IMPROVING CARE TRANSITIONS FOR PEOPLE EXPERIENCING HOMELESSNESS

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Care transitions refer to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change.[1] While health reform has created a number of new initiatives, care transition for people who are experiencing homelessness is challenging due to lack of affordable housing and transportation options, poor health literacy, and limited social support. Additionally, while a number of evidence-based care transition models offer guidelines for care transition, most target older adults enrolled in Medicare; very few models have been tested for adults under the age of 65. This paper defines care transitions, describes health reform initiatives to systemize care transitions, explores various evidence-based care transition models, and offers practice and policy recommendations for improving care transitions for people experiencing homelessness.

DEFINING CARE TRANSITION

The formal definition of "care transition" addresses the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change. This may include the transition from the hospital to a primary care provider, home, or nursing facility.[2] For people experiencing homelessness, transitions can also involve medical respite programs, supportive housing, emergency shelters, and various other community settings.

Care transition differs from care coordination. **Care coordination** involves numerous providers who are dependent upon each other to carry out disparate activities in a patient's care. In order to carry out these activities in a coordinated way, each provider needs adequate knowledge about their own and others' roles and available resources and often relies on exchange of information in order to gain this knowledge.[3] **Care transitions** are a subpart of the broader concept of care coordination. Care transition models ensure that patients and their caregivers are able to understand and use health information and those patients are able to move seamlessly from one health setting or provider to another.

Care transition initiatives aim to improve quality and continuity of care while reducing costs related to hospital readmissions. Currently, most care transition initiatives focus on high-cost Medicare beneficiaries. Research looking at hospital utilization trends of Medicare beneficiaries attributes inadequate care coordination, particularly poor care transitions, as a contributing factor to higher-than-average hospital readmission rates for this population. While other high-cost populations, like people experiencing homelessness, would benefit from improved care transitions, hospital readmissions data for this population is limited.

BARRIERS TO CARE TRANSITIONS FOR PEOPLE EXPERIENCING HOMELESSNESS

Often patients transitioning from one health setting to another are in poor health, recovering from an illness or injury, or have a new diagnosis that requires ongoing self-management. Once discharged from an acute care setting, patients usually assume primary responsibility for following through with discharge instructions, accessing transportation to attend follow-up appointments, and relaying pertinent medical information to their next provider regarding changes to their health status. As such, continuity of care largely rests on patients' ability to adequately understand and follow through with care coordination and information sharing across settings.

For people experiencing homelessness, care transitions are wrought with obstacles often leading to an interruption in care and resulting in higher health care costs from readmissions and duplications in tests and services.

- ***Lack of housing.*** After hospital discharge, most patients and their caregivers are sent home with instructions to rest, complete a course of medication, keep wounds clean, etc. However, for people who live on the streets or in shelters, following such instructions is extremely difficult. Rest is compromised as shelters are generally closed during the day and, increasingly, laws prevent people from sitting or lying down in public places for extended lengths of time. Limited access to public restrooms creates challenges for people whose condition requires a frequent need for a toilet or regular wound care. Medication is often lost, stolen, sold or compromised if refrigeration is required. Additionally, instructions to follow specific diets are difficult when individuals must rely on free and inexpensive food. Indeed, patients who do not have immediate access to their primary care provider after a hospitalization are likely to arrive in poor health if they are not readmitted to the hospital first.

- ***Lack of transportation***. In a study of care transitions from hospital to shelter for people experiencing homelessness, 59% of those surveyed reported no post-discharge transportation plan. Many of the participants were particularly concerned about their safety when discharged after dark, particularly as they made their way to a shelter for the night or attempted to locate a safe place outdoors to rest.[4] Another study looking at substance use treatment barriers for patients with frequent hospital admissions, most of whom were homeless or unstably housed, found that patients who were referred to treatment programs after an acute hospital episode faced a number of obstacles in getting to treatment facilities on their own. For example, one provider noted that between one hospital and the nearest subway station, a patient must walk past 17 liquor stores.[5]

- ***Health literacy and cognitive impairment.*** Limited health literacy and cognitive impairment are more prevalent among people who have a lower socioeconomic status, including those experiencing homelessness.[6] Poor health literacy and cognitive impairments are contributing factors to poor self-management during the transition of care leading to adverse events and increased likelihood of hospital readmission.[7] Additionally, primary care providers may be dependent on the patient for information about the acute episode and hospital treatment. Unless a system of health information exchange is established, primary care providers are likely to receive fragmented and even inaccurate information from patients who may have limited health literacy or cognitive impairment that affected comprehension of discharge instructions.

- ***Transition to housing.*** Affordable and subsidized housing can take years to acquire depending on wait lists and housing requirements that must be met. Even when housing is available, the transition from street to housing can be challenging particularly when an individual has lived on the streets for a prolonged period. Once housed, individuals may feel isolated or guilty for having a home when their peers are still living outside. As such, some people may return to the streets or invite their peers to double up with them, thus risking problems with their landlords.[8] Other issues such as physical and behavioral health problems, loss of employment and inadequate financial management can result in housing instability. As such, care transitions for people experiencing homelessness must integrate practices that bolster housing stability which are not currently emphasized in existing care transition models.

- ***Lack of insurance.*** Nearly 65% of individuals experiencing homelessness are uninsured.[9] Lacking health insurance, patients are dependent on the hospital for any needed prescriptions or medical devices. Additionally, hospitals sometimes help uninsured patients get follow-up outpatient visits, often relying on volunteer or charity providers that may lack standardized processes for care transitions. In a study of healthcare professional views on care transitions, one medical specialist noted, "Anything that's not acutely addressed during hospitalization is subject to being foiled by lack of insurance."[10]

HEALTH REFORM INITIATIVES TO IMPROVE CARE TRANSITIONS

The Affordable Care Act creates a number of initiatives aimed at improving care coordination, with some initiatives specifically aimed at improving and systemizing care transitions across settings. While most of these programs offer incentives for participation, others, like the Hospital Readmission Reductions Program, include penalties for some hospital readmissions.

The Community-based Care Transition Program (CCTP)

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

The CCTP, launched in 2011, as part of the Partnership for Patients initiative, will run for 5 years. As of August 2012, 47 community based organizations (CBOs) have been selected to participate in the program.[11] The CBOs will be paid an all-inclusive rate per eligible discharge based on the costs of care transition services provided at the patient level (e.g., coaching, medicine reconciliation) and of implementing systemic changes at the hospital level (e.g., Project Boost, RED). CBOs will only be paid once per eligible discharge in a 180-day period of time for any given beneficiary.

The Hospital Readmissions Reduction Program (HRRP)

In its June 2007 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) attributed high hospital readmissions by Medicare beneficiaries to inadequate care transition at discharge from the hospital and recommended transitional care interventions.[12] Based on these recommendations, Congress included the Hospital Readmissions Reduction Program (HRRP) in Section 3025 of the Affordable Care Act.

Beginning October 1, 2012 the Centers for Medicare and Medicaid Services will reduce payment rates for all acute care hospitals that experience higher-than-average readmission rates for three conditions (heart attack, heart failure, and pneumonia). In FY 2013, the maximum payment reduction is 1 percent, 2 percent in FY 2014, and capped at 3 percent for FY 2015 and beyond. In FY 2015, the scope of conditions expands to include chronic obstructive pulmonary disease, coronary artery bypass grafting, percutaneous transluminal coronary angioplasty and other vascular conditions.

Physician Quality Reporting Initiative

Section 10331 of the Affordable Care Act requires that certain performance-related information on physicians and other professionals participating in the Medicare Physician Quality Reporting Initiative be made publicly available through the Physician Compare Web Site.[13] The Web Site is intended to provide Medicare beneficiaries with timely information about provider performance so that patients can select higher performing health care providers. The Centers for Medicare and Medicaid Services can also use this information for evaluating services and suppliers.

Assessments of continuity and coordination of care and care transitions are included within the list of measures that will be made publicly available through the Physician Compare Web Site. CMS is required to make this information available to the public no later than January 1, 2013 (related to information collected during the measurement period beginning January 1, 2012). By January 1, 2015, the Secretary of Health and Human Services will provide a report to

Congress regarding the website and may expand the program to other health care professionals. By January 1, 2019, the Secretary may establish a demonstration program to steer Medicare beneficiaries toward high quality clinicians.

Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office)

Section 2602 of the Affordable Care Act created the Federal Coordinated Health Care Office (FCHCO). The Office was established to ensure that duel eligible individuals get full access to the items and services to which they are entitled under the Medicaid and Medicare programs and to improve coordination between the Federal Government and States in the delivery of benefits for such individuals. The Affordable Care Act established eight goals for the Office, one of which is to ensure safe and effective care transition services. To do this, the Office provides technical assistance and support to States, health plans, physicians, caregivers and individuals. A list of initiatives and resources available through the Office is available on the FCHCO web site.[14]

State Option to Provide Health Homes for Enrollees with Chronic Conditions

Section 2703 of the Affordable Care Act created an option for states to make an amendment to their state Medicaid plans to provide health homes for Medicaid enrollees with certain chronic conditions. Among other services, health home services must include comprehensive transitional care, including appropriate follow up, from inpatient to other settings. States receive a 90% Federal Matching Assistance Percentage (FMAP) during the first eight quarters that the state plan amendment is in effect. After, States revert to their regular FMAP for health home services.

Medicare Shared Savings Program

Section 3022 of the Affordable Care Act created the Medicare Shared Savings Program in order to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. The program facilitates the development of Accountable Care Organizations (ACO), defined as groups of doctors, hospitals, and other health care providers who coordinate high quality care to their Medicare patients. ACOs must meet quality performance standards to receive shared savings under the Medicare Shared Savings Program. While care transition measures are not yet defined for the Medicare Shared Savings Program, CMS believes that assessing care coordination, and in particular care transitions, is an important aspect of evaluating the overall quality of the care furnished by ACOs.[15]

OTHER INCENTIVES TO IMPROVE CARE TRANSITIONS

Several other initiatives aim to improve care transitions. The **Comprehensive Primary Care Initiative**, made possible by the Affordable Care Act, is a multi-payer initiative fostering collaboration between public and private health care payers to help compensate for the costs of care coordination and care transitions by providing primary care practices with monthly payments of about $20 per Medicare beneficiary for the first two years of the demonstration and $15 combined with shared savings thereafter. This initiative is a limited demonstration project involving 500 primary care practices across seven markets.[16] The **Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration**, made possible by the Affordable Care Act, is a three-year demonstration program that pays health centers $6 per Medicare beneficiary per month after meeting certain health home requirements which include processes that would improve care transitions for health center patients admitted to hospitals. There are 500 FQHCs participating in this demonstration.[17] The **Multi-payer Advanced Primary Care Practice Demonstration (MAPCP)**, authorized by Section 402 of the Social Security Amendments of 1967 (as amended), pays $10 per month per Medicare beneficiary to practices in eight states that have been formally recognized as medical homes to cover the cost of services such as care transition planning.[18] The **Bundled Payments for Care Improvement Initiative**, made possible by the Affordable Care Act, aims to link payments for multiple services Medicare beneficiaries receive during an episode of care and align incentives for providers to

partner closely across all specialties and settings that a patient may encounter. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together. The Bundled Payments initiative will test both retrospective and prospective bundled payments.[19]
The Balancing Incentive Program, made possible by the Affordable Care Act, increases the FMAP to States that make structural reforms to increase nursing home diversions and access to non-institutional long term services and supports. States participating in this program are required to capture data related to care transitions.[20]

Hence, there are a number of initiatives, demonstrations, and evaluations in process to incentivize or otherwise identify promising practices in patient care that have an emphasis on quality of care across service venues. As models are more fully developed and more outcome data becomes available, broader policy changes are likely to be introduced to a wider set of service venues and patient groups.

CARE TRANSITION MODELS

Several care transition models are considered to be evidence-based (i.e., they apply the best available research findings); however, most of these models are designed for targeted populations moving from one specific setting to another. Nonetheless, all care transition models share common elements (see Figure 1). While an evidence-based care transition model for people experiencing homelessness is not currently available, some practitioners serving this population have carefully adapted existing models.[21] Only a couple of care transition models are considered to be appropriate for adults under 65; however, homeless service providers may find that models targeting older adults, particularly those transitioning to a nursing home or other supportive environment, might benefit those clients who are transitioning to medical respite care or supportive housing.

Figure 1

Elements for safe, effective and efficient care transitions

- Patient and caregiver training to increase self-care skills and activation (i.e., motivation to follow through with health care related activities or tasks)
- Patient-centered care plans that are shared across care settings
- Standardized, accurate communication and information exchange between transferring and receiving provider.
- Medication reconciliation and safe medication practices
- Transportation for health care-related travel
- Procurement and timely delivery of durable medical equipment (if needed)
- Formal hand-off procedures that ensure full responsibility between sending/receiving provider

Source: U.S. Department of Health and Human Services. (2011). Roadmap to better care transitions and fewer readmissions. Retrieved from www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html

Care Transitions Intervention (CTI)

CTI is an evidence-based model developed by Eric Coleman with a goal to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move *from hospital to home*. CTI uses a simple personal health record to facilitate cross-site information transfer, a discharge preparation checklist designed to empower patients before hospital discharge, and a "Transitions Coach" (usually a social worker or nurse) located in the hospital to help patients and their caregivers understand the personal health record and discharge preparation list. The Transitions Coach also conducts follow up visits to ensure health maintenance. The intervention is based around four pillars, or conceptual areas: medication self-management, ability to use and manage the personal health record, participation in follow-up appointments, and ability of the patient to recognize signs of worsening health and respond accordingly. CTI is widely used as it can be applied to a wide range of patient populations and free online training and tools are available and in the public domain.[22]

The Transitional Care Model

The Transitional Care Model is an evidence-based model developed by Mary Naylor and is designed to prevent health complications and rehospitalizations of chronically ill, elderly hospital patients by providing them with comprehensive discharge planning and home follow-up, coordinated by a master's-level "Transitional Care Nurse." The Transitional Care Nurse meets with the patient upon admission and conducts a comprehensive assessment of the patient's health status, health behaviors, social support, and goals; works with the patient and doctors to develop an individualized care plan; and meets with the patient daily to ensure that the patient is able to manage his/her health once discharged. Following discharge the nurse conducts periodic home visits (or scheduled phone contacts) to ensure that the patient is successfully managing his/her health. [23]

Better Outcomes for Older Adults through Safe Transitions (BOOST)

BOOST is an evidence-based model targeting high risk patients, particularly older adults. The model aims to improve the discharge process by reducing 30-day readmissions, improving patient satisfaction, improving flow of information across providers, reducing adverse events in high-risk patients through targeted interventions, and improving patient and caregiver preparation for discharge. Project BOOST, a training and technical assistance initiative designed by a national advisory board of recognized leaders in care transitions, offers communities tools and support for systemizing care transitions using the BOOST model. The model uses evidence-based interventions advocated by The Joint Commission, the National Quality Forum (NQF) and the Agency for Healthcare Research and Quality (AHRQ).[24]

Project RED (Re-Engineered Discharge)

Project RED, developed at Boston University Medical Center, is an evidence-based, patient-centered, standardized approach to discharge planning and discharge education. The intervention delineates roles and responsibilities among hospital staff, delivers patient education throughout the hospital stay, adopts a system of seamless information flow between the hospital team and primary care provider, and provides an easy to read discharge plan for the patient. Patients know at all times who is responsible for their care and how to contact them. In addition, patients receive a follow up call within three days of discharge. A Discharge Advocate (DA) coordinates the intervention, thus reducing information gaps and redundancies that can adversely affect patient care and costs. The DA position can be filled by a nurse, trained patient advocate, social worker, or other support personnel. The Joint Commission, with funding from AHRQ, assists hospitals in implementing the Project RED intervention. Currently 225 hospital organizations are deploying the RED intervention.[25]

Figure 2

Components of Re-Engineered Discharge

1. Ascertain need for and obtain language assistance.
2. Make appointments for follow up medical appointments and post discharge tests/labs.
3. Plan for the follow up of results from lab tests or studies that are pending at discharge.
4. Organize post-discharge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain and take them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis.
9. Assess the degree of the patient's understanding of the discharge plan.
10. Review with the patient what to do if a problem arises.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.
12. Provide telephone reinforcement of the Discharge Plan.

The Bridge Program

The Bridge Program is an evidence-based approach to transitional care recognized by the U.S. Administration on Aging. Bridge combines the evidence-based practices from Rush University Medical Center's Enhanced Discharge Planning Program with best practices from the Aging Resource Center Program (developed by Aging Care Connections). This social work-based approach helps older adults safely transition back to the community through intensive care coordination that starts in the hospital and continues after discharge to the community. Master's prepared social workers, called "Bridge Care Coordinators," coordinate post-discharge older adult care and integrate Aging Resource Centers (ARC) inside hospitals. The ARCs provide a dedicated space for older adults and their caregivers to explore community resources, health information, and caregiving materials, and to develop community care plans prior to discharge. The Bridge Care Coordinators acts as both the patient advocate and the connecting link between numerous silos of care surrounding the patient.[26]

State Action on Avoidable Rehospitalizations (STAAR)

STAAR was launched by the Institute of Healthcare Improvement (IHI) with the goal to reduce rehospitalizations by working across organizational boundaries and by engaging payers; stakeholders at the state, regional and national level; patients and families; and caregivers at multiple care sites and clinical interfaces (e.g., networks, initiatives). The STAAR initiative is grounded in a two-part strategy for reducing rates of rehospitalization. First, states participating in the STAAR initiative aim to improve transitions of care by having partners across the continuum of care problem-solve and co-design an efficient care transition system. Second, the STAAR initiative brings together state-level leadership to address systemic barriers to change. Currently, four states (Massachusetts, Michigan, Ohio, and Washington) are partnering with IHI to implement STAAR. As the work progresses, IHI will make programming and information available for other states, regions, or organizations across the continuum to learn from the initiative.[27]

Geriatric Resources for Assessment and Care of Elders (GRACE)

The GRACE model targets low-income seniors in order to optimize health and functional status, decrease excess healthcare use, and prevent long-term nursing home placement. The GRACE model integrates a geriatrics team within the primary care environment; implements in-home assessment and care management provided by a social worker and nurse practitioner team; uses extensive use of specific care protocols; utilizes integrated electronic medical record and a web-based care management tracking tool; and integrates affiliated pharmacy, mental health, home health, community-based, and inpatient geriatric care services.[28, 29, 30]

Guided Care

The Guided Care model was developed by the Johns Hopkins Bloomberg School of Public Health and uses a team-based approach consisting of a specially trained registered nurse, two to five physicians, and members of a primary care office staff. This team provides clinical services to a panel of 50 to 60 of the practice's older patients at highest risk of using health care heavily during the following year. For each patient, the "Guided Care Nurse" performs a comprehensive assessment at home, creates an action plan, monitors the patient, coordinates care and transitions across sites, uses motivational interviewing to promote patient self-management, provides caregiver support, and facilitates access to community resources.[31,32]

Figure 3

Information that should be provided across care settings includes:

1. Primary diagnoses and major health problems
2. Care plan that includes patient goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable)
3. Patient's goals of care, advance directives, and power of attorney
4. Emergency plan and contact number and person
5. Reconciled medication list
6. Follow-up with the patient and/or caregiver within 48 hours after discharge from a setting
7. Identification of, and contact information for, transferring clinician/institution
8. Patient's cognitive and functional status
9. Test results/pending results and planned interventions
10. Follow-up appointment schedule with contact information
11. Formal and informal caregiver status and contact information
12. Designated community-based care provider, long-term services, and social supports as appropriate.

Source: U.S. Department of Health and Human Services. (2011). Roadmap to better care transitions and fewer readmissions. Retrieved from www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html

Numerous care transition models are available, each offering different interventions to address transitional care gaps and reduce readmissions for certain populations. The Institute for Healthcare Improvement groups these models into three categories: improvements to existing processes in transitions in care, supplemental services during transitions, and effective patient and family engagement based on sound health literacy principles.[33] In order to determine the best model (or combination of models) for a targeted population, health care leaders will need to engage in conversations about existing transitional care gaps and assess the impact of the various interventions on targeted populations. Additionally, health care leaders will need to determine how best to align these robust care transition models with existing initiatives such as Patient-Centered Medical Homes which are already employing some transitional care elements.

The following recommendations offer some guidance to health care leaders who are beginning to think about opportunities to improve transitional care. While these recommendations are broadly applicable, they are especially relevant to efforts to improve care transitions for people experiencing homelessness, a population that is particularly vulnerable to interruptions in care.

RECOMMENDATIONS FOR PRACTICE

- ***Standardize the care transition process.*** Several models provide a starting point for standardizing the care transition process across settings. Outpatient providers should engage in a discussion with referring hospitals about their care transition process and opportunities to establish a standardized approach to implement across settings.

- ***Identify expectations for cross-site communication.*** Providers have different perspectives on how and when health information should be communicated as well as the kind of information that needs to be shared. Providers working across settings should engage in discussions to explicitly identify communication expectations and develop a cross-site contract specifying inpatient and outpatient responsibilities. The Department of Health and Human Services offers guidance for information that should be shared across care settings (see Figure 3); this guidance may provide a starting point for conversations.

- ***Develop strategies to align existing initiatives to improve transitional care.*** Primary care practices are engaging in a number of initiatives that integrate elements of safe, effective, and efficient transitional care. Consider how existing initiatives such as Patient-Centered Medical Homes and Meaningful Use of electronic health records can be used to optimize care transitions.

- ***Dedicate a staff person to act as a hospital liaison.*** Outpatient settings should assign one staff person to receive notification from hospitals about incoming referrals, coordinate timely information transfer, confirm that contact has been made with a mutual patient, and formally acknowledge that the organization is assuming responsibility for care. Having one staff person dedicated to coordinating care transitions will streamline communications and provides hospitals with a point of contact for cross-site communication.

- ***Increase accountability for care transitions.*** When developing a care transitions program, ensure that the hospital takes responsibility for patients until confirmation is received from the receiving health care provider or entity. Additionally, accountability should be established for care transition interventions such as medication reconciliation and patient education. Staff members involved in any aspect of a care transitions programs should receive comprehensive training on the goals of the program as well as roles and responsibilities of all who are involved.

- ***Ensure access to transportation.*** The care transition process is interrupted when patients do not arrive for follow-up appointments. Ensure that patients have transportation to and from the service point. Transportation provided by a health care entity is most effective since patients may have difficulty following directions if traveling on their own or may be tempted to use transportation vouchers for other purposes.

- ***Make sure patients know who is responsible for their care.*** Patients should know who is responsible for their care and how to contact them at any point during care transition. This information should be written down for them and also entered in the electronic medical record.

- ***Include care transition interventions that promote housing placement and stability.*** Transitional care models targeting people experiencing homelessness should include efforts to assist patients in accessing and maintaining housing so that health is not compromised by complications from living on the streets.

- ***Engage in continuous quality improvement.*** Standardized metrics should be established in order to guide continuous quality improvement and accountability. Established care transition measures are widely available and should be integrated into existing quality improvement efforts.[34, 35, 36]

- ***Explore opportunities to receive technical assistance and support for implementing a care transition program.*** Work with local and state health care coalitions and associations to facilitate conversations around systemic changes needed to facilitate effective and efficient care transitions across settings. Conversations can include opportunities to participate in care transition initiatives such as those described in this paper.

RECOMMENDATIONS FOR POLICY

- ***Expand more care transition programs to Medicaid beneficiaries.*** Most federal care transition programs target Medicare beneficiaries. Homeless and unstably housed Medicaid beneficiaries are also among the most costly health care utilizers, often due to fragmented care and lack of adequate care transition services. With many states considering Medicaid expansion to many of those earning at or below 138% of the federal poverty level, a significant number of people experiencing homelessness will become eligible for Medicaid benefits. CMS and state Medicaid agencies can create additional opportunities to engage communities in efforts to improve care transitions among this high-risk, high-cost population.

- ***Increase incentives for tracking housing status.*** Currently ICD-9 and ICD-10 codes are available for tracking and reporting homelessness; however, hospitals rarely use this code. HHS could establish incentives for hospitals to track housing status using the existing classification code. Additionally, future care coordination and care transition initiatives should require hospitals to track housing status in order to target and assess the impact of these initiatives for people experiencing homelessness.

- ***Support medical respite care programs.*** Medical respite care programs provide post-acute care and social services for homeless persons who are not sick enough to stay in the hospital but too sick to be on the streets. Medical respite programs are an ideal setting for patients to recuperate, complete a course of medication, receive patient education, and be connected to social services. Additionally, patients participating in medical respite programs are closely monitored and receive assistance in going to follow up appointments. There is a need for incentives to foster public and private partnerships to establish and sustain these critical programs.[37]

- ***Extend the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration to Medicaid beneficiaries and increase payments.*** Medicare beneficiaries make up less than 8% of the national FQHC patient base, but only 5% for Health Care for the Homeless grantees. At $6 per

Medicare beneficiary per month, payments may be insufficient to significantly benefit practice. Extending the demonstration to Medicaid beneficiaries would create a greater incentive for FQHC participation and target another population with similar risks. Payment rates should be increased to a level that allows for dedicated staff to manage care transitions. Many FQHC patients, particularly those who are homeless, have very complex health care, psychosocial, and socioeconomic needs that complicate the delivery of health home services, making it more time intensive and costly to serve this population.

CONCLUSION

People experiencing homelessness would benefit greatly from standardized and systemized care transition programs. While existing care transition programs have primarily targeted the aging Medicare population, models such as the Care Transitions Intervention (CTI) and Project RED, may be adopted for a broader population of high-risk patient populations. Models targeting aging Medicare beneficiaries who are transitioning to a nursing home or other supported living environment should be considered by homeless health care providers, as these models could be adapted to assist individuals experiencing homelessness who are transitioning into permanent supportive housing. A significant number of resources are available to organizations seeking support for improving care transitions for their patients. With new initiatives made available through the Affordable Care Act, new funding opportunities to support such initiatives are more widely available as well.

NOTES

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