3-minute case study: Respite care reduces readmissions

By Lia Novotny | January 16, 2018

What innovations drive success in healthcare? Here's a tactic from a leading healthcare organization.

The problem

Transitional care from hospital to home is especially challenging when patients have no home. Shelters for homeless people often have a shortage of beds, are not prepared to care for post-acute patients, and often require that clients leave for the day. The result is that recently discharged homeless patients are often readmitted in a cycle of costly, ineffective care.

The solution

In 1985, the Boston Health Care for the Homeless Program (BHCHP) set aside 25 beds at a local shelter for homeless patients needing transitional care. The essential need for the service led BHCHP to establish the Barbara McInnis House in 1993, named for a beloved registered nurse who dedicated decades to caring for Boston's homeless population.

Barbara Mcinnis House provides respite care for homeless patients recovering from acute illnesses or otherwise too sick to be on the street. Today the program has grown to provide 124 beds, including a new step-down facility opened in 2016.

Each patient is assigned a care team that includes a physician, nurse, medical assistant, case manager, social worker, and psychiatrist or psychiatric nurse practitioner. Specialists in neurology, dermatology, and podiatry can see patients onsite, and case managers help patients apply for disability or transitional assistance at their bedside. Patients stay for an average of two weeks, during which time the care team works to stabilize the medical, behavioral health, and addiction issues they face.

And that's just the beginning, says David Munson, M.D., medical director at McInnis House. The facility "is just one part of our larger program. We rely on the outpatient clinical team, case managers, and social workers to carry the process forward when folks leave McInnis House, including the housing plan, which can sometimes take months, if not years."

The outcome

McInnis House treats approximately 2,200 patients each year. Internal research shows that the program decreased 90-day readmissions at Boston Medical Center, BHCHP's nearest inpatient partner. Massachusetts General Hospital has found that McInnis House allows it to safely discharge patients who would otherwise remain in the hospital, often letting them fill that bed with an insured patient.

"I know we shorten hospital stays. If we didn't exist, folks would just stay in the hospital longer," says Munson. "The city and our hospital partners recognize our value and often wish we had more beds."

Versions of BHCHP's program can be established anywhere, says Munson. The key is to gather stakeholders – hospitals, payers, outpatient caregivers – "and then, be creative with the resources that you have. There is no reason why a motel room with a daily nurse visit can't be medical respite."

Lia Novotny is a frequent contributor to athenaInsight.

athenainsight

A daily news hub reporting from the heart of the health care internet, with access to a comprehensive data set of health care transactions from athenahealth's nationwide network. We equip leaders with actionable insight and inspiration for making health care work as it should.

Stay in the know

Sign up for weekly data and news:
insight.athenahealth.com/newsletter