Restorative Experience for a Safer Transition - Pilot Evaluation

August 1, 2021 - January 31st, 2022

Executive Summary

The Interfaith Works (IW) Restorative Experience for a Safer Transition (REST) program offers recuperative and supportive services for those experiencing homelessness with acute medical needs. This report is intended to provide our partners and collaborators with a review of services provided to date, along with the final pilot evaluation of the REST program's outcome metrics and future growth potential and needs.

Introduction

Every night in Thurston County more than 1,000 people sleep in doorways, on cold concrete sidewalks, and in wooded areas. This public health emergency, recognized by government officials across the county, is challenging for those needing shelter and for our community. A key part of addressing that challenge has been Interfaith Works' dedication to meeting emergency shelter needs and commitment to long-term solutions.

The hospital system is not tailored to serve those who no longer require medical care but have no safe place to be discharged to. The REST program provides a short-term (≤30 days) safe, resource-rich environment in which patients experiencing homelessness can recover while engaging in community health support services to address basic needs, connection to primary care, and housing resources. Our pilot program capacity was six 24/7 beds.

The REST pilot program was a collaborative endeavor between Interfaith Works, Providence St Peter Hospital, MultiCare Capital Medical Center, and Thurston County and was designed to address the mutual need for support for our most vulnerable neighbors experiencing homelessness. REST began August 2021 as a pilot program serving qualified discharges from the Providence and MultiCare Capital Medical Center hospitals in Olympia, WA, and continues as a program at the Interfaith Works Unity Commons Shelter. No on-site medical care is provided, and the REST Navigator (Case Manager) supports and coordinates outside visiting providers. The REST Navigators also work on a safe step-down plan for exit from the program within the 30-day time frame.

Our Model

The model for REST was built on two foundational components; best practices for respite programs, and IW's extensive experience providing shelter, case management, and services to our most vulnerable neighbors experiencing homelessness. Previously, IW often received uncoordinated hospital discharges which put strain both on local hospitals and on our ability to serve participants. In the REST model, individuals with acute medical needs are discharged from participating providers with coordination to REST after meeting the referral criteria. Once in the REST program, IW Navigators offer

certified peer support based wrap-around case management to encourage the best connection to services and resources upon discharge from the program. 24/7 supportive services and active, client-led case management means that each individual in the REST program has the support they need to recover in an environment of sufficiency and deep service connection. We believe that this supportive environment and connection to services and resources in turn decreases the likelihood of hospital readmittance and improves individual health outcomes while offering significant benefit to the lives of those served. The IW REST program model drew inspiration heavily from the Edward Thomas House Medical Respite program with Harborview in Seattle, WA. This program is also structured around 24/7 services, and operates with harm reduction principles at its core. The Catholic Charities Transitional Respite Program in Spokane, WA also offered inspiration for the IW REST model, with its resource rich environment and shelter co-location. Both programs have a bed capacity in excess of 30 24/7 beds.

The IW REST Program strives to meet the 8 standards for Medical Respite Care Programs as designated by the National Institute for Medical Respite Care (NIMRC).

Standards:

1. Medical respite program provides safe and quality accommodations.
2. Medical respite program provides quality environmental services
3. Medical respite program manages timely and safe care transitions to medical respite from acute care, speciality care and/or community settings.
4. Medical respite program administers high quality post-acute clinical care.
5. Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services.
6. Medical respite program facilitates safe and appropriate care transitions out of medical respite care.
7. Medical respite care personnel are equipped to address the needs of people experiencing homelessness.
8. Medical respite care is driven by quality improvement.

IW REST Program submitted a Medical Respite Care Organizational Self-Assessment after the 6 month pilot to NIMRC to assess current quality of care being provided. In this evaluation, “Good Fidelity” and compliance with the NIMRC Standards of Care constituted a score of 70% or more. On 2/17/22, the IW REST Program scored an overall score of 82% fidelity. The IW REST Program is in the process of using this assessment to improve operations and the quality of care provided to participants.

Program Goals

The REST program seeks to;

- Improve health outcomes for participants
- See a marked increase in resource connectivity
- Increase medical management and literacy for participants
- Reduce hospital recidivism and EMS service utilization
- Decrease strain on the homelessness response system and medical system
- Increase collaboration and communication between service agencies and stakeholders
- Provide competent and inclusive services in a cost-effective manner
- Reduce risk of preventable death or further medical challenges for participants with tri-morbidity experiencing homelessness

- Attempt to stop the cycle of homelessness for participants through intensive case management and creative interventions

Our Partners

The two participating medical providers with discharge rights are MultiCare Capital Medical Center (2 beds) and Providence St Peter Hospital (4 beds), both located in Olympia, WA. This partnership was also joined by Thurston County Public Health and Human Services in the form of significant funding support for the early stages of the pilot.

Participant Story #1

LB was discharged to us with a diagnosis of respiratory failure and cancer. He was referred to hospice care, and it was impossible to find him a placement due to Covid protocols and program capacities. His biggest fear was passing away on the streets. Our navigators were able to connect him to a volunteer hospice program where he spent the end of his life in warmth and safety. L passed away with agency, dignity, and comfort, surrounded by care.*

**Initials have been changed to protect client identity.*

Other Program Collaborators

Along with our partners, we are pleased to have participation from many other entities in contributing to serving our most vulnerable neighbors. Interfaith Works' long standing relationship with Valley View Health Clinic has resulted in increased services offered to the individuals in the program. This partnership with Valley View has grown to include Providence Home Health in order to streamline support to REST participants. Being able to efficiently provide connection to PCP and Home Health services when needed has been an incredible benefit to both the REST program and the participants. Through this new partnership, a total of 4 clients have successfully received wraparound services through this partnership. The Amahoro House has also provided vital support as the REST pilot navigates individual needs for hospice care and the lack of existing supports for this need.

Our Plan

This pilot is intended to assess the mutual need of the community and our partners, for benefits from increased services for individuals with acute medical conditions experiencing homelessness.On March 1st, 2022 the REST program became co-located with the Interfaith Works Unity Commons Shelter. The opportunity for co-location provides increased support for REST participants due to the shelter's 24 hour staffing model.

REFERRALS

Referral Criteria

The REST program is designed to offer support and recuperative space to individuals with acute medical needs who no longer meet the threshold of requiring medical care who might otherwise remain in the hospital as a social admit. The REST program is not a medical treatment, psychiatric, skilled nursing, assisted living, rehabilitation, long term shelter, substance use, or mental health care facility. The REST program only serves those individuals who meet the referral criteria and simply require a restful place to heal. No on-site medical care is provided, and the REST Navigators (case managers) support and coordinate outside visiting healthcare and caregiving providers.

The referral criteria are designed to ensure that individuals receive the level of care and services required by their needs.

Referral Process

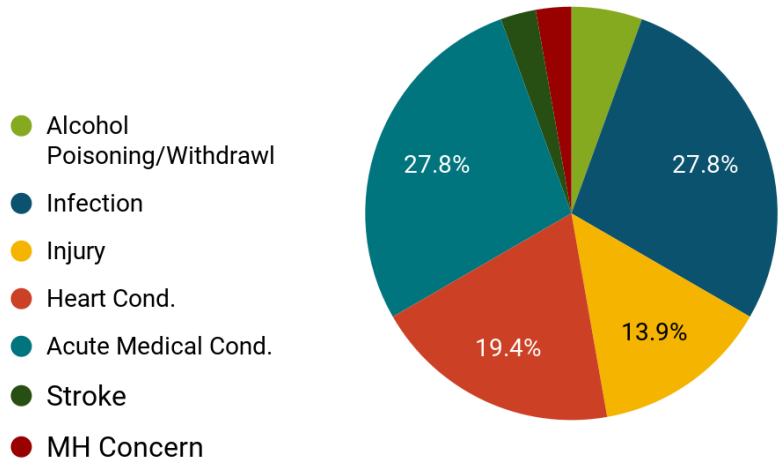
The REST referral process depends on our discharging partners clearly understanding what level of service REST can provide, and making appropriate referrals. Discharging planners begin the referral process by assessing an individual's fit for the program using the IW Referral Criteria. Additionally, the discharging party must also provide a release of information, IW Space Use agreement signed by the individual being referred, and the hospital's after visit summary. This packet is scanned and sent directly to iwrestreferral@iwshelter.org. The discharging party then makes a call to the REST hotline, and connects with a REST Navigator. Both parties will review the referral packet for the individual, and the REST Navigator will either accept the referral or deny the referral. At this time, the hospital's discharge planners should also be arranging any supported care needs and transportation needs.

REFERRALS	
Unique ind.	*38*
Program Readmittance	*4*
Failure to Appear	*4*
Providence Referral	*74*
MultiCare Referral	*12*
Admitted Referrals	*38*
Denied Referrals - Capacity	*36*
Denied Referrals - Condition	*8*
Total Attempted Referrals	*86*

Referral Statistics

At the end of our pilot, REST had received 86 referrals and accepted 42 referrals of 38 unique individuals. 36 referrals had been denied due to program capacity, and an additional eight referrals had been denied due to the individuals not meeting the referral criteria. These referral denials were clearly communicated with partners along with the reasoning for the denial.

Frequency of Discharging Conditions



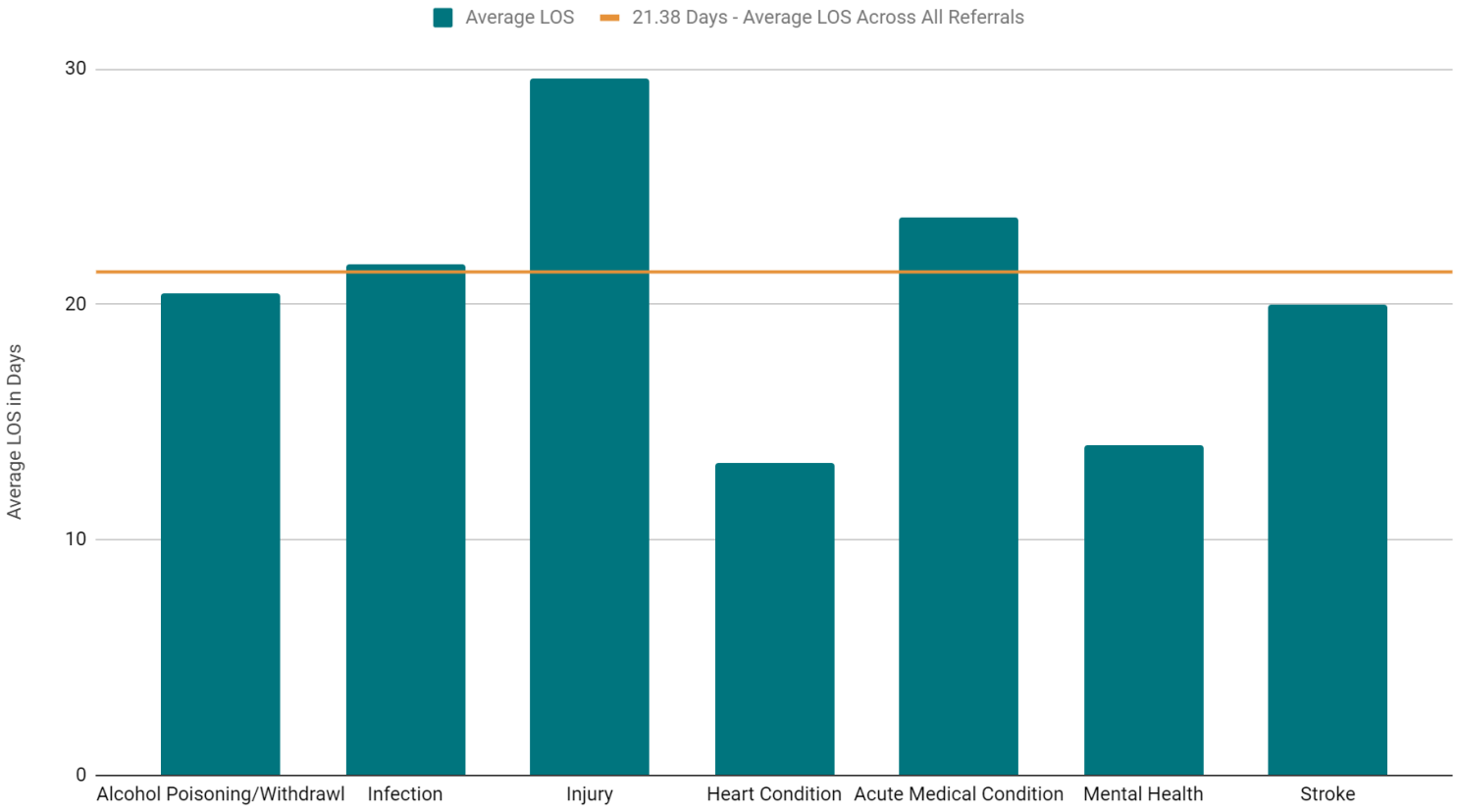
Discharging Conditions

The most common discharging conditions at this time are infection and acute medical conditions, both accounting for 27.8% of referrals. The next most common discharging condition is heart conditions, accounting for 19.4%. The overall average length of stay (LOS) encompassing all discharges from the REST pilot program is **21.38 days**. Though heart conditions are one of the most common reasons for referral to REST, early data show that these stays are often significantly shorter than other discharging conditions.

Twice Weekly Program Assessments

Twice a week, REST Navigators complete participant reported assessments with each individual. These assessments are designed to offer REST Navigators and participants the ability to objectively observe recuperative progress in the context of the specific individual's needs. These assessments cover many key areas of recuperation; sleep consistency and satisfaction, appetite, comfort with any new medical needs, pain levels, ability to remember or track, and mobility and engagement. These assessments gather valuable information on the benefits participants see from the program and complement the case notes kept by REST Navigators.

Average Length of Stay by Condition



PARTICIPANTS

At the end of pilot evaluation, REST had seen 38 successful referrals to the pilot. With an average LOS of 21.38, a similar 6 bed capacity program would see 102 referrals served in one 12 month period. To date, our average REST participant is approximately 61 years old, with 78.9% being male identified. The average hospital stay before referral to REST is approximately 10.42 days. A significant 68.4% have a disability of some type. On referral, 97% of participants were experiencing homelessness. Of the participants who responded to race and ethnicity questions, 11.76% identified as Hispanic/Latino and 88.24% did not. 84.38% of participants identified as white, 6.23% as American Indian/Alaska Native/Indigenous, and 3.13% are Black/African American. 3.13% are two or more races. 17.65% of guests are veterans.

PARTICIPANTS DEMOGRAPHICS	
Median Age	61
Disabled	28
Not Disabled	6
Unknown	5
Male	31
Female	7
Gender Non-Conforming	1

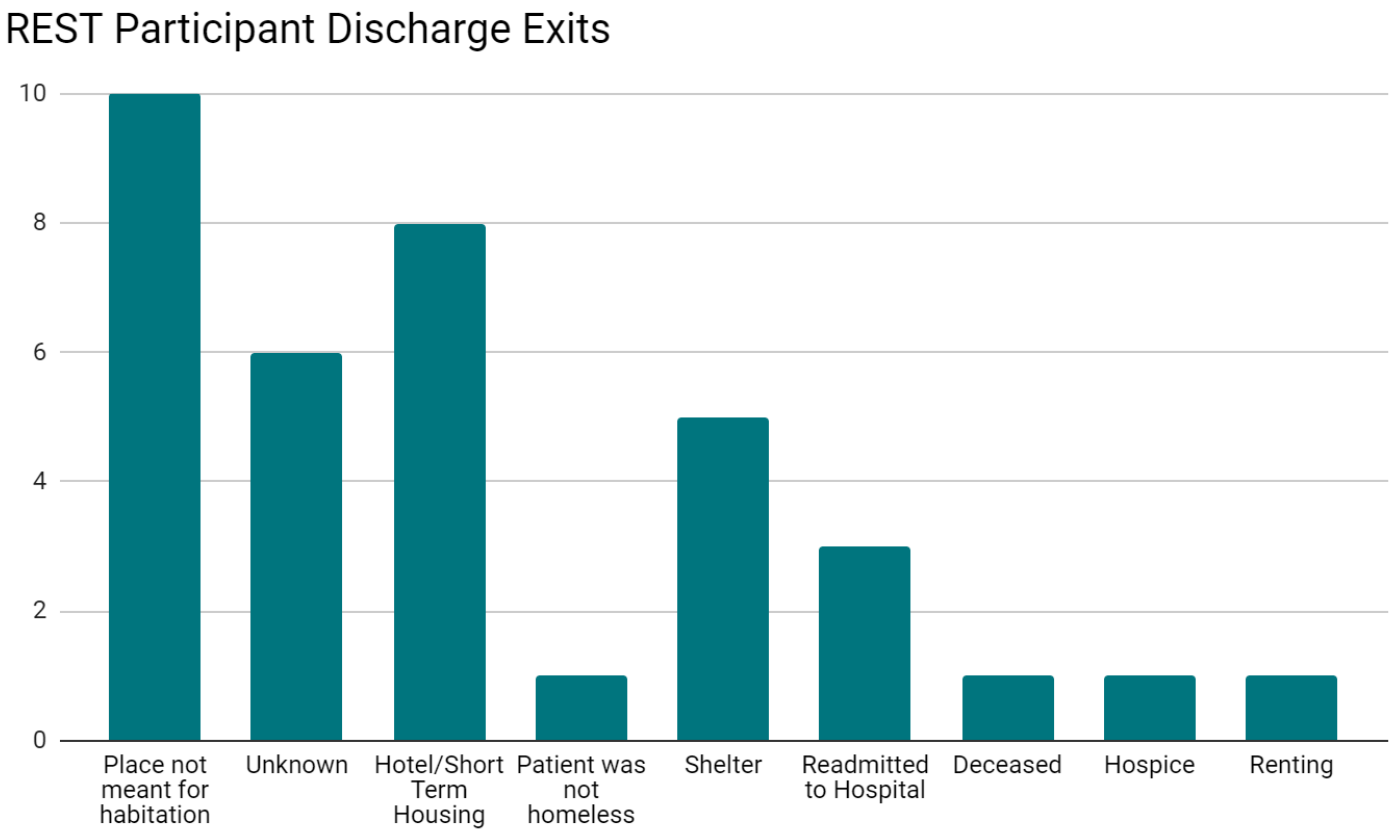
Participant Story #2

GP was hospitalized for a venous leg ulcer. While hospitalized, she was also diagnosed with cancer and Hepatitis C. REST navigators helped her connect with primary care, an oncology specialist, multiple imaging and lab appointments, and a Hep C care navigator. She was also connected to another case manager to support her after discharging our program.

Participant Outcomes

Below is a graph of our discharge outcomes.

At this time, a significant lack of housing in Thurston County, and the COVID 19 pandemic response limitations on shelters, means that the REST program's ability to discharge to housing within a 30 day time frame is significantly hindered. Evidence of this is seen in average monthly rental rates of $1,160 and a vacancy rate of 3.4%, according to the Thurston Regional Planning Council. One discharge outcome, readmittance to hospital, is of particular note. In this particular individual's case, readmittance may have been avoided through a slightly extended program stay cap.



IW Unity Commons Shelter Bed Assignment

Although REST is now co-located with the IW Unity Commons Shelter, there is no direct ability to transfer a participant from the REST program to a shelter bed consistently. IW Unity Commons Shelter beds, like many shelter beds in our county, are assigned through the Coordinated Entry (CE) system of Thurston County. This waitlist is managed by Community Action Council of Lewis, Mason, and Thurston County (CACLMT). If a REST participant indicates an interest in a long term shelter bed or other housing option, REST navigators assist the participant in the CE intake process which is the first step to being assigned a long term shelter bed and accessing additional coordinated resources and services.

Program Supplies

REST strives to provide all participants with the necessities needed for a recuperative stay. The program provides many supplies to this end. While general supplies look like having the most common supplies on hand (incontinence supplies, socks, clothes, etc.) REST also provides specific supplies as needed to match participants' care needs. Examples of participant specific supplies that have been provided include wheelchair cushions for a participant with a herniated disc, over-the-counter medications that were recommended in the participants after visit summary, and assistance with vital document replacement to increase access to resources.

Quotes from Former Participants

"I never really felt comfortable getting help from anyone until I met you guys. You make me feel like a person, I feel seen by you."

"You all have done so much for me, I am so very grateful."

"There is a place in heaven for you people, because you're angels."

Medical

REST provides common over-the-counter medications for participants, such as Ibuprofen, Tylenol, etc. While REST does not provide wound care services, there are supplies on hand for participants to care for their own wounds properly. Items such as bandaids, bandages, antibacterial ointment - are all available to participants as needed. Additionally, we provide personal care items such as toothbrushes, toothpaste, deodorant, soap, hand sanitizer, masks, and lotion.

REST has naloxone on site and all REST navigators are trained and required to intervene in cases of opioid overdose. To date, there have been no overdose reversals on site. REST Navigators distribute naloxone based on participant request and need. Sharps containers are also available for the proper disposal of syringes. These items are supplied along with education on increased risks of overdose, and safer use practices to participants along with regularly conducted risk assessments.

REST Navigators also help participants obtain mobility devices such as walkers or crutches, slings, support pillows, weekly medicine planners, and other items tailored to the participants recuperative needs. Comfortable, loose clothing is also made available to participants, as many may not have clothes suited to restricted motion or ability. Mattress protectors and incontinence supplies are available to all participants as needed.

Meals

Consistent meals are also one of the benefits participants see in the REST program. By providing food, participants have less need of seeking out meals, making for a more recuperative experience through reduced strain, fear, and stress. Snacks are on hand for participants as well as electrolytes. Specific dietary needs are met through collaborative work with the REST Navigators, so that all participants may have healthy and nutritious meals that meet their needs. Dietary restrictions such as low sodium, low sugar, gluten-free, or allergen-free, can all pose significant barriers to unhoused individuals as many of the food resources available do not have a wide enough variety or selection to meet these needs.

Collaboration with Other Agencies

Since the REST program does not provide medical care, it has been crucial to establish and maintain collaborations with agencies who can appropriately treat guests' needs. Valley View Health Clinic (VVHC) has provided case managers with intake packets for primary care and are currently scheduling new patient visits within 10-14 days. Six REST participants have been connected to primary care this way. Through a collaboration between IW REST Program, VVHC and Providence Home Health, participants are able to establish care with a PCP via the VVHC clinic at the Providence Community Care Center. Additionally, participants receive follow up wound care and other home health services with the support of REST Navigators. This collaboration was established part way through the pilot and 4 participants benefited from successful wrap around care. Once established with primary care providers, patients will be more able to address ongoing health concerns. Flu and COVID vaccines are also made available through VVHC as well as The Olympia Free Clinic. IW continues to grow additional connections for primary and specialty care through our vast network of partnerships. We view collaborations with other agencies as a vital way of providing the best possible care to our participants.

CASE MANAGEMENT

The role of REST Navigators requires flexibility and individual responsiveness. They act as the center point of balance and collaboration between many different influencers. Not only do they ensure the day to day safety and comfort of the guests in the REST program, they work with those guests towards their future goals and attempt to set them up for success under an extremely brief time frame. REST Navigators also actively collaborate and problem solve with hospital discharge planners, as well as other collaborators and service providers, to ensure that participants and partners are supported. So far this has presented in; crisis de-escalation, medical education, care plan reiteration, responding to incontinence, assisting clients in reuniting with family members, providing nutritious meals, and primarily providing a safe, calm space for people to recover from serious medical issues.

REST Navigators are certified peer counselors (CPC), bringing their own life experience with homelessness, substance use challenges, poverty, mental health challenges, to offer a framework of unconditional positive regard. REST Navigators are highly trained to offer case management services as well as having their CPC. A list of trainings and certifications is below.

Certifications

- WA State Division of Behavioral Health Resources Certified Peer Counselor (CPC)
- CPR/First Aid Certification
- Bloodborne Pathogen Certification
- Food Handlers Permit

Additional trainings required/provided by IW

- Trauma Informed Care Principles in Practice
- Adverse Childhood Experiences - What they are and how we respond
- Harm Reduction Principles in Practice
- Significant Mental Illness - Providing services for individuals experiencing significant mental illness
- Substance Use and Co-occurring Context
- Professional Boundaries
- Self Preservation in Social Work
- Compassion Fatigue and Secondary Trauma - Recognizing where we are
- Professional Documentation
- Understanding Bias - What we bring to our work
- Interactions With Outside Agencies
- De-escalation
- Group Cohesion and Power Dynamics
- Responding to Opioid Overdose

REST Navigators

"One measure of the success of our program is seeing what happens to our guests in the first couple of days. Upon leaving the hospital, most of our guests are exhausted and are often coming down off a myriad of medications. It is difficult to consider what it must be like to be in that state and try to go out and immediately re-engage in the work of survival: carrying all of their belongings around, looking for a dry place to sleep, obtaining meals. Sometimes our guests are fully recovered after a week or two and get discharged as they are once again capable of surviving on their own. Sometimes our guests are in need of a clean place to sleep and regular access to showers so their wounds can heal properly. We have seen some guests take a full month to be able to build back the strength they need to be back out on the streets."

-REST Navigator

Areas of Active Case Management

Medical

REST Navigators provide valuable support as participants navigate the changes brought on by recent medical issues and hospital stays. This includes; helping arrange transportation to appointments, facilitating the pickup of prescriptions medications, obtaining recovery items (weight scales, mobility devices), reading prescriptions labels with participants, and reading AVS with participants. This support enables participants to be actively engaged in their own medical care while not being left to address these issues alone. Additionally, REST Navigators provide care education, reiterating AVS aftercare guidance and assisting with participants' understanding of next steps. REST Navigators also provide assistance with obtaining health insurance information and assistance with document filling and filing to support participants in continuing their care.

Housing

While REST Navigators support participants with their immediate medical care, they are also attempting to address a participant's housing needs as this is a major factor in hospital readmissions. This area of case management can be especially challenging with the ≤30 day stays in the REST

program. This can look like connecting individuals with formal support through existing community resources via the coordinated emergency shelter system, or helping individuals connect with other existing 'soft supports' such as family members, or friends who may be able to provide short term housing options. At this time, Thurston County is experiencing extremely low housing inventory especially for individuals with limited resources. Additionally, the COVID 19 pandemic has restricted some of the existing resources for housing. This often results in a large number of participants being discharged to places not meant for habitation, or other unknown exits which are often still to places not meant for habitation but without confirmation.

Resources/Supports

Working within the short-stay time frame, REST Navigators are able to assist with many resource connections for participants. These are often existing non-government resources or government benefits. The intention of these supports is to widen the options a participant may have upon discharge from REST to help reduce unnecessary hospital readmittance and increase beneficial social and resource outcomes for participants. People's experiences of living without shelter often lead to mistrust of medical systems and a lowered belief in their ability to follow through on their self-determined goals. Through building trust with REST navigators and experiencing success together, such as making it to a follow-up medical appointment, REST Navigators are able to help meet guests immediate needs as well as build the guest's sense of self-efficacy for future successes. REST Navigators also work to provide assistance in obtaining government issued identification/vital documents, as participants' possession of certain vital documents can be foundational to seeking other support and resources.

Government Benefits/Supports

- *SNAP/EBT benefits*
- *ABD (Aged/Blind/Disabled) interim assistance*
- *Social Security Income benefits*
- *Paid Family Medical Leave*
- *Medicaid/Medicare Enrollment*
- *Pandemic Related Assistance (stimulus checks)*
- *Identification/Vital document Replacement (ID or license, social security card, birth certificate)*

Non-Government Benefits/Supports

- *Tribal Benefits*
- *Transportation coordination*
- *Coordinated Entry assessments*
- *Other Nonprofit Service Provider Resources*

Other Roles

The REST Navigators are supported in their work by four key roles; the Navigation Team Program Manager, the Navigation Team Operations Administrator, the Homeless Services Program Coordinator, and the Executive Director. The REST program currently has a constant 24/7 on-call management presence. These supports are sufficient for the pilot, but program extension would benefit from dedicated program specific administrative and managerial supports.

Program Model Adjustments

Extended Stays

At 30 days, the REST program has a shorter length of stay than 60% of medical respite care programs. To further align with best practices of existing respite programs, IW would recommend that the short-stay have a heightened cap of 45 days to reduce hospital readmittance in extreme cases. This is still much less than the Edward Thomas House stay maximum of 3 months. Allowing for this flexibility could prove extremely beneficial for partners and participants. For example, one participant was readmitted to the hospital following a 30 day REST stay and subsequently re-referred to REST for an additional 27 day stay whereupon they were readmitted to the hospital and given a third referral to REST. This readmittance to the hospital may not have been necessary without discharge from REST that, while it was in keeping with the short-stay model, may have been premature for the participants' condition. This extension could be structured as an IW recommendation, but approved at the discretion of our partners.

Staffing

Early in the pilot phase it became clear that a third Rest Navigator was necessary to support daily, wrap-around services for REST guests, and effectively plan for stable discharge from the REST program. In month four of the pilot, we added a third REST Navigator at no additional cost to our partners. This staffing change greatly improved our ability to be consistent, communicative, and thorough in our service delivery. However, this staffing change alone is not sufficient for sustainability long term. Program continuity and longevity past the initial phase would also find two additional positions beneficial to the REST structure. An additional transitional community supports Navigator that would provide continuity of case management to participants during the three months upon discharge from REST would be especially beneficial for gathering outcome data and reducing hospital readmittance while continuing to strengthen participants' resource and service connection. The ability to further the work of REST Navigators who are unable to see certain resource and service connection to completion in the short-stay timeframe would further solidify REST as a long-term solution program in line with the Thurston County Homeless Crisis Response Plan. Additionally, a REST specific program manager would strengthen the support of Navigators and the program to help with the continued response to partner and community needs.

Expanded Partner Network

We recognize a need for expanding our network of licensed medical providers to support the REST program. While we have made significant inroads in partnership with Providence Home Health and Valley View, we see additional need for nursing, dietary, medication management and wound care support for our REST guests on a more consistent basis. Not everyone qualifies for Home Health services, and having on-site nursing support would allow our REST Navigators to consult and more appropriately seek assessment when making discharge decisions and working with medically fragile people on follow up care needs. We plan to continue growing our partner network to include the St. Martins, Clover Park Technical College, and South Puget Sound Community College Nursing Programs, as well as deepen our relationship with local providers and the Olympia Free Clinic. Further, with the high rate of veterans we are serving, we plan to connect more broadly with services specific to veterans in Thurston County.

Growth

Data from the pilot project clearly shows that with increased capacity, we will be able to accept a much higher rate of referrals from the hospitals. We strongly believe that the REST program will show increased effectiveness and cost savings to the hospitals if more beds are contracted for medical respite. In 2022, we are prepared to increase capacity by 4 beds and will be actively searching for partners to meet that capacity.

REPORT SUMMARY

Even in the short time REST has been operational, benefits have begun to emerge. The continued dedication of our partners to equity in medical care access, and the profound community care brought to this partnership is contributing to the program's success with participants and the larger community. IW has already seen that the services provided through this program can be both life-saving and life-changing for our community's most vulnerable members. Average LOS of 21.38 days support that this model is working as intended to serve as short-stay support for immediate recuperative needs, while bridging many of the existing gaps in the community service network. Continued partnership could result in a strong respite program as well as an extremely valuable community asset for addressing homelessness in Thurston County.

For questions about this report, or about the REST program, please contact;

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