MEDICAL RESPITE CARE AND HOMELESSNESS

2012 Policy Statement

SUMMARY OF RECOMMENDATIONS

1. **CMS should encourage states to use existing state options under Medicaid to support medical respite programs.**
2. **HRSA should offer targeted Service Expansion and New Access Point funding opportunities to Health Centers for the provision of medical respite services.**
3. **HUD, HHS and the VA should collaboratively provide comprehensive and stable funding for medical respite programs.**
4. **Medical respite care should be part of key health reform initiatives targeting vulnerable populations.**

► ***Medical respite care*** *is defined 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 who are not ill enough to be in a hospital.*

Homelessness exacerbates health problems, complicates treatment, and disrupts the continuity of care. People experiencing homelessness encounter high rates of physical and mental illness, increased mortality, and frequent hospitalizations. Homeless persons are three to four times more likely to die prematurely than their housed counterparts.[1] These deaths are most highly associated with acute and chronic medical conditions exacerbated by life on the streets or in shelters. Homeless adults are hospitalized more frequently than those in the general population and often require longer inpatient stays; however, their lack of a stable home environment diminishes the long-term effectiveness of their hospital care. Living on the streets after hospital discharge creates competing priorities for homeless patients. Challenges such as obtaining healthy food, accessing transportation, and finding a safe and clean place to rest can compromise adherence to medications, other physician instructions, and follow-up appointments, thus increasing the probability of future hospitalizations.[2]

Medical respite care is an essential component within the continuum of care needed to serve individuals experiencing homelessness or at risk of homelessness. Medical respite care provides short-term residential care that allows homeless individuals to rest while receiving medical care for acute illness or injury. Medical respite programs offer hospitals an alternative to discharging patients to the streets while ensuring that the medical care received in a hospital or clinic setting is not compromised due to unstable living situations. Combined with housing placement services and effective case management, medical respite care allows individuals with complex medical and psycho-social needs to recover from an acute medical condition in a stable environment while reducing future hospital utilization.

Medical respite care improves health outcomes and housing stability. A multi-year evaluation of 10 HCH medical respite programs showed improvements in symptoms and increased access to housing and income. Upon admission, over 500 individuals (one-third of the study participants) reported the hospital as their place of residence. Upon exiting the program, only 8% of the study

participants listed the hospital as their residence.[3] The same study showed increased access to income sources such as food stamps and Supplemental Security Income.

Medical respite care results in cost avoidance for hospitals and health care systems. Research demonstrates that after 3 months and 12 months post-discharge, homeless patients who were discharged to a medical respite program had fewer hospitalizations and reduced hospital readmissions than homeless patients who were discharged to their own care. [2,4] These outcomes are attributed in part to the time that medical respite care providers spend with patients to establish a relationship between the patient and a primary care provider.

Recommendations in Detail

1. CMS should encourage states to use existing state options under Medicaid to support medical respite programs.

Reductions in hospital readmissions through quality health care and robust discharge planning programs are an important part of the Affordable Care Act particularly as we prepare to expand Medicaid more broadly to low-income individuals. Research demonstrates that even brief stays in a medical respite program decrease hospitalization, reduces readmissions, and reduces costs for hospitals and the health care system.[2, 4] Despite the evidence-base, many state decision makers are unaware that medical respite programs are available in their state.

Ideally, HHS should define a national standard of benefits, to include medical respite care, with states encouraged to improve upon this baseline. However, until medical respite care is established as a baseline service, CMS should encourage states to use existing options under the federal Medicaid program to fund medical respite services and receive a federal match.

CMS should send a "Dear State Medicaid Director" letter describing medical respite programs, their impact on health outcomes and costs, as well as existing state options under Medicaid that can be used to finance medical respite programs. Such a letter from CMS would also support the U.S. Interagency Council on Homelessness' Federal Strategic Plan to Prevent and End Homelessness which describes medical respite care as a strategy to end homelessness.[5] Two options that could be used by states to support their medical respite programs include a state plan amendment to provide targeted home and community-based services under Section 1915(i) of the Social Security Act and a demonstration waiver under Section 1115 of the Social Security Act.

Under Section 1915(i) of the Social Security Act, states are permitted to provide home and community-based services to individuals that earn less than 150% of the Federal Poverty Level and require less than institutional levels of care. The Affordable Care Act made some changes to the HCBS program that could be used to finance medical respite services:

- States may now propose additional services beyond those traditionally covered under the HCBS program (case management, homemaker/home health aide, personal care, adult day health, habilitation).
- States can establish specific packages of services for targeted populations. For example, a state could propose a package of home and community-based services to be available to people who are experiencing homelessness and in need of recuperative care.
- States can also create a new Medicaid eligibility category for individuals receiving home and community-based services. This is a good opportunity to incrementally implement early Medicaid expansion to a targeted population that tends to be frequent hospital users and further minimize costs for states with federal matching funds.

CMS should strongly consider any 1915(i) state plan amendment that includes medical respite care for people who are experiencing homelessness.

Under Section 1115 of the Social Security Act, states can receive waivers to conduct demonstrations that promote the objectives of the Act. States may use the 1115 waiver to provide medical respite services to Medicaid beneficiaries as long as the services covered under the waiver are budget neutral (meaning federal spending is not more than it would have been in the absence of the demonstration). States can make a very strong argument for using the 1115 waiver to pay for cost-efficient medical respite services in lieu of more costly hospital inpatient stays. CMS should strongly consider any 1115 waiver application submitted by states that would like to cover medical respite care for homeless beneficiaries.

2. Provide targeted Service Expansion and New Access Point funding opportunities through HRSA for Health Centers for the provision of medical respite services.

In May 2000, HRSA provided grants to ten HCH grantees to demonstrate the impact of medical respite care on patient health.[3] Despite positive results, targeted funding for medical respite programs has not become available. A small number of HCH grantees have patched together various funding sources to provide safe beds and medical supervision for a small segment of consumers in their community; however, there is still a significant unmet need. While the number of HCH grantees starting medical respite programs is minimal, there is a great interest in expanding such services. Indeed, in our recent needs assessment, we found that the greatest barrier preventing HCH grantees from establishing medical respite programs is start up limitations related to funding.[6]

On average, patients stay two to three weeks in a medical respite program, providing health centers with a mechanism for providing "enabling services." Enabling services are non-clinical services that support the delivery of basic health services and facilitate access to comprehensive patient care as well as social services.[7] Federal law emphasizes the importance of enabling services for underserved and vulnerable populations and requires health centers to provide these services for their patients. HCH projects on average spend a greater percentage of resources providing enabling services than other federally qualified health centers. In 2010, 18.2% of clinic visits at HCH projects were comprised of enabling services compared to 6.5% at all health centers.[8] Enabling services provided at medical respite programs include case management, benefit counseling or eligibility assistance, health education and supportive counseling, transportation, interpretation, and education regarding the appropriate use of health services.

Providing stable funding to homeless health care programs that incorporate medical respite services into their existing care models is the most effective and cost-efficient solution to address this gap in the safety net. We recommend that HRSA target a portion of the health center funding to provide targeted Service Expansion and New Access Point funding opportunities to Health Centers in order to provide medical respite care. Because the goal of medical respite care is to improve the quality and effectiveness of care, funding opportunities for medical respite programs should focus on expanding the breadth and depth of services available to the community's continuum of care so that both new and existing Health Center patients might benefit. Medical respite care funding should be flexible enough to allow for varying lengths of stay among patients, and not have rigid requirements for meeting new patient targets. Medical respite care is not emergency or transitional housing but does require overnight beds. HRSA should allow health centers to use HRSA funds to support facility costs associated to their medical respite programs.

We further recommend meaningful cost-of-living adjustments to Heath Center grants to provide a stable base for these activities.

3. **HUD, HHS, and the VA should collaboratively provide comprehensive and stable funding for medical respite programs.**

Medical respite programs not related to federally qualified health centers also need stable and comprehensive funding. Currently, nearly half of all medical respite programs are operated independently of federally qualified health centers. Without adequate funding to pay for both the staffing and housing component, existing medical respite programs are challenged to find local funding sources, often with uncertain continuity or longevity. Concerns about stable funding serve as a barrier for other communities to start new programs. Medical respite programs contribute to the overall goals of a number of federal agencies, facilitate stable housing, improve physical and behavioral health outcomes, and serve a large demographic (including veterans). Indeed, medical respite care is recognized as a strategy to integrate health and housing services in the 2010 Federal Strategic Plan to Prevent and End Homelessness. HUD, HHS (including SAMHSA and HRSA) and the VA should develop mechanisms to coordinate more systematic funding for medical respite care programs. For example, coordinated HUD housing vouchers and HHS/VA supportive services could be offered at medical respite programs to help transition individuals from a care setting to stable housing.

4. **Medical respite care should be included in key health reform initiatives targeting vulnerable and underserved populations.**

The Patient Protection and Affordable Care Act (PPACA) includes a number of provisions aimed at reducing costs and improving quality of care for people who have chronic and complex health care needs. States have considerable flexibility in how they will implement some of these provisions. Many state decision makers may not be aware of the benefits that medical respite can offer to meet the complex health care needs of someone who is living on the streets. HHS should provide guidance to states and local communities that are planning and implementing health reform to ensure that their plans are inclusive of vulnerable populations, including people who are experiencing homelessness. Discussion of medical respite care for people who are experiencing homelessness should be part of CMS guidance and technical assistance related to patient-centered health homes, shared savings through Accountable Care Organizations, comprehensive hospital discharge programs, and state plan amendments to expand Home and Community Based Services.

States establishing patient-centered health homes are expected to operate under a “whole-person” philosophy, caring not just for an individual’s physical condition, but providing linkages to long-term community care services and supports, social services, and family services. Further, provider teams supporting health homes are expected to provide appropriate discharge planning and 24-hour care management and support during transitions in care settings. In most communities, patients who are experiencing homelessness have no other choice but to remain in a hospital for an extended length of time until their illness or injury is resolved. Communities that have medical respite programs offer a cost-efficient transitional care option. States submitting state plan amendments should describe how their health home plan will provide for the needs of their patients experiencing homelessness, with a recommendation that a medical respite care program be developed if there is currently none available.

Accountable Care Organizations (ACO) participating in the Medicare Shared Savings Program are expected to demonstrate quality of care. For people who are experiencing homelessness, partnerships and referrals to a medical respite program should be considered evidence of quality of care indicating appropriate care transitions and hospital discharge planning. We recommend that ACOs participating in the Medicare Shared Savings Programs be encouraged to invest in medical respite programs in order to improve quality of care and reduce costs associated to avoidable hospital utilization and readmission by patients who are experiencing homelessness. ACOs should also be strictly monitored for any activities that indicate avoidance of at-risk patients

Beginning on January 1, 2015, a qualified health plan operating under a state health exchange may contract with a hospital with greater than 50 beds only if the hospital implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge. Clear guidelines should be established to evaluate adherence to this provision, which might include a process for evaluating discharge planning programs for people who are experiencing homelessness including access to recuperative care.

Notes

[1] O'Connell JJ. Premature Mortality in Homeless Populations: A Review of the Literature. National Health Care for the Homeless Council, Dec 2005. Available at: http://www.nhchc.org/PrematureMortalityFinal.pdf
[2] Buchanan D, Doblin B, Sai T, Garcia P. The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health*, 96(7), 1278-1281, July 2006.
[3] Zerger, S. An evaluation of the respite pilot initiative: Final report, 2006. Available at: http://www.nhchc.org/Research/RespiteRpt0306.pdf
[4] Kertesz, S, et al. Post-hospital medical respite care and hospital readmission of homeless persons. *Journal of Prevention and Intervention in the Community*, 37(2), 129-42, April 2009
[5] U.S. Interagency Council on Homelessness (2010). Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. (p.44-45). Available at: http://www.usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf
[6] National Health Care for the Homeless Council. (2010). Knowledge and Skills Needs Assessment: Identifying the Needs of the HCH Field. Available at: http://www.nhchc.org/Research/Knowlege_and_Skills_Needs_Assessment_09202010.pdf
[7] Enabling services: http://www.hrsa.gov/grants/technicalassistance/enablingservicespresentation.htm
[8] HRSA 2010 UDS data available at: http://bphc.hrsa.gov/uds/view.aspx?year=2010

The National Health Care for the Homeless Council hosts the Respite Care Providers Network (RCPN), whose mission is to improve the health status of individuals who are homeless by supporting programs that provide medical respite and related services. For more information about medical respite care, there is a wealth of information available at: http://www.nhchc.org/resources/clinical/medical-respite/.