



## IMPROVING CARE FOR MEDICALLY COMPLEX PATIENTS: MEDICAL RESPITE AND SUPPORTIVE HOUSING

Profiles Bridging Health & Housing | April 2017

### Terminology

#### Medical Respite:

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.<sup>1</sup>

#### Supportive Housing:

Affordable permanent housing with supportive services to help people live with stability, autonomy, and dignity.<sup>2</sup>

#### Continuum of Care (CoC):

A local coalition that promotes community commitment to ending homelessness, funding for efforts to rehouse people without homes, and access to mainstream programs.<sup>3</sup>

#### Coordinated Assessment:

Also called Coordinated Entry, Coordinated Assessment is a system wide process for prioritizing and connecting people experiencing homelessness to appropriate housing and supports.<sup>4</sup>

### Resources

#### Medical Respite Standards:

<https://www.nhchc.org/standards-for-medical-respite-programs/>

#### Medical Respite Toolkit:

<https://www.nhchc.org/resources/clinical/medical-respite/tool-kit/>

#### Medical Respite Workbook:

<http://www.nhchc.org/wp-content/uploads/2011/09/WorkBook.pdf>

### Overview

Medical respite programs are as unique as the individuals and communities they serve. From shelter-based care to stand-alone facilities, medical respite provides a transition for those exiting the hospital who have no permanent residence and are not well enough to return to the street. Hospital partners have seen the benefit of medical respite programs as they not only stabilize health needs, but also reduce hospital readmissions. In addition to providing necessary care, this transitional step is an opportunity to connect vulnerable individuals to permanent housing. This profile highlights two programs that have exemplified how medical respite care can be an effective bridge to supportive housing. Strong involvement between the health center and their local Continuum of Care, including through the coordinated assessment process, results in high rates of discharge to supportive housing.



Circle the City Consumer getting Housing

#### Yakima Neighborhood Health Services, Yakima, WA

Yakima Neighborhood Health Services (YNHS) received Health Care for the Homeless funding in 2004. Early on, the Health Center Board began conducting quarterly focus groups with consumers to gather feedback on services. In the first focus group, consumers asked for a place to go when they are sick which led to the development of a medical respite program. YNHS approached the local Continuum of Care (CoC), which they are a part of, for assistance in establishing the six bed program. YNHS has been able to access financial support for medical respite services by working with three local managed care organizations, funding through the CoC, and local support. They hope to benefit from the new the Washington State Medicaid Waiver as it rolls out. YNHS classifies medical respite as an emergency shelter and sees it as a bridge to supportive housing. Overall, about 70% of consumers exit to supportive housing.

#### Circle the City, Phoenix, AZ

Circle the City launched in 2012 as a freestanding medical respite center that later became a Health Care for the Homeless (HCH) program in 2015. Originally established by a Catholic Sister who is a physician and the HCH director at another local program who identified a gap in care for medically vulnerable patients experiencing homelessness, Circle the City's respite center has 50 beds and provides round the clock care to high acuity consumers. Circle the City's respite program has a \$3.6 million operating budget with funding from Medicaid, hospital contracts, grants, philanthropy, and locally supported events. To ensure that as many consumers as possible exit medical respite to some form of housing, Circle the City participates in coordinated assessment in their community and 80% of consumers exit medical respite to somewhere other than the street.

<sup>1</sup> <https://www.nhchc.org/resources/clinical/medical-respite/>

<sup>2</sup> <http://www.csh.org/supportive-housing-facts/introduction-to-supportive-housing/>

<sup>3</sup> <https://www.hudexchange.info/programs/coc/>

<sup>4</sup> <http://www.csh.org/toolkit/supportive-housing-quality-toolkit/community/coordinated-access/>

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## Population

Medical respite serves individuals who are homeless and medically stable enough to be discharged from a hospital setting but are too ill to recover on the street. Eligibility criteria is determined by each community, but individuals in medical respite typically require acute or post-acute medical care and have a higher level of need than individuals typically seen at a health center.

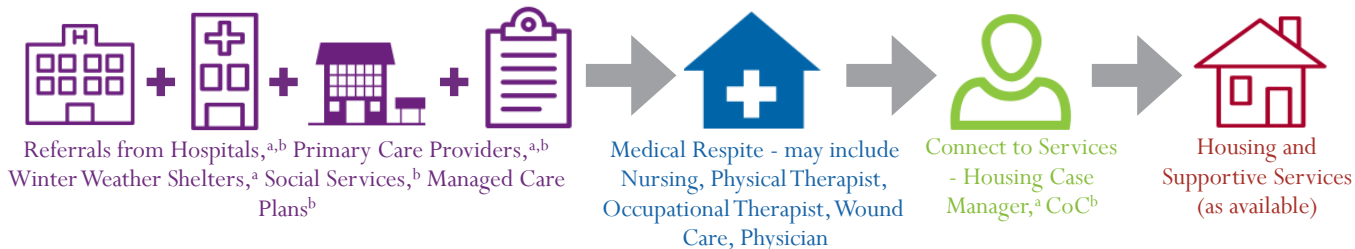


\* Includes those who temporarily can't access their housing due to medical need

<p><b>HRSA (UDS) Definition of Homeless</b>                  Patients who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and individuals who reside in transitional housing or permanent supportive housing.<sup>5</sup></p>	<p><b>HUD Definition of Chronic Homeless<sup>6</sup></b>                  To be considered chronically homeless, a person must have a disability and have been living in a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 months continuously or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months.<sup>7</sup></p>
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## Service Approach

Medical respite programs receive referrals from health providers when an individual is exiting care - in many cases this is discharge from the hospital, but it could also be from a primary care provider, social services provider, a shelter facility, or a health plan that is looking to prevent hospitalization. The hospital or other referring agency determines the medical need for respite and connects with medical respite staff to coordinate the discharge plan, including determining appropriate and necessary services. On discharge, individuals are brought to medical respite where their health care needs continue to be addressed and they can be connected to additional services. Both Yakima Neighborhood Health Services and Circle the City provide connections to housing navigators and the broader housing system. The length of stay in medical respite varies by program and consumer based on medical need, program capacity, and funder requirements. Upon discharge from medical respite, the goal is for individuals to be connected to primary care and housing. The staffing profile varies by program, but can include nurses, physicians, physician assistants, nurse practitioners, social workers and/or case managers. These individuals may be employed by the respite program or provide services through a partner agency. Additional partners may include behavioral health providers, housing navigators, occupational and/or physical therapists.

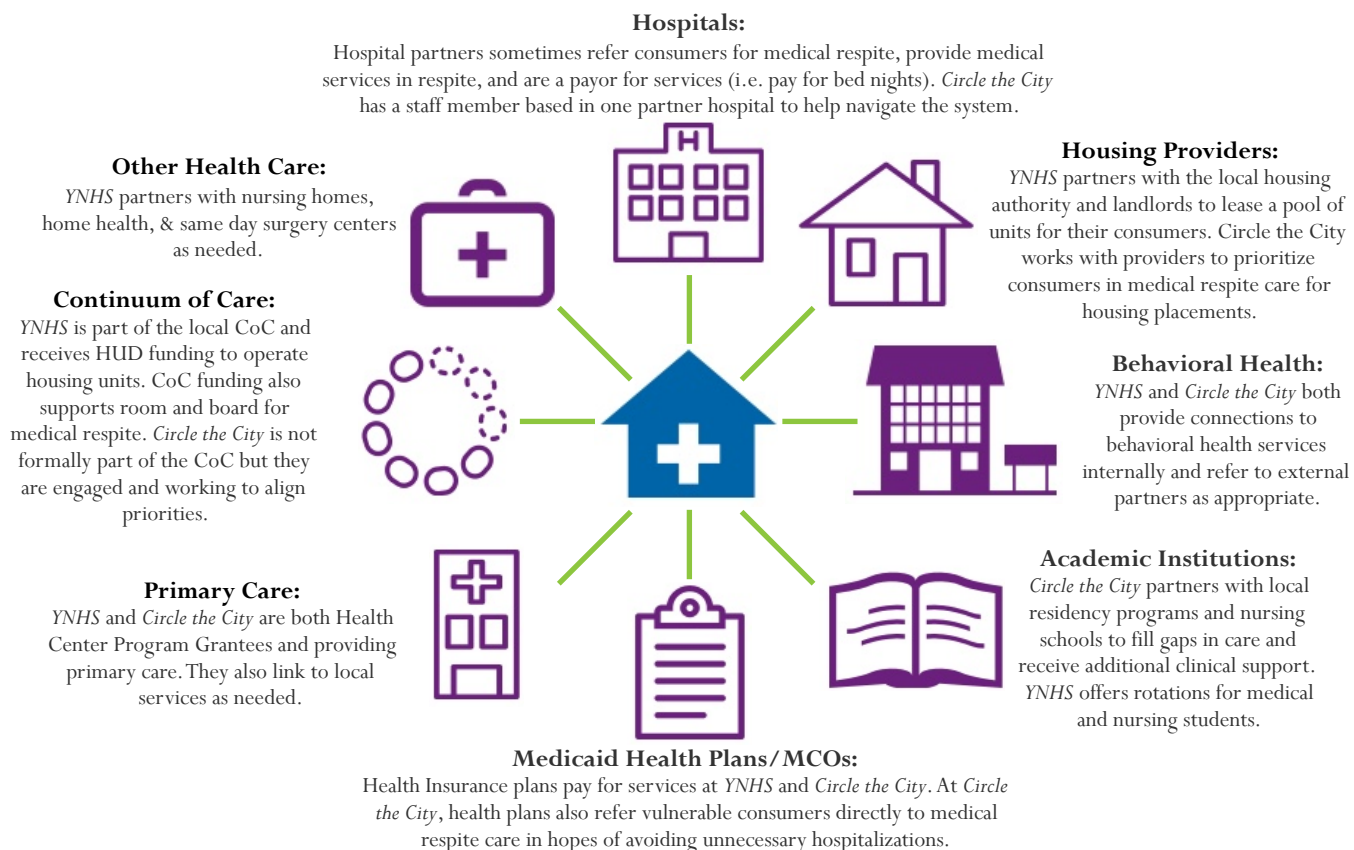


<p><b>Circle the City:</b>                  Staff engage the consumer at the hospital. When in medical respite, the individual sees the physician daily and nurses as needed throughout the day. Housing applications are started as soon as possible and never go untouched for more than 24 hours. If more permanent housing options are unavailable, consumers are connected to transitional housing options.</p>	<p><b>Yakima Neighborhood Health Services:</b>                  Staff focus on the transition from medical respite to supportive housing as soon as possible. There is a warm handoff to the Housing team and the medical respite nurse continues to provide services as needed. YNHS has also integrated consumer's HMIS identification numbers into EHR to compare housing and health measures.</p>
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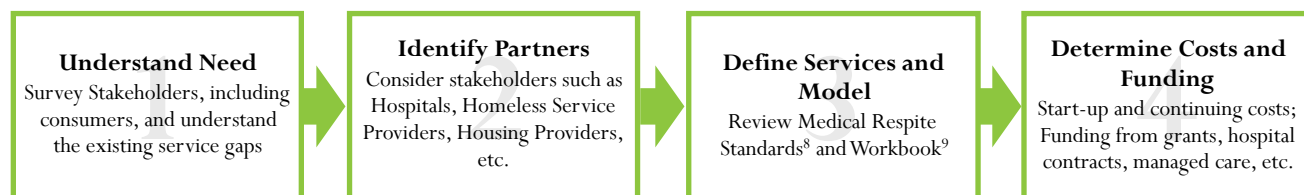
<sup>5</sup> [http://www.bphcddata.net/docs/uds\\_rep\\_instr.pdf](http://www.bphcddata.net/docs/uds_rep_instr.pdf)  
<sup>6</sup> The HUD Definition of Homeless includes individuals living in transitional housing.  
<sup>7</sup> <https://www.hudexchange.info/resource/4847/hearth-defining-chronically-homeless-final-rule/>  
<sup>a</sup> Yakima Neighborhood Health Services  
<sup>b</sup> Circle the City

## Partners

Medical respite programs vary in the types of partners they engage. In most cases one or more hospital partners are involved, as well as primary care providers to ensure a smooth transition to care.



## Getting Started



## Challenges & Opportunities

Implementing a medical respite program and developing strong cross-sector relationships between health and housing agencies is not without challenges. But expanding established relationships, aligning missions, and using data can overcome these challenges and a stronger, more coordinated system can emerge.

### Challenges

- Fragmented health & housing sector data
- Engaging hospitals in initial value conversation
- Negotiating length of stay based on medical and service need
- Insufficient downstream housing resources
- Establishing a common practice culture
- 24/7 care makes it difficult to replicate best practices like Trauma Informed Care and Harm Reduction

### Opportunities

- Community partner support that builds on established partnerships
- Support from State Medicaid by demonstrating the value of medical respite. The Arizona State Medicaid agency has endorsed *Circle the City* as an innovative care model.
- Demonstrating value to Managed Care Organizations opens up opportunities for financial partnerships.

<sup>8</sup> <https://www.nhchc.org/standards-for-medical-respite-programs/>

<sup>9</sup> <http://www.nhchc.org/wp-content/uploads/2011/09/Workbook.pdf>

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## About CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit [csh.org](http://csh.org) to learn how CSH has and can make a difference where you live.

## About NHCHC

The National Health Care for the Homeless Council is a network of doctors, nurses, social workers, consumers, and advocates who share the mission to eliminate homelessness. Since 1986 we have been the leading organization to call for comprehensive health care and secure housing for all. We produce leading research in the field and provide the highest level of training and resources related to care for persons experiencing homelessness. We collaborate with government agencies and private institutions in order to solve complex problems associated with homelessness. Additionally, we provide support to publicly funded health centers and Health Care for the Homeless programs in all 50 states. Visit [nhchc.org](http://nhchc.org) to learn more.

*"This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number # U30CS26935, Training and Technical Assistance National Cooperative Agreement (NCA) for \$325,000 with 0% of the total NCA project financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government."*



<sup>10</sup> <http://www.ynhs.org>

<sup>11</sup> <http://www.circlethecity.org>

## Impact

### Circle the City:<sup>10</sup>



80% Discharged to situation other than the street  
~25% to supportive housing



35-60% Reduction in emergency room (ER) & inpatient admissions 12 months after medical respite



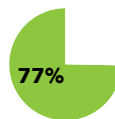
97% Transition to long-term primary care provider



Respite nurses have become certified in intravenous fluid maintenance and wound care to meet the needs of local homeless consumers.



72% Total cost reduction



77% ER cost reduction



36% Inpatient cost reduction

### Yakima Neighborhood Health Services:<sup>11</sup>

1

Out of 47 consumers served in 2015, there was only one hospital readmission within 30 days of discharge



70% Exit medical respite to supportive housing



To speed up the housing process, three YNHS staff have become certified housing inspectors, working in partnership with the city to meet needs.



Health center data pulled from the Electronic Health Record (EHR) shows that individuals in respite housing and supportive housing have health outcomes greater than or equal to the general HCH population when comparing selected diagnoses.

*"There was a man who was at the mission for about ten years on and off. He had worked in the fishing industry in Alaska and moved to Washington to work in the food industry. He lost his job and ended up at the mission. He didn't want to go to the doctor- he would always say 'I'm strong.' At one point he ended up in the emergency room multiple times because of shortness of breath. We convinced him to go to the doctor and connected him to the Heart Center for oxygen. He was diagnosed with Chronic Systolic Heart Failure and given 6 months. We brought him into medical respite and transitioned him to supportive housing. His health has improved to the point that they took their '6 month' label off."*

-Yakima Neighborhood Health Services



Respite Nurse at Circle the City  
Phoenix, AZ