so these data are not reflective of some community needs we've identified through conversations with hospital providers, discussed in the next section.*

"We love CCP. We love what you do. We wish you could do more of it."

Hospital Case Manager

Community Experience

Referrals

Hospitals, homeless agencies, nursing homes and other health care agencies across Baltimore City and County refer clients to CCP. During the first ten months of 2019, 671 clients were referred to CCP. Due to bed space and staffing difficulties, we accepted 198 of those referrals.

Referral Entity	# Referrals[7]	# Accepted	% Accepted	% of Referrals
Johns Hopkins Hospital*	167	57	34%	25%
UMMC	81	19	23%	12%
Johns Hopkins Bayview Medical Center*	70	23	33%	10%
Mercy Medical Center*	58	21	36%	9%
Health Care for the Homeless[8]	52	36	69%	8%
Other hospitals	33	2	6%	5%
Other nursing homes	27	2	7%	4%
Other health care clinics	26	5	19%	4%
MedStar Union Memorial Hospital	25	6	24%	4%
Sinai Hospital*	23	8	35%	3%
UMMC Midtown Campus	18	3	17%	3%
MedStar Franklin Square Medical Center*	11	4	36%	2%
Northwest Hospital	9	0	0%	1%
Greater Baltimore Medical Center	7	1	14%	1%
Baltimore VA Medical Center	8	0	0%	1%
Grace Medical Center (formerly Bon Secours Hospital)	7	2	29%	1%
FutureCare	5	1	20%	1%
Genesis HealthCare	6	1	17%	1%
Homeless agencies	6	2	33%	1%
UM St. Joseph Medical Center	5	1	20%	1%
MedStar Harbor Hospital*	6	0	0%	1%
Ascension St. Agnes Hospital	8	4	50%	1%
Maryland Division of Correction	2	0	0%	.5%
Fayette Health and Rehabilitation Center	2	0	0%	.5%
ManorCare	5	0	0%	1%
MedStar Good Samaritan Hospital	2	0	0%	.5%
AbsoluteCARE	1	0	0%	.5%

[7] Either directly referred from the source or had been discharged within 30 days of being referred to CPP.
[8] Many Health Care for the Homeless referrals were for short-term stays for colonoscopies (two-night stay) or recovery from a procedure.
*CHPB hospitals

Brinton Woods	1	0	0%	.5%
Total	**671**	**198**	**Acceptance Rate: 19%**	

Health Care for the Homeless Client Hospital Visits

There is no comprehensive way to track how many people experiencing homelessness visit hospitals. However, a good proxy is the number of Health Care for the Homeless clients who visit the hospital. In 2018, we saw 8,438 unique clients across all of our clinics. We looked at how many of those clients went to a hospital at least once within a six-month period.

Potential Referrals

In 2018, 1,049 clients who were included in our sample were admitted or kept for observation by Baltimore City and County hospitals and could be potential referrals for CCP. In addition, over 1,000 clients visited an emergency department (ED) three times or more within six months. Most likely, many of these "high utilizers" would make strong candidates for CCP.

Visits	ED	Inpatient	OBS>23
1	1,103	488	212
2	536	174	26
3	302	64	8
4	177	36	1
5	106	19	1
6-10	226	20	0
11-15	75	0	0
16 and up	128	0	0
Clients	**2,653**	**801**	**248**

Visits by Hospital

Hospitals	ED	Inpatient	OBS>23
Grace Medical Center (formally Bon Secours Hospital)	674	98	7
Greater Baltimore Medical Center	63	9	0
Johns Hopkins	1824	296	30
Johns Hopkins Bayview Acute Care	728	87	14
MedStar Franklin Square	546	121	31
MedStar Good Samaritan	152	45	13
MedStar Harbor Hospital	296	61	6
MedStar Union Memorial	518	71	26
Mercy Medical Center	2729	183	61
Northwest Hospital	159	35	4
Ascension Saint Agnes Hospital	351	47	7
Sinai Hospital	422	69	12
UM Medical Center Midtown Campus	957	51	34
UM Rehab & Orthopedic Institute	0	11	0
UM Saint Joseph Medical Center	90	20	3
University of Maryland	1918	152	44
University of Maryland Shock Trauma	24	17	0
Non-Baltimore City/County Hospitals	291	54	5
Total visits	**11,742**	**1,427**	**297**

Linkage to Care

When we asked community members about clinic location, we received conflicting feedback. Clients said being close to homeless resources is vital to gaining stability. They are also familiar with homeless service organizations and feel more comfortable staying in an area they know.

However, twenty-eight percent (28%) of people who were accepted into the program didn't make it to CCP. Hospital partners and CCP staff told us that the shelter environment can be off-putting and some people may decide to leave shortly after arriving or find another place to stay. Anecdotally, we have been told that some people may have a hard time getting from the referring program to CCP. Other times, individuals may make it to WHRC but have trouble finding CCP on the third floor.

Clients, staff and hospitals told us that they would like to see a program in East or West Baltimore, since we already have a program downtown.

Source	Accepted	Presented	Show rate
UMMC Midtown Campus	3	0	0%
Other health care clinics	5	2	40%
Grace Medical Center (formally Bon Secours Hospital)	2	1	50%
Johns Hopkins Bayview Medical Center	22	12	55%
UMMC	19	14	69%
Johns Hopkins Hospital	57	42	74%
Ascension St. Agnes Hospital	4	3	75%
Sinai Hospital	8	6	75%
Other nursing homes	4	3	75%
MedStar Franklin Square Medical Center	4	3	75%
Health Care for the Homeless	36	28	78%
Mercy Medical Center	21	17	81%
MedStar Union Memorial Hospital	6	5	83%
Other hospitals	2	2	100%
Homeless services agencies	2	2	100%
Greater Baltimore Medical Center	1	1	100%
Genesis Healthcare	1	1	100%
FutureCare	1	1	100%
Total	**198**	**143**	**69%**

Hospital Feedback

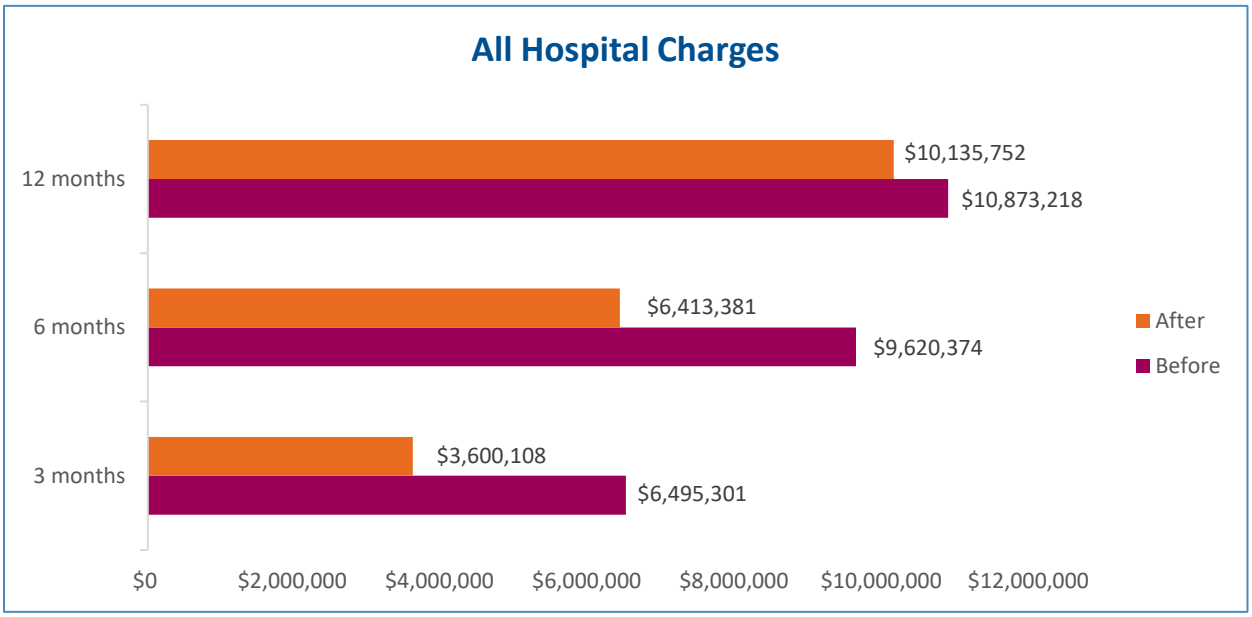
Hospital partners identify **oxygen** and **chronic conditions** as the two biggest unmet needs within CCP that prevent them from referring clients. The need for palliative care and the treatment of influenza also came up but with less frequency. Due to an increase in Medicaid reimbursements for six-week antibiotic treatment, IVs are available at many other programs and thus in low demand at CCP. Our research has helped determine what is needed to provide each service at CCP.

	Description	Space	Staff Demands	Stay	Challenges	Need
Oxygen	Clients who require two liters or less of oxygen per day	Storage for tanks; Fire Marshall approval	CNA order and track equipment and supplies	4 wks	Not many appropriate discharge options; supplying oxygen and concentrators; smoking risk	**High**
Chronic Disease	Stabilizing and coordinating care for uncontrolled chronic conditions	None	Social work assistance with care coordination programs	4 wks	Not many appropriate discharge options; goal-setting	**High**
Palliative Care	End stage diseases; clients not yet hospice eligible	Private room	Social work coordination with hospice programs; social work to refer to Assisted Living Facilities	3-9 mths	Not many appropriate discharge options	**Med.**
Influenza	Short-term admission to recover from influenza	Private room	Additional cleaning precautions; droplet precautions; Possible IV fluids	2 wks	Risk of spreading infection; food must be brought to clients	**Med.**
IV	IVs for medication	Storage for supplies	Nurse coordination of medical supplies; medically assisted treatment for substance use disorders	4-6 wks	Risk of overdose for IV drug users with central lines	**Low**

Financial Impact

While recuperative care programs decrease hospitalizations, inpatient stays and 90-day readmission rates,[9] we do not have enough data to fully substantiate the positive effects in the scope of our study. That said, an analysis of hospital charges suggests that CCP improves health and saves money.

We looked at the before and after hospital utilization[10] charges of clients who entered CCP in 2018 using the CRISP Reporting Services platform. Of the 181 individuals served during this period, 173 clients were included in the three-month and six-month analysis; 140 clients were included in the 12-month analysis.[11] Out of 21 hospitals with data, 14 saw reduced charges. **Overall, hospital charges decreased by $2,895,193 in the three-month comparison.**



Some clients visited the hospital more frequently after CCP; and still, their hospital charges decreased. This is likely because clients received more appropriate and less costly care during and after CCP. For instance, CCP clients had 99 more visits at **Johns Hopkins Hospital**, but charges decreased by $1,326,190 in six months after CCP than the six months before. Clients had 19 more visits at **UMMC,** but charges decreased by $366,127. **Sinai Hospital** had 14 more visits, but charges decreased by $285,305.

For a more complete picture of the financial impact of recuperative care, an analysis of the following data would be necessary: (1) the types of care accessed following recuperative care; (2) the costs and reimbursements for that care; and (3) opportunities created by reduced readmission rates and rapid discharges.

[9]Biederman DJ, Gamble J, Wilson S, Douglas C, Feigal J. *Health care utilization following a homeless medical respite pilot program*. Public Health Nurs. 2019;00:1–7. https://doi.org/10.1111/phn.12589 (accessed Nov. 18, 2019).
[10] See Appendix A for hospitals visited in this timeframe.
[11] Some clients may have been discharged or did not have data available.

2020 Opportunities

Our community faces tremendous opportunities in 2020 to better address unmet recuperative care needs, further reduce hospital readmissions and improve the health of vulnerable populations. In order to accomplish these goals, we need to develop a sustainable, regional system to increase the number of clients who access recuperative care and improve client experience and health benefits in the most cost-effective manner.

Increase the number of beds

The most important step we can take is to increase the number of beds at CCP.

Based on current data, each of our 25 beds serves seven people per year. A total bed count of 55 could result in 385 unique clients served per year—a 100% increase from our current program.

Shorten the referral wait time

Twenty-four percent (24%) of CCP denials are due to problems with linkage of care. By adding a full-time referral screener, we can increase timely communications with referral partners and admit clients more quickly.

Together, addressing the shortage of beds and the referrals could resolve 75% of CCP denials.

Ease eligibility requirements

Based on the needs identified by our hospital partners, CCP should expand to accommodate clients who need oxygen and offer private spaces for clients with communicable diseases.

Add a standalone facility

There is no room for programmatic growth at our current CCP site. Therefore, we propose to create an additional site with expanded services and 30 new beds, in addition to maintaining our current site at WHRC.

Our ability to offer healthier food and better quality beds and bedding is dependent on the owner and operator of the facility. The models that follow offer a range of possibilities. The solution that provides the greatest control and potential benefits is a standalone facility.

Facility Expansion Options

	Co-Located *Owner provides ancillary services*	**Co-Located** *We provide ancillary services*	**Standalone**
Personnel	Clinical Administration	Clinical Administration Ancillary support	Clinical Administration Ancillary support Facilities
Operations	Information technology	Laundry/linens Dietary Housekeeping Information technology	Laundry/linens Dietary Security Facilities Housekeeping Information technology
Supplies	Medical equipment	Medical equipment Furniture/fixtures	Medical equipment Furniture/fixtures
Capital	Renovations	Renovations	New building

Potential Cost-Benefit

Access to recuperative care creates opportunity in Maryland. Clients can work with their providers to pursue long-term health goals rather than mitigating crisis after crisis. And when difficult discharges are easily managed, hospital beds are freed up for other needs.

The data suggest that CCP costs less than maintaining the status quo. And with Maryland's commitment to reducing avoidable hospitalizations and readmissions through the Readmission Reduction Incentive Program, recuperative care represents a promising strategy to earn incentives and avoid penalties.

Our current program accepts roughly 30% of referrals each year. Expansion would allow us to accept almost 60% of those referrals. Given hospitals charged $3,172 less per client in the three months after CCP admission compared to three months prior, there is significant potential for our broader health system to enjoy financial benefits while better caring for clients.

Proposed Standalone Facility

Services

- Post-acute medical issues
- Chronic conditions[12]
- Oxygen
- Isolation needs (flu, certain behavioral illnesses or wounds, etc.)

Total beds: 30*

- Two dorms: 8 men each
- One dorm: 8 women
- 6 private rooms with bathrooms
- 6 beds with oxygen concentrators (3 men, 2 women, 1 private)
- One bathroom per dorm
- Two exam rooms
- One medication room
- Two interview rooms for behavioral health staff
- Day/group room
- Kitchen and dining room
- Approved for home oxygen use by the Fire Marshal

Staffing

Additional personnel would be necessary to expand services and address operational needs, including a Referral Screener, clinical staff and support staff.

CALIFORNIA MEDICAID WAIVER

In October 2019, California submitted a Medicaid waiver application to make recuperative care a statewide Medicaid benefit.

Recuperative care is defined as care that helps individuals achieve or maintain medical stability and prevents hospital admission or readmission. This may require behavioral health interventions.

Funds would not cover stays longer than 90 days in continuous duration or costs for building modification or rehabilitation.

Funding Strategies

The most common funding sources for recuperative care across the country are hospitals, Medicaid and Medicare reimbursements and MCOs.[13]

Hospital Collaboration

Data show that 76% of referrals come from hospitals; CHPB partners account for 50% of all referrals. Currently, hospital partners pay a fee to reserve a CCP bed for their clients. Increasing those hospital partnerships would be a vital component to an expanded program. In 2020, Health Care for the Homeless will meet with hospital representatives to share data, best practices and expansion goals.

[12] A client could only be admitted for chronic conditions once a year for 30 days. No more than 15 beds would be reserved for chronic conditions across both sites.

[13] National Health Care for the Homeless Council (June 2017). *Medical Respite Care: Financing Approaches.* https://nhchc.org/wp-content/uploads/2019/08/policy-brief-respite-financing.pdf.

Medicaid Waivers

As an FQHC, we are able to bill Medicaid and Medicare for some recuperative care services. But only 25% of all visits were reimbursable through Medicaid and Medicare (Jan.-Oct. 2019)**.** Medicaid waivers would allow us to increase those billable services.

California has already begun the Medicaid waiver process for their recuperative care program and could provide guidance for Maryland.[14] Maryland has a recuperative care program in St. Mary's County with two additional programs planned in Montgomery and Carroll Counties.

Managed Care Organizations (MCOs)

Some states that have chosen to expand Medicaid have done so through Medicaid managed care organizations.

Recuperative care programs in Yakima (WA), Seattle, Chicago, Los Angeles and Santa Barbara have negotiated individual payment rates with one or more of their MCOs. Some determined the costs of staff and services (meals, transportation, bedding, rent, administration, etc.) and negotiated a per diem rate with individual MCOs. In other cases, the MCO agreed to a one-time payment for each admission per calendar year, regardless of the length of stay.

Payment Models

Recuperative care programs across the country have negotiated payment rates in a variety of ways:

1. Per diem rate
2. Capitated per-member-per-month (PMPM) amount
3. One-time case rate (e.g., paying a lump sum for each admission per time period, regardless of length of stay)
4. Monthly payment to reserve a designated number of beds

Other recuperative care programs have told us that charging hospitals a monthly or annual flat rate is usually the easiest financing model, but per diem rates are also an option.

	Phoenix	SB	LA	Seattle	Chicago[15]	Boston	Yakima
Medicaid/FQHC payments	X					X	
MCO/per diem rate				X	X		X
MCO/capitated PMPM		X					
MCO/one-time case rate					X		X
MCO/pre-purchased beds			X		X		

[14] This waiver is currently out for public comment and has not yet been approved by CMS. The National Health Care for the Homeless Council is currently completing a report on this option; the draft application is here: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

[15] Chicago has three different MCO payment arrangements

Appendix A: Hospitals in Pre/Post Analysis

Includes all hospitals CCP clients visited in 2018.

Anne Arundel Medical Center
Atlantic General Hospital
Grace Medical Center (formerly Bon Secours Hospital)
Carroll Hospital Center
Doctors Community Hospital
Frederick Memorial Hospital
Greater Baltimore Medical Center
Holy Cross Hospital
Howard County General Hospital
Johns Hopkins Hospital
Johns Hopkins Bayview Medical Center
Levindale Hebrew Geriatric Center and Hospital
Mercy Medical Center
MedStar Franklin Square Medical Center
MedStar Harbor Hospital
MedStar Good Samaritan Hospital
MedStar Montgomery Medical Center
MedStar Union Memorial Hospital
Meritus Medical Center
Northwest Hospital
Peninsula Regional Health System
Ascension Saint Agnes Hospital
Sinai Hospital
Suburban Hospital
University of Maryland Baltimore Washington Medical Center
University of Maryland Harford Memorial Hospital
University of Maryland Prince George's Hospital Center
University of Maryland Rehabilitation & Orthopedic Institute
University of Maryland Medical Center
University of Maryland Medical Center Midtown Campus
University of Maryland Medical Center Shock Trauma
University of Maryland Shore Medical Center at Easton
University of Maryland Upper Chesapeake Medical Center
University of Maryland St. Joseph Medical Center
Washington Adventist

Appendix B: Community Interviews

Overview

Hospital	Current Program	New Program Recommendations		Potential referrals
	Barriers	**Location**	**New Services**	**Weekly**
Mercy Medical Center	No beds open; Referral turn-around too long; No evening referrals	Close to other homeless service providers	1. Oxygen 2. Chronic conditions 3. IVs	2-3
Johns Hopkins Hospital	No beds open; Referral turn-around too long; No evening referrals	East Baltimore	1. Oxygen 2. Chronic conditions 3. Private rooms	5 (ER only)
Ascension St. Agnes	No beds open	West Baltimore	1. Oxygen 2. Chronic conditions	Unknown
UMMC	No beds open	Downtown	1. IVs 2. Oxygen	Unknown
Johns Hopkins Bayview Medical Center	No beds open	Close to other homeless service providers; East Baltimore	1. Oxygen 2. Private rooms	Unknown
Sinai Hospital	No beds open; Referral turn-around too long	Downtown	1. Chronic conditions	1-2 (in-patient only)

Mercy Medical Center

Interviewees: Sally Ratcliffe—Director of Social Work; Sue Filipowicz—Case Manager, Cynthia Thurston—Case Manager	
What additional services are most needed?	• Access to oxygen is the biggest need. They recommend CCP discharging these clients to assisted living once they recover. • Many clients experiencing homeless don't have an acute need but are sick and can't manage their medication ("high utilizers"). They would refer more clients like this if CCP had capacity. • IVs are also an important need for uninsured clients and those with substance use disorders. • Private beds would be utilized for influenza. • Probably not as much need for end-of-life care because they refer clients to Gilchrist. But potentially some need for palliative care for clients who aren't yet sick enough for hospice.
How can we improve the referral process?	• There aren't enough beds available. • The wait time is too long. CCP has a 24-hour response policy. CCP gets back to them before 24 hours but it still doesn't meet their needs. ("24 hours feels like days. Our clients are well on their way by then.")They suggest a faster turnaround. Ideally, 2-4 hours. • They have people discharging clients up to 9 pm. CCP has been lacking evening staff so referral processing has stopped at 5 pm. They didn't know that if the client is accepted, they can usually send the client after CCP staff leaves.
How often do you think you would refer if we had expanded services?	If CCP had more capacity, they would refer several times a week. CCP data says they made 57 referrals in 2018. They think they made more. ("Really? It feels like we made a lot more than that!")
Where should a new program be located?	Close to other homeless service providers or drop in centers to increase client familiarity with the area (Beans and Bread, My Sister's Place, Paul's Place, HOPE, etc.)
Other feedback	The fact that the program is in a shelter turns some people off.

Johns Hopkins Hospital

Interviewees: Tina Vest—RN Case Manager (ER); Amy O'Neil—RN Case Manager (ER)	
What additional services are most needed?	• Many clients have chronic conditions and don't meet the "acute" definition but they still need help with managing medication and getting stable. • Oxygen is the biggest need. They suggested having hospitals provide an oxygen tank. They recommended reaching out to Johns Hopkins Pharmaquip to provide oxygen compressors. • IVs are occasionally needed but are not the most common. • They have seen an uptick in patients who have been assaulted, including many women. Abuse victims would need an isolated room.
How can we improve the referral process?	• The wait time is too long. The emergency department needs to be able to refer people within an hour or two. The in-patient case managers can typically wait a little longer. • There is no one there to receive the client after hours. The majority of ER patients are discharged late in the day. If they had to choose between making referrals in the morning or evening, they prefer evening.
How often do you think you would refer if we had expanded services?	• The emergency department could make around five referrals a week. • In-patient case managers could also make referrals but they're not sure how many.
Where should a new program be located?	• Their population is typically in East Baltimore so that would serve them best. • The majority of their patients take cabs to CCP • so it wouldn't be a big deal is we had another program further away.

Sinai Hospital

Interviewees: Conchetta Jackson—Manager Care Coordination; Anthony Trcka	
What additional services are most needed?	• Dual-diagnosis (mental health and substance use) • Chronic conditions
How can we improve the referral process?	• The turn-around time needs to be faster. • Not enough beds • It would be helpful if instead of admitting people to inpatient from the ED, to send them to CCP. That would be the biggest cost-savings.
How often do you think you would refer if we had expanded services?	• 6 or 7 a month (only includes inpatient)
Where should a new program be located?	• No one has ever refused to go to CCP because it's in a shelter. • The majority of their clients live closer to Sinai than downtown Baltimore.

Ascension St. Agnes Hospital

Interviewees: Jennifer Broaddus–Director of Population Health; Cassandra Dobbs–Social Work Manager (Remote Team); Gladys Bourne-Carter–Social Work Manager (Inpatient Team); Jennifer Petty–Social Worker (Remote Team); Brandi Clayton–Social Worker (Transitional Care Team); Alexandra Shreves–Social Worker (ED)	
What additional services are most needed?	• Clients with chronic conditions who need stabilization. They don't typically call us for these issues because most times the client isn't dealing with a post-acute need. • Oxygen is another huge need. • IVs are less needed because usually those clients can be discharged to a nursing home or some other facility.
How can we improve the referral process?	• The biggest issue is just getting a bed. Most times they reach out, all the beds are full. Some staff have stopped trying altogether.
How often do you think you would refer if we had expanded services?	• Always a few in-patient clients who could be referred. • It's hard to gauge emergency department patients, but with winter months coming up, it will likely increase.
Where should a new program be located?	• They've never had a client be turned off because the program is in the city. However, they would love something closer. The St. Agnes hospital is a community hub so easy for people to reach. • There currently isn't much in West Baltimore.

Johns Hopkins Bayview Medical Center

Interviewees: Kai Shae—Director of Social Work	
What additional services are most needed?	• Oxygen is the biggest need they see (besides not having enough beds). • Due to a partnership with Genesis Heritage, IVs are not needed. • Bayview is home to the Adult Burn Center. Many burn patients are experiencing homelessness. It would be great to have a private room at convalescent care to refer them. • Many clients have behavioral health needs. When clients are highly irritable and disruptive, they don't know where to send them
How can we improve the referral process?	• They think it's important to be able to reach a live person on the phone more often.
How often do you think you would refer if we had expanded services?	• Unable to say.
Where should a new program be located?	• Their clients come from Dundalk/Essex and East Baltimore. • Most street homelessness are from Highlandtown. • Many clients don't want to go to Fallsway because it's far from where they live in East Baltimore. • They recommend a location in East Baltimore, perhaps closer to a homeless service provider like Beans and Bread or Helping Up Mission.

UMMC

Interviewees: Shannon Mullen—Interim Manager for Social Work; Dr. Chuck Callahan—Vice President of Population Health	
What additional services are most needed?	• IVs are big for them. • Clients with psychiatric diagnoses (this may have more to do with unavailable beds than our criteria). • Oxygen • Wound care—currently accepted into the program but their staff weren't aware.
How can we improve the referral process?	• People have become discouraged from referring because there are never any beds available. • Social workers have conflicting information on admission criteria.
How often do you think you would refer if we had expanded services?	• Several times a week
Where should a new program be located?	• Downtown

Mayor's Office of Homelessness Services

Interviewee: Angela McCauley—Emergency Services Coordinator, Homeless Services Program	
How can we improve the referral process?	• More education about the program and criteria for being admitted. Many City and hospital officials don't know about it. • Angela recently started asking hospitals that reach out to her if they're tried CCP and roughly 75% say no.
How often do you think you would refer if we had expanded services?	• Not sure but there is a huge need for it.
Where should a new program be located?	• There is already plenty of services located downtown. • East Baltimore also has some services in place. • It would be nice to have something in West Baltimore. For instance, close to Pinderhughes Shelter or Sarah's Hope.
Other Feedback	• Every year, hospitals and the City come together to discuss winter shelter plans. It just happened this year but in following years, this would be a good occasion to educate people about CCP.

CCP Clients

Interviewee: Thirteen clients currently in CCP	
What amenities would you like to see at a new program?	• Beds and linens that are more comfortable • Healthy food and the ability to bring and cook their own food • More clothing options • A private transportation system • Monthly bus passes • Therapy pets, especially dogs • More privacy, where the men and women are properly separated • More bathrooms • A quiet space
How do you think the unit should be staffed?	• 24-hour nursing staff • Fair and ethical treatment from staffing ("We need workers that have great training and great human values") • On-call doctors
Where should a new program be located?	• Use abandon apartments • North East, East Baltimore, Arundel County • Transportation might be hard in the County, although maybe it would be good for people recovering from substance use. • Close to the other hospitals, where the program is currently situated. • Close to shelter because a shelter gives people somewhere to go and connects them to other resources.
How many more clients do you think we could have if we added more staffing?	• 50 clients at least
Other feedback	• "The staff here are the best people I've ever worked with." • "It was the best place to turn to when all these things happened."