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MEDICAL RESPITE PROGRAMS: A CRITICAL SERVICE FOR INDIVIDUALS EXPERIENCING HOMELESSNESS

KEY POINTS

- Medical respite programs (MRPs) offer a safe transitional space for people experiencing homelessness who have been in acute or post-acute care, but who are too frail to be discharged to the street or shelter. However, the services offered vary across programs based on factors such as staffing, funding sources, and external partnerships.
- Newer Medicaid financing opportunities under Section 1115 demonstrations have made it possible for states to cover health-related social needs to enable beneficiaries to maintain access to health care. These can include respite, post-respite services, and nutrition services, but these opportunities are still limited to a small number of states (CMS, 2024).
- At present, MRPs do not consistently track and report data, such as on participant demographics or outcomes. This makes it difficult to assess on a national level who participates in these programs, where they are discharged to, and what health or supportive services they seek after discharge.
- Outcomes can be assessed using claims and encounter data, but programs often cannot or do not systematically track housing status after discharge.

BACKGROUND

People experiencing homelessness often have complex health care and social service needs which present significant care challenges to hospitals, such as longer lengths of stays, higher readmission rates, and complicated chronic illnesses. Mental health or substance use disorders (SUDs) and unmet social needs often exacerbate these challenges (Kushel, Vittinghoff, & Haas, 2001; Wadhera, et al., 2019). People experiencing homelessness who have medical or behavioral health conditions tend to make frequent visits to emergency departments, which contribute to the high health care costs commonly incurred among this population (Koh, et al., 2020; Ku, et al., 2010). Transitions from emergency department visits or hospital inpatient stays can be a dangerous experience for people experiencing homelessness, as they tend to lack a safe space to recuperate. Since the 1980s, more than 100 medical respite programs (MRPs) have been developed in the United States to address this gap in transitional care to help people experiencing homelessness recover from acute care stays in a safe and supportive environment before returning to the community (Stevens, 2023). At present there are 152 MRPs located in 40 states and the District of Columbia (NIMRC, 2023).

As defined by the National Institute for Medical Respite Care (NIMRC) at the National Health Care for the Homeless Council (NHCHC), medical respite care, also referred to as recuperative care, is "acute and post-acute care for people experiencing homeless who are too ill or frail to recover from an injury on the streets or in a shelter, but who do not require hospital-level care.” These programs provide an alternative to delaying discharge of people experiencing homelessness from hospitals or discharging them to ill-equipped shelters or the street. Medical respite care thus enables them to recover in a supportive environment for the necessary duration, which may vary from a few weeks to several months. As catalogued in the NIMRC's directory of medical respite care, MRPs differ in scope based on local needs and available resources, and they are offered

in diverse settings such as shelters, apartments, hotels/motels, and transitional housing. Various entities, including non-profit organizations, health centers, hospitals, and government agencies, sponsor and support these programs.

There is a strong body of evidence on the need for and effectiveness of MRPs, as synthesized by the NIMRC in its 2021 literature review (NIMRC, 2021b). The key findings of this review were that MRPs were heterogeneous in organizational structure, associated with positive health outcomes, filled a gap in the continuum of care, and were valued by consumers. Under contract from ASPE, Mathematica and the subcontractor Mission Analytics built on the work of NIMRC. This issue brief supplements that review with studies that have been published since its release. Additionally, this brief adds to the existing literature through key informant interviews. The Mission Analytics team conducted interviews with ten staff from six MRPs, one of whom had been a participant of a Medical Respite program themselves. In addition, the Mission Analytics team conducted interviews with four staff from four Medicaid managed care plans (MCPs), which play an increasingly large role financing medical respite services.

REVIEW OF THE LITERATURE SINCE 2020

We identified seventeen documents published since 2020 on the topic of medical respite care, including six peer-reviewed articles. Findings from this literature were consistent with those from earlier studies, illustrating the significant need for MRPs: people experiencing homelessness tend to have longer hospitalizations and a lack of appropriate discharge options, and MRPs can reduce the time spent in hospitals, the use of emergency departments, and readmission rates (NIMRC, 2021b). Common conditions among MRP participants, including those precipitating need for medical respite care, include heart disease, diabetes, post-operative and peri-procedural care, mental health and/or SUDs, traumatic brain injury, and wound care, as well as comorbid chronic illness (Biederman, et al., 2022b; Lawson, Bowie, & Neufeld, 2021).

Per both the NIMRC review and our own review and interviews, MRPs have shown promising results in promoting improved recovery, reducing care costs, hospital admissions, and emergency department visits, and preventing returns to homelessness (Doran, et al., 2013; Biederman, et al., 2022a; NIMRC, 2021b; Lawson, Bowie, & Neufeld, 2021). One study examining cost effectiveness of a MRP in Durham, North Carolina found that, compared with their counterparts who did not utilize MRPs, participants had reduced health care costs and utilization for ongoing medical needs. The findings suggest that medical respite services improve both health and financial outcomes for those who receive them, despite often having complex additional health needs (Biederman, et al., 2022b).

Information on participant demographics is limited, given the lack of consistent data collection and reporting among existing MRPs. In a two-year pilot MRP, the 29 participants were predominantly Black, non-Hispanic, and male, and the average age of participants was approximately 47 years of age (Biederman, et al., 2019). In another, longer-term pilot MRP implemented in the same county, the 125 participants were also predominantly non-Hispanic Black and male, but they had a slightly higher average age of 51 years (Biederman, et al., 2022b). We identified no other United States-based studies with demographic information, highlighting the need for improved data collection and reporting by MRPs.

FINDINGS FROM KEY INFORMANT INTERVIEWS

Four main themes emerged from key informant interviews: variation in program design, variation in program financing, barriers to securing post-respite long-term housing for participants, and the impact of the public health emergency related to COVID-19. For full descriptions of the programs and findings from the interviews, see the ***Appendix B***.

Variation in Program Design

MRPs provide a wide array of services that address both medical needs and health-related social needs (HRSNs), such as nutrition services, transportation, and caregiver support. All key informants report doing so by taking a holistic, person-centered approach. Discussions with MRP staff and participants emphasized the importance of creating environments where participants can not only rest but feel safe and supported by those who care for them and whom they trust. Participants can especially benefit from MRPs adhering to the tenets of trauma-informed and person-centered care. More broadly, programs should acknowledge and work to overcome the mistrust and trauma that unhoused individuals often bring to their encounters with health care (Canham, et al., 2020).

Based on our interviews, MRPs tend to have two primary goals: addressing needs that program participants have in respite and connecting them to housing and services post-respite that will allow them to live healthy lives in stable housing arrangements. However, programs vary in structure, staffing, and ability to meet certain care needs, which can result in different participant makeup, service provision, and outcomes. For example, some programs require that participants have the capacity to perform activities of daily living like bathing and dressing. Other programs cannot adequately accommodate the behavioral health needs of unhoused individuals, which may be intensive. Interviewees reported that this was largely due to not having respite care staff onsite past business hours (e.g., Sojourner House, House of Charity).

Variation in Program Financing

To open and operate, MRPs depend on a mixture of public and private funds (NHCHC, 2017). Program staff we interviewed highlighted Medicaid, Federally Qualified Health Centers (FQHCs),[i] other governmental funds (local, state, and federal), and payments from hospitals or hospital systems as especially beneficial. While they repeatedly praised their partnerships with funders, the MRP staff we interviewed simultaneously expressed reservations about relying too heavily on funding streams that either invite stiff competition from other programming, such as hospital community benefit funds, or are subject to cuts in cases of economic downturn, such as city and county funding. Interviewees pointed out that uncertainties associated with these types of funding streams can make it difficult to conduct long-term financial planning.

Medicaid and Managed Care Plans

Medicaid funding for medical respite care currently serves an important role in making those programs viable and Medicaid plays a growing role in funding these services through Section 1115 demonstrations. Several states have started to cover HRSNs, including housing-related services and supports and medical respite, through Medicaid 1115 demonstrations (McCarthy & Waugh, 2021; NHCHC, 2022).

States often deliver benefits through Medicaid managed care plans (MCPs). The role that Medicaid MCPs play in financing medical respite care and housing services is still evolving (NHCHC, 2022). In some states, this role is growing; however, challenges remain, such as the siloed nature of medical and homelessness systems. As one former Medicaid MCP staffer noted, "Homeless services tend to be funded with homeless system dollars, which are flexible but scarce, while managed care focuses primarily on issues that are more clearly medical. The systems that know an immense amount about our physical health know nothing about our housing status."

[i] According to the federal Health Resources and Services Administration, FQHCs deliver comprehensive, culturally competent primary care, along with supportive services such as transportation; charge for services on a sliding fee scale; provide integrated, person-centered care that meets the needs of underserved areas and populations. FQHCs can be reimbursed for services to Medicare and Medicaid beneficiaries

As part of program integrity requirements, Medicaid MCPs establish policies for participants' level of need and authorization for medical respite services. In many cases, individuals must have a specific kind of need, like wound care or long-term intravenous antibiotics.

One of the major barriers to financing reported by Medicaid managed care informants is a lack of certification for MRPs, which leads to variability among programs and, consequently, greater complexity and variation in contractual negotiations between Medicaid MCPs and individual programs. As one Medicaid MCP staffer interviewed succinctly phrased it, "When you've spoken to one medical respite program, you've spoken to one medical respite program." The NIMRC standards provide a good starting point, but NIMRC does not certify programs or provide a "seal of approval". One Medicaid MCP staffer suggested that MCPs should require that medical respite providers comply with NIMRC standards and demonstrate evidence of that compliance.

Partnerships: Federally Qualified Health Centers and Shelters

Some MRPs are operated by or partner with FQHCs and/or shelters. This both creates additional funding opportunities and may decrease siloes across medical and homelessness systems, though gaps in funding persist (NIMRC, 2021a; Wang, et al., 2021). These gaps differ based on which partnership is in effect. MRPs that partner with or are operated by FQHCs (e.g., The Boulevard, Stout Street) are often better situated to provide a broader range of services to program participants, such as primary care services, psychiatric and health assessments, outpatient treatment, and Medication Assisted Treatment (MAT) to individuals with SUD. Additionally, these MRPs' services can largely be covered by the FQHCs Medicaid-provided bundled payment, which can be used to pay for the provision of comprehensive care to patients. However, these funds, which are provided through the Medicaid Prospective Payment System, cannot be used for housing or housing-related services; this leaves MRPs with a gap in paying for room and board (NIMRC, 2021a).

Conversely, according to key informants, MRPs that partner with or are co-located in homeless shelters tend to have stronger relationships and increased funding opportunities for covering room and board and facilitating participants' transitions to housing or other long-term shelter options. These MRPs, however, must seek funding for medical and health-related services, as well as medical respite staff, from other avenues (NIMRC, 2021a). Mission Analytics interviewed MRP staff at a shelter-based site (House of Charity) who also noted that respite services can put more pressure on the non-medical or non-respite shelter staff, as medical respite staff are not on site after close of business hours.

Other Sources and Local, State, and Federal Funds

According to key informants, one of the most reliable mechanisms for funding is to have services covered by being an FQHC or for the MRP to partner with one. In addition, many programs provide Medicaid-covered services. Beyond FQHC funding and Medicaid-covered services, the MRPs whose staff we spoke with depend on a range of additional governmental and non-governmental funding sources. These sources may include grants from private and philanthropic organizations, hospitals and health systems, public health departments, and governments (NIMRC, 2021a; NHCHC, 2017). Each of these sources has shortcomings. Grants tend to provide short-term funding and applying for grants requires significant time and resources. These factors can prevent MRPs from scaling up and developing long-term, sustainable program plans (NIMRC, 2021a).

Grant funding remains a predominant source of funding. Local and state governments for example, may provide annual need-based grants. Federal funds may provide longer-term financial opportunities, but, depending on the source, the type of services that can be funded varies greatly. For example, staff at The Boulevard noted that government funding mostly goes toward transitional or interim housing and less toward medical respite services.

Hospital and health systems often fund MRPs. Staff noted this funding is especially valuable because it is so flexible; however, hospital-provided funds, particularly those offered through grants, are in high-demand among MRPs and other community-serving programs. Because of the competition for these funds, MRPs cannot rely on this source of funding alone. Philanthropic and private institutions may also offer funding opportunities with great flexibility, but even with these sources MRPs are likely to face similar challenges of competition, resources and time used to obtain funding, and short-term funding options (NHCHC, 2017).

In sum, financial stability is a challenge for MRPs. Most programs need to braid funding sources, some of which are scarce or subject to contraction in economic downturns; or which may not be available indefinitely such as hospital subsidies.

Connecting Clients to Long-Term Housing

All programs reported working as quickly as possible to help participants find an appropriate form of housing post-respite, which might include shelters, interim housing, subsidized housing without services, or permanent supportive housing (PSH). All staff were emphatic about the challenges of finding housing arrangements, including long wait lists for housing vouchers and a growing affordability crisis in most parts of the country (Technical Assistance Collaborative, 2020).

Our key informants described several barriers to connecting participants with post-respite housing. They highlighted long waitlists for housing vouchers; a severe shortage of affordable housing, particularly for individuals who have Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) income; and a mismatch between the location of affordable single room occupancy (SRO) unit and necessities such as transit and groceries. They also explained strategies MRPs use to overcome and circumvent these barriers. For example, MRP staff may start coordinating housing shortly after participants have arrived at the MRP to accommodate for long waitlists or use dedicated vouchers and housing pools to bypass public housing authority wait lists. Some programs are able to co-locate interim housing or shelter beds with the MRP. If temporary or permanent housing cannot be secured in time, MRPs may have to discharge participants to a shelter, recognizing that it is safer than being discharged back to the streets.

Impact of COVID-19

The to multiple key informants, the public health emergency related to the COVID-19 pandemic had a marked impact on MRPs. Isolation and social distancing requirements reduced the census in many MRPs, and programs incurred additional costs such as air purifiers and surveillance testing, the latter of which was often covered as a lab cost. Community rooms were shut down. Methadone deliveries had to be made on site, and it was hard for people with poorly managed mental and behavioral health issues to remain in quarantine.

At the start of the pandemic, Colorado Coalition for the Homeless helped Denver open a 700-bed congregate shelter at the National Coliseum, where the Coalition already had a clinic. They ultimately managed the homelessness response not only for Denver but for all surrounding counties. In Chicago, the COVID-19 pandemic caused the census at The Boulevard to decrease from 65 to 45; though this began to increase following the formal end of the public health emergency. Housing Forward in Chicago worked with Cook County Health to set up the RISE Center as a hotel-based COVID-19 respite setting (Wang, et al., 2021).

Staff from several MRPs noted that addressing the COVID-19 pandemic led to improved relationships with local hospital systems. Before the vaccines were widely distributed in mid-2021, hospitals were often overwhelmed with COVID-19 cases. MRP staff we interviewed noted that hospitals viewed MRPs as a "relief valve" for individuals experiencing homelessness, many of whom required care for acute needs in addition to or distinct from COVID-19. Addressing the COVID-19 pandemic also gave programs an opportunity to work with new community partners.

In the early days of the COVID-19 pandemic, global disruptions to medical care and housing, and the need to isolate and socially distance, made it difficult to provide unhoused individuals with medical respite. In some cases, partners of many different kinds -- city and county governments, health departments, and MRPs -- came together to minimize these barriers with a coordinated, whole-of-system response that simultaneously took pressure off hospitals and provided unhoused individuals with acute care needs with a place to recuperate and avoid new infection or injury.

CONCLUSION

Medical respite services for people experiencing homelessness are not yet widely available. Many communities do not have any MRPs, and among those that do, these programs are also still fairly novel. Additionally, MRPs are not yet standardized. NIMRC and the Respite Care Providers Network have created program standards to help guide MRPs to operate safely and seamlessly with local health care systems. (NIMRC, 2021c) However, there is still considerable variation between MRPs in terms of the services they offer, the populations they serve, and the funding arrangements they depend on. The experiences described by key informants suggest that MRPs can improve their effectiveness, replicability, and scalability by sharing best practices, establishing, or expanding data collection, and promulgating standards of program evaluation. Sharing best practices and establishing standards for the collection of data on participant demographics and outcomes would enable MRPs to improve their services through a feedback process. Additionally, increased data collection on costs could help determine whether there is a business case to be made for MRPs. Although the literature indicates that MRP participants have reduced hospital use and costs, there is limited research regarding whether these programs lead to cost savings for hospital systems or communities. Learning more about these financial outcomes could incentivize more communities and systems to implement MRPs.

Though not yet the standard, in communities with MRPs these programs fill a critical gap in the continuum of care for people experiencing homelessness. The medical and behavioral health services MRPs offer help people experiencing homelessness regain and retain their health in a safe environment. As one Medicaid MCP staffer put it, “Nobody goes straight from the hospital -- from acute care -- and goes right to work. Nobody does that! Everybody has to go home and recuperate.” Simultaneously, MRP case management can facilitate connections to resources and benefits and offer a pathway to permanent housing.

As more states implement Medicaid 1115 demonstrations covering HRSNs, there may be more opportunities for communities and for homelessness and health care systems to stand up MRPs. Continuing to recognize the benefits of MRPs while addressing current challenges, is critical to improving existing programs and to ensuring new programs’ effectiveness and capacity (Shetler & Shepard, 2018).

APPENDIX A. KEY INFORMANTS

We interviewed staff at seven MRPs operated by six entities; we chose them in part for their geographic diversity and in part for the variation in funding streams they depend on. We also interviewed staff from four Medicaid MCPs. Information about their affiliated organizations is listed in ***Table A1***.

Table A1. Key Informant Organizations		
Type of Entity	**Name**	**Location/Coverage**
Medical Respite Programs (MRPs)	Stout Street Recuperative Care Center (Colorado Coalition for the Homeless)	Denver, CO
	Sojourner House and the RISE Center (Housing Forward)	Oak Park, IL
	The Boulevard	Chicago, IL
	Durham Homeless Care Transitions	Durham, NC
	House of Charity (Catholic Charities Eastern Washington)	Spokane, WA
	Edward Thomas House (Harborview Medical Center)	Seattle, WA
Medicaid Managed Care Plans (MCPs)	CalOptima Health, a county-organized health system	Orange County, CA
	Community Health Plan of Washington	Statewide coverage
	United HealthCare Services	Western Washington State
	Aetna Better Health of Illinois	Statewide coverage

We asked both groups a similar set of questions about financing, sustainability, and partnerships; the services and post-respite housing coordination they provide in respite care; outcome tracking; and the impact of COVID-19 on their programs (in the case of MPRs) or partnerships (in the case of Medicaid MCPs). All MRPs serve single individuals above the ages of 18 or 21 -- though they vary in the level of need they can safely accommodate, as discussed in ***Appendix B***.

APPENDIX B. PROGRAM EXAMPLES

Stout Street Recuperative Care Center (Colorado Coalition for the Homeless)

https://www.coloradocoalition.org/respite
Denver, CO

Stout Street, a single-building 75-bed facility, offers robust case management and peer support, along with peer-led recovery programs and MAT to administer medications such as suboxone that help manage opioid use disorders. The Coalition is currently adding services that address a broad range of HRSNs, including exercise and yoga classes. It operates a justice, equity, diversity, and inclusivity committee to ensure that participants of all backgrounds and life experiences feel comfortable in the program, with services and care planning that address their individualized needs. The Coalition will only partner with organizations that are explicitly person-centered and trauma-informed. Staff work to ensure that people are reunited with family or friends, as such connections often increase the long-term stability of the individual's health and housing situation; they reported success in 15-20% of cases.

Colorado Coalition for the Homeless (Colorado Coalition), which operates the Stout Street Recuperative Care Center (Stout Street), is an FQHC that sees roughly 16,000 patients a year. Colorado Coalition provides a range of services including primary care services, psychiatric and health assessments, outpatient treatment, and MAT for SUDs. Enhanced federal FQHC funding helps Stout Street offer their participants a comprehensive set of physical and behavioral health services. Importantly, however, other services are not reimbursable under the FQHC model, including most housing-related services, such as housing navigation, transitional housing, and PSH, all of which must be funded with different sources.

In Colorado, the Department of Health Care Policy and Financing (HCPF) has partnered with the University of Colorado School of Medicine to provide one year of grant funding to Ascending to Health, an MRP in the Pikes Peak Region south of Denver. This exploratory grant will inform the development of a broader Medicaid funding of medical respite, which would eventually benefit Stout Street and other programs in the state. An immediate benefit to the Coalition has come in a grant from HCPF for 30 PSH vouchers targeted at "high utilizers" of Medicaid services, a group of people for whom stable, affordable housing with services may bring the most benefit; the grant will help those participants at the Coalition bypass a wait list that can run between 12 and 18 months, leaving them erratically housed or unhoused altogether. The Coalition has also been working with HCPF to help shape its Hospital Transformation Program, which will penalize hospitals for high readmission rates and avoidable medical problems of the kind that increase the demand for medical respite care and make providing such care to more challenging.

Financing: Colorado Coalition's startup costs for Stout Street were covered by a mixture of New Market Tax Credits and an agreement with the city of Denver to rent the land on which their building sits for 99 years for $1, and it receives grants from Kaiser to help cover ongoing costs.

Sojourner House and the RISE Center (Housing Forward)

https://www.housingforward.org/programs/medical-respite
Oak Park, IL

Housing Forward operates two MRPs in Oak Park, Illinois. Sojourner House is a "five-flat" house divided into apartments with onsite laundry. Because the program is not staffed 24/7, it requires that people can live independently and do not have intensive behavioral health needs. Case managers visit seven days a week. Participants can receive all their services onsite. The Chief Medical Officer of a nearby hospital provides primary care visits onsite. Staff also help arrange transportation to doctor's visits for those who need it. Housing Forward works to connect participants to the Supplemental Nutrition Assistance Program, with frozen meals from a hospital cafeteria brought onsite for participants to heat up.

Housing Forward launched the Recuperation in a Supportive Environment (RISE) Center in December 2020 as a hotel-based emergency shelter to give unhoused people a place to socially distance or isolate after an acute care stay during COVID-19. Housing Forward's main partner at RISE is Cook County Health, meaning they can accept referrals from any suburban hospital in the county. Housing Forward provides nutrition services. RISE Center is staffed 24/7, with certified nursing assistants working overnight, allowing the program to accommodate participants with more intensive needs. Pre-packaged "to go" meals are provided for breakfast and lunch and a full meal for dinner. For participants in both facilities, Housing Forward applies a harm reduction model and provides transportation as needed to methadone treatment, along with referrals to mental health support groups, Alcoholics Anonymous, and Narcotics Anonymous. In describing Housing Forward's approach to delivering person-centered services, one staffer said, "We try to train staff around understanding diversity, beyond the 'usual suspects' of race and gender, but the entire span of diverse people who may come to us."

Connection to post-respite housing: At Sojourner House, the process of finding permanent housing begins on day seven. Housing Forward has its own housing pool, with 165 landlords as partners in the Greater Chicago Area, making them the largest supplier of permanent housing in suburban Cook County. The RISE Center also offers interim housing, for which dedicated vouchers are available. As a person-centered practice, Housing Forward does its best to match people to housing circumstances that feel comfortable to them. For example, many individuals recovering from SUD prefer not to return to areas where they previously used, as they might be tempted to begin using drugs again.

Financing: In Illinois, Housing Forward, which operates Sojourner House and the RISE Center, has received money from the state under the American Rescue Plan Act (Public Law 117-2).

The Boulevard

https://www.blvd.org/
Chicago, IL

The Boulevard partners closely with an FQHC, the PCC Community Wellness Center (PCC). The Boulevard can thus provide a range of services to participants, including primary care services, psychiatric and health assessments, outpatient treatment, and MAT for SUDs. Enhanced federal FQHC funding helps The Boulevard offer their participants a comprehensive set of physical and behavioral health services.

Staff at The Boulevard use evidence-based practices in trauma-informed care and harm reduction. To help make the care they deliver more person-centered, they gather feedback from participants during respite and in exit interviews regarding effectiveness and ideas for changes or improvements. In addition, The Boulevard provides population-specific programming for individuals with HIV/AIDS and has beds reserved for veterans.

Connection to post-respite housing: At The Boulevard, staff often refer individuals directly to the Flexible Housing Pool, a set of living units funded by community stakeholders and developed in coordination with Cook County Health and the City of Chicago. The Boulevard's partner, PCC, supports medical respite participants in documenting their disabilities so they can be prioritized for housing once they are on a wait list. The Boulevard also serves about 300 people already connected to PSH, with wraparound case management and other services. When participants receive SSI or SSDI, staff try to connect them to affordable housing -- though affordable units are increasingly difficult to find. Staff also try to help individuals "upskill" so they can secure an income that is sufficient to let them afford a SRO unit. Moving to an SRO can pose new challenges, though; staff noted that many SROs are not near transit, groceries, and other necessities.

At The Boulevard, fewer than 30% of participants exit immediately to a long-term housing arrangement, while others exit to temporary housing. The program staff work hard to not discharge participants to the street, with some staying four months or longer to avoid this. The program has not previously assessed outcomes, but staff are preparing to do so after developing a strategic plan. At the time of this report, there is no scheduled follow-up with previous participants, although some government funders have asked them to track whether people are still housed 6-12 months after discharge. Their internal goal is 85% remaining housed, but they do yet have the systems in place to verify whether that goal is being met. One problem, as staff at other programs have noted, is that unhoused individuals are difficult to contact, and few actively stay in touch.

Financing: At The Boulevard, half of all revenue comes from government funds, including the U.S. Department of Housing and Urban Development, the U.S. Department of Veterans Affairs (VA) and the Chicago Department of Public Health. The other half comes from Medicaid MCPs (including Aetna Better Health) and hospital systems, along with philanthropy. Government funding mostly does not support The Boulevard's medical respite services, but instead supports transitional or interim housing. The Boulevard has contemplated forming a coalition with other medical providers to negotiate the cost of goods and services; staff also plan to explore ways to have more of the services they receive from PCC (their partner FQHC) covered completely. With the VA, The Boulevard has a per diem contract for a small number of beds; that contract is administered through the VA's Jesse Brown Medical Center as part of their Hospital to Housing program.

Durham Homeless Care Transitions

https://projectaccessdurham.org/projects/dhct/
Durham, NC

Durham operates a scattered site model (multiple units in non-adjoining buildings) using mostly sober houses with 4-6 beds. Durham's main services include primary, specialty, and mental health care, along with SUD treatment, home health for intravenous (IV) lines (e.g., for long-term antibiotic therapy), wound care, and physical and occupational therapy. Staff also help participants connect to benefits for which they might be eligible. Before participants exit respite, staff ensure they have phones to keep them connected to their family and friends and to the program; not having a phone is a common challenge for unhoused individuals because they often cannot afford one or have lost theirs or had it stolen. Durham's scattered site arrangement has made providing nutrition services challenging, as there is no central way to provide food. The program has instead arranged Meals on Wheels and used Instacart to send groceries, including meals people can prepare with a microwave.

Connection to post-respite housing: Durham works to connect medical respite participants with housing, including rehousing, PSH, vouchers through the local housing authority, senior housing, and shared housing.

Durham receives almost all its funding from the county, city, and local public health system.

Financing: To date, Durham Health Care Transitions (Durham) has not engaged the North Carolina Medicaid agency, largely because the state only recently elected to expand Medicaid, and Durham County was not among the three counties included in the state's Healthy Opportunities Pilots, which covers medical respite care. Durham has instead been supported by funds from the city, county, and local public health system. With Medicaid expansion slated to begin October 1, 2023, staff at Durham will likely explore a partnership with Medicaid MCPs to cover many of the services the program delivers.

House of Charity (Catholic Charities Eastern Washington)

https://www.cceasternwa.org/house-of-charity
Spokane, WA

House of Charity (Catholic Charities Eastern Washington)
https://www.cceasternwa.org/house-of-charity
Spokane, WA

House of Charity in Spokane is shelter-based. While that model has advantages, such as making transitions from medical respite to longer-term shelter easier, it also presents challenges. There are no respite staff onsite after business hours, and this absence puts pressure on non-respite shelter staff, especially when participants display behavioral health challenges. House of Charity applies a wide lens focus on HRSNs. The program employs a case manager focused solely on such needs who administers an HRSN-focused assessment at intake and later plans activities that give participants opportunities to practice participating in community-based activities including bingo, art classes, game nights, and movie days. House of Charity has recently added a behavioral health navigator to assess people and help connect them to community resources. The program also hosts a "Wellbriety" group to meet the culturally specific sobriety needs of Native Americans.

House of Charity receives "hospital community benefit" funds that not-for-profit hospitals are required by law to distribute to maintain their tax-exempt status (James, 2016; NHCHC, 2016). Staff find those funds especially valuable because they are flexible, but they are also in high demand, making it important that House of Charity diversify its funding streams as much as possible. One way the program diversifies is by working with a community health clinic, which manages a "street medicine" program and comes onsite two or more times a week to provide primary care to medical respite participants who are reluctant to return to the hospital for any sort of care. House of Charity also has two contracted beds with a mental health provider and a community health clinic, along with ten beds at a per diem rate available to other payors.

Connection to post-respite housing: At House of Charity, most people exit to shelter rather than to permanent housing arrangements, because the number of beds in Spokane is limited. The program's housing case manager provides a warm handoff to the shelter case management team, so services and supports can continue. Staff observed that, while shelter is better than a return to the streets, it often has drawbacks. Unless individuals receive the services and supports they need their physical health can decline rapidly, even as their housing remains stable.

Edward Thomas House (Harborview Medical Center)

https://www.uwmedicine.org/practitioner-resources/refer-patient/medical-respite
Seattle, WA

Edward Thomas House has a team of providers onsite every day for 12 hours. It includes nurses, mental health professionals, case managers, and medical assistants. Because it is an open facility, and participants can come and go, the case manager connects people with outpatient services and community groups for socialization. Onsite, the program provides a bundle of services, including wound care for burns (which unhoused individuals often receive from using propane stoves or heating units in tents), and extended intravenous antibiotics for heart valve infections, joint infections, or abscesses around the spinal column. To support participants with SUD, Edward Thomas House applies a harm reduction strategy, educating users about safer injection sites and encouraging them to smoke rather than inject. Program staff are guided in their work by a recognition that many unhoused people feel alienated from traditional systems of care. In the words of one staffer, "One of the most important things we do here is help patients reestablish a sense of trust in health care that often has been attenuated just from their prior interactions with health care systems."

Connection to post-respite housing: Medical respite participants at Edward Thomas House meet with a case manager to assess their housing needs. The case manager makes sure they get on all appropriate housing wait lists. They also help people secure essential documentation, including income verification. As often as possible, the program works to place people with Plymouth Housing in Seattle, which provides PSH.

Edward Thomas House is heavily subsidized by the Seattle area Harborview Hospital system -- a necessary infusion of funds, given that the program runs a deficit. Program staff indicated they would like to rely less on hospital subsidies -- a main reason they have been working so closely with the state Medicaid agency on the recently approved Section 1115 demonstration. Edward Thomas House works closely with a steering committee of six hospitals that meets quarterly. At those meetings, staff provide information on who they are serving for how many days and the number of referrals they are getting from partners; they also discuss how they can collectively work more closely to better serve the individuals who need medical respite services.

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ABOUT THE AUTHORS

Edward Kako, Ph.D., and Breck Frye, M.B.A., work at Mission Analytics.

Emma Nye, M.P.A., Emily Rosenoff, M.P.A., and Damian Da Costa, Ph.D., work in the Office of Behavioral Health, Disability, and Aging Policy in the Office of the Assistant Secretary for Planning and Evaluation.

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