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REFLECTIONS FROM THE NATIONAL HCH CONFERENCE: A NOTE FROM THE EDITOR

The debate over the national debt and the threat to entitlement and safety net programs has many of us biting our fingernails. With this cloud looming over our programs, you would think that homeless health care providers would be frantic or at least in a dark state of despair. But not a single provider or consumer was seen shedding a tear at this year's national HCH conference (except for our dear Executive Director who was distraught after being forced to play air-banjo during the conference reception). Instead, the current political climate seemed to amplify the camaraderie and energy of the nearly 800 people who gathered in Washington, DC.

Perhaps the most apparent display of camaraderie was at the medical respite pre-conference institute. A sea of individuals both new and seasoned to medical respite care could be seen trading business cards and making promises to connect. In addition to the shared stories and lessons learned gleaned during the introduction and coffee breaks, attendees participated in several presentations aimed at growing and sustaining medical respite programs. While those new to medical respite care attended a beginners session facilitated by national experts Sarah Ciambrone and Leslie Enzian (from the Boston and Seattle Medical Respite Programs, respectively), seasoned providers attended a series of panels aimed at enriching services in order to address a broader spectrum of needs.

Several medical respite workshops were offered during the days that followed. Perhaps the most memorable for this writer was the workshop presented by Joanne Guarino and Sal Salas, former consumers of the Boston and San Francisco Medical Respite Programs. During the workshop, Guarino and Salas shared their experiences and offered advice to providers. Guarino courageously described her journey into and out of homelessness. Temporarily shifting the mood in the room, Guarino offered a humorous anecdote involving canny attempts to hide from the medical respite discharge worker for three days in order to stay in the program. She then described her transition into housing from the program:"I was used to having people around me all the time. When I moved into housing, I was left with my own thoughts, which were dangerous for me. I was my own worst enemy." Guarino challenged medical respite providers to develop networking opportunities for people who are transitioning into housing. She championed leadership and volunteer opportunities for former program participants and applauded San Francisco for establishing a medical respite alumni group.

I would be remiss to not mention Sal Salas' presentation, which sparked a lively debate among the audience. Salas, who stayed in a shelter-based medical respite program, described discrimination by shelter staff, saying, "Shelter staff had rules for some residents, a different set for others, and then another set for themselves." He added, "We all need to be treated equally." Though we would hope that all providers act on egalitarian principles, it reminds us that we must work with our partners to ensure proper care and treatment in all settings.

This year's conference was one to write home about, or at least to write in an e-newsletter about. Presentations and workshop materials have been added to the **2011 Conference webpage**. Next year's conference in Kansas City promises to be just as energetic, educational, and thought provoking. I hope to see you there.

ORANGE COUNTY HOSPITALS REIMBURSED FOR THE COST OF MEDICAL RESPITE CARE

The California-based managed care organization, Medical Services Initiative (MSI), adopted a resolution this year to reimburse hospitals for the cost of medical respite care. Beginning last month, Orange County hospitals sending beneficiaries to a medical respite program can be reimbursed $150 per day for up to 6 days. MSI is not the first managed care organization to offer medical respite care for beneficiaries. CareOregon, a managed care organization based out of Portland, authorizes up to a 30-day stay at Central City Concern's Recuperative Care Program for eligible beneficiaries.

NEW STUDY COMPARES HOSPITALIZATION COSTS FOR HOMELESS AND HOUSED PATIENTS

A study based out of Toronto, Canada, compared data from 93,426 admissions at an academic teaching hospital over 5 years. The study found that homeless patient admissions cost $2,559 more than housed

patient admissions. For patients admitted for medical or surgical services, much of the expense was associated with days spent in the hospital, during which patients did not require the level of services provided in an acute care facility. The study is comparable to a New York study by Salit et al. (1998) which found an excess cost of $2,414 per admission for homeless patients. The study makes clear that, even with universal health care, people who are experiencing homelessness continue to have higher health care costs in part due to lack of alternative sites for recuperation. Medical respite programs are described as a potential avenue for reducing overall health care costs for homeless individuals.

Hwang, S.W., Weaver, J., Aubry, T., and Hoch, J.S. (April 2011). Hospital Costs and Length of Stay Among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services. *Medical Care*, 49(4): 350-354.

Salit, S.A., Kuhn, E.M., Hartz, A.J., Vu, J.M., Mosso, A.L.. (1998). Hospitalization Costs Associated with Homelessness in New York City. *New England Journal of Medicine*, 338(24): 1734-40.

CMS REMINDS STATES OF MEDICAID ELIGIBILITY OPTION FOR INDIVIDUALS INFECTED WITH TUBERCULOSIS

In an Informational Bulletin released June 16, 2011, the Centers for Medicare and Medicaid Services reminds states of the option to extend Medicaid eligibility to low-income individuals infected with tuberculosis (TB), with federal financial participation. This option was made available by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). At the time this provision was enacted, there had been a resurgence of TB across the country, particularly multi-drug resistant TB. States that elected this option provide certain outpatient services related to the TB infection. To date, Arkansas, California, Connecticut, Louisiana, Minnesota, New York, Oklahoma, Utah, and Wyoming have elected to include this option in their state Medicaid plans.

According the to the Centers for Disease Control and Prevention (CDC), **6.5%** of TB cases occur in persons who are experiencing homelessness or who are unstably housed.

MEDICAL RESPITE PROGRAMS PLAY A KEY ROLE IN IMPROVING CARE TRANSITIONS

In the May 2011 issue of *Respite News*, we described a new care transition program authorized through the Affordable Care Act. The Community-Based Care Transitions Program supports community-based organizations partnering with eligible hospitals to help Medicare beneficiaries safely transition between settings of care. Medical respite programs are encouraged to discuss this partnership opportunity with their local hospitals/hospital association. A recent article published in ***The Hospitalist***, a publication of the Society of Hospital Medicine, encourages hospitals to improve care transitions for indigent patients by partnering with medical respite programs.

NEW DISCUSSION FORUM FOR MEDICAL RESPITE PROVIDERS

A new discussion forum allows medical respite providers, advocates, and consumers to share information and lend support to their peers. The recently launched discussion forum is part of BHTalk, an online networking site developed by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Join BHTalk:

- Register at **www.BHTalk.org**
- Once your registration is processed, join the National Health Care for the Homeless Group
- Click on the medical respite discussion forum
- Read or respond to discussions or start a new discussion thread

Detailed instructions

NEW RCPN STEERING COMMITTEE MEMBERS

The RCPN Steering Committee is composed of RCPN members who help guide the medical respite activities of the National Health Care for the Homeless Council on behalf of the entire network. A call for nominations to participate in the RCPN Steering Committee was published in the January issue of *Respite News*. A slate of nominees developed by the RCPN Nominating Committee was announced and approved by RCPN members attending the 2011 Medical Respite Pre-conference Institute on June 22, 2011. We welcome our newest Steering

Committee members:

1.0579710144927536

Ed Dwyer-O'Connor, BS, RN Manager, Harborview Medical Center & Public Health Seattle & King County

Ed brings clinical and administrative expertise to the Steering Committee. After many years as a psychiatric nurse, he now serves as Manager of Downtown Programs at Harborview Medical Center and is overseeing the development of a 34-bed medical respite program in Seattle.

1.0597014925373133

Jennifer Nelson-Seals, MSHRM, Executive Director, Interfaith House, Chicago

Jennifer is the Executive Director at Interfaith House, one of the few medical respite programs based out of transitional housing. Her work has led to innovative collaborations and partnerships, including a role in the Chicago Health and Housing Partnership which received international recognition after a study published in the Journal of the American Medical Association (JAMA) reported increased housing stability when patients transition to permanent housing through programs such as hers.

1.05

Jessie Gaeta, MD, Medical Director, Barbara McInnis House, Boston Health Care for the Homeless Program

Jessie is the Medical Director at the Barbara McInnis House, the largest medical respite program in the United States. When not in the medical respite setting, she spends much of her time advocating for systems change in the state of Massachusetts. She is also a member of the Medical Respite Clinical Task Force which is developing clinical recommendations for the medical respite setting.

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The Respite Care Providers' Network develops and distributes *Respite News* with support from the Health Resources & Services Administration. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of HRSA or the National Health Care for the Homeless Council.