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NATIONAL HEALTH FOUNDATION

National Health Foundation staffers practice social distancing in front of the foundation's Pico-Union Recuperative Care facility in Los Angeles. Staff includes social workers, guest service associates and operations.

Refuge from COVID-19

Using medical respite to stanch the pandemic's spread among the homeless may offer a path for its growth

By Steven Ross Johnson

ONE OF THE MORE PREDICTABLE consequences of the current COVID-19 pandemic has been its disproportionate impact on a traditionally marginalized group, the homeless. The more than 560,000 people who were homeless on any given night in 2019, according to the Housing and Urban Development Department, has stretched the usual array of support services to their limits.

"The regular services we provide our clients—shelter, treatment, rehabilitation, case management, crisis management, family support—all of that stuff that is part of our normal day we've had to put that on hold so we could address what do we have to do for COVID-19," said Sharon Dorr, vice president of homeless services at Services for the UnderServed, one of New York City's largest not-for-profit social service and housing support organizations.

Across the country, organizations serving the homeless faced the same dilemma: ensuring homeless residents' safety. Their response was designating locations where those with the virus could be quarantined and those at higher risk could be isolated. Such emergency

housing programs often offer routine medical checks, meals and help connecting with social services and aid toward procuring more permanent housing.

"People who live in congregate shelters can't just close their doors to avoid all contact with others," said Megan Cunningham, managing deputy commissioner at the Chicago Public Health Department. In March, the city and local stakeholders began providing more than 1,000 hotel rooms for those mildly ill from the virus, exposed to COVID-19 or at high risk and didn't need hospital care but couldn't self-isolate.

While the concept may be new to some, temporary, comprehensive care meeting the medical, behavioral and social needs of homeless patients is a model that's been practiced on the medical establishment's margins since the 1980s.

Medical respite, also known as recuperative care, has served as a bridge to help homeless individuals recover from illness when they are too sick to be on the street but not sick enough to go to or remain at a hospital.

Prior to the pandemic, the vast majority of the 100 or so recognized medical respite-care programs operating were run by not-for-profits at such locations as motels, apartment buildings, nursing facilities, homeless shelters and transitional housing facilities. But now a growing number of cities and states are adopting similar care models to stem COVID-19's spread in their homeless populations. Many of these temporary, emergency initiatives are recruiting medical respite-care providers to offer technical expertise.

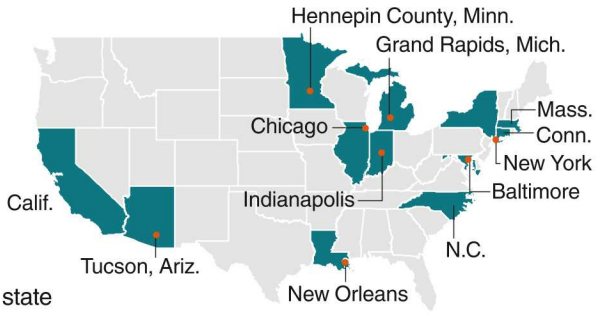
In Chicago, the city partnered with providers with experience delivering healthcare to the homeless. Local hospital networks, including UI Health, Cook County Health and Rush University System for Health, joined the initiative to operate clinical services at emergency sites. "They understand that this is different from delivering care to someone who is stably housed who has a pretty straightforward and mild case of COVID," Cunningham said.

Now medical respite providers are considering how to lobby stakeholders to expand their programs and make them a more permanent part of the primary-care framework. "We know there is a strong need for more medical respite beds," said Jennifer Nelson-Seals, CEO of the Boulevard of Chicago, a temporary residential facility providing homeless individuals with respite care on the city's West Side. "This is now a great opportunity for legislators and medical respite providers across the country."

THE TAKEAWAY

Medical respite-care providers are hopeful that increased interest in their model during the pandemic will generate greater investment in such services after the crisis passes.

Finding hotel rooms for the homeless



By state

Arizona: In April, Tucson moved more than 30 homeless people into hotel rooms.

California: Statewide effort called Project Roomkey secured 10,974 hotel and motel rooms and 1,133 trailers by mid-April.

Connecticut: Homeless shelters across the state were relocating many of their residents to hotels in March.

Illinois: Chicago partnered with five hotels in March to house, quarantine and isolate individuals diagnosed with COVID-19.

Indiana: Reports indicate Indianapolis is setting up a contract with a local hotel to house homeless people who are either older or have underlying medical conditions.

Louisiana: New Orleans has moved more than 400 occupants of homeless encampments to local hotels since March.

Maryland: In late April, Baltimore moved 150 homeless people from shelters to hotel rooms.

Massachusetts: At least five cities across the state have moved homeless individuals from shelters to hotel rooms.

Michigan: Grand Rapids has moved more than 220 people out of homeless shelters and into hotel rooms.

Minnesota: 540 homeless people in Hennepin County were moved to hotels from shelters.

New York: On April 11, New York City Mayor Bill de Blasio announced an initiative to relocate 6,000 homeless individuals to hotels.

North Carolina: More than 16,500 rooms in hotels, dormitories and other facilities were made available for homeless people.

Source: Modern Healthcare reporting

Meeting the need

Thus far, 20 Boulevard residents have tested positive for COVID-19, according to Nelson-Seals. Having a federally qualified health center at Boulevard's 64-bed facility meant those patients quickly got care in an area separate from the other residents. The impact has decreased the beds available for residents who aren't infected while the need has only risen.

Nelson-Seals said Boulevard and other stakeholders gave the Chicago Public Health Department their input

on the city's temporary medical respite model.

The homeless population will remain at increased risk for COVID-19 even after the pandemic subsides. In response, the organization plans to add a second residential facility reserved for COVID patients. The 30- to 60-bed facility is expected to open by year-end, Nelson-Seals said. The move is part of the organization's effort to expand services and increase access. "If we would have had more medical respite beds, I think we could have reacted more quickly (to the pandemic) and saved more lives," she said.

The number of U.S. medical respite-care programs has grown from approximately 65 in 2014 to 104, according to National Health Care for the Homeless Council estimates. Much of the expansion has been in Western states like California—which has a quarter of all programs—while up to 16 states have none.

As greater attention has been paid to the social determinants of health in recent years, there's been a growing awareness of the need for medical respite, said Kelly Bruno, CEO of the National Health Foundation in Los Angeles, one of the largest medical respite-care programs in the U.S.

Individuals who lack housing are more likely to have underlying health issues that increase their risk of developing more severe forms of COVID-19. Yet traditional solutions like homeless shelters are a health hazard during a pandemic. The often crowded quarters of such facilities make social distancing and self-isolation difficult, increasing the risk of spreading the virus.

A recent study by researchers at the University of Pennsylvania, the University of California at Los Angeles and Boston University estimated more than 21,000 hospitalizations and 3,400 deaths would occur among the country's homeless population as a result of the pandemic. "Housing is health," Bruno said. "You cannot be healthy without housing, and anybody living on the street is ultimately going to need some medical care; it's just inevitable."

The National Health Foundation participates in the state of California's Project Roomkey initiative. Launched April 3, its goal is securing up to 15,000 hotel and motel rooms to move homeless people off the street and out of shelters and into isolation, aiming to slow the virus' spread.

Besides operating three traditional medical respite-care sites, the foundation is overseeing development of a 100-bed recuperative care site that's part of the state initiative. Bruno said she believes state emergency measures like California's to temporarily house homeless individuals will help highlight the need for medical respite care and show its value.

And medical respite helps reestablish homeless individuals' trust of the healthcare system, said Dr. Leslie

The National Health Care for the Homeless Council's Standards for Medical Respite Programs

Standard and selected criteria

1 Medical respite program provides safe and quality accommodations
- A bed is available to each patient 24 hours a day while they are admitted to the program
- Three meals a day are provided
- 24/7 on-call medical support

2 Medical respite program provides quality environmental services
- Has written policy and procedure for safe storage, disposal and handling of biomedical and pharmaceutical waste
- Follows state regulations for the storage, handling, security and disposal of patient medications
- Has written protocols to promote infection control and reports cases of communicable diseases

3 Program manages timely and safe care transitions to medical respite from acute-care, specialty-care and/or community settings
- Has clear policies and procedures for screening and managing client referrals into the medical respite program
- Notifies existing primary-care providers about a patient's transition into the program
- Maintains clinical summary

4 Medical respite program administers high quality post-acute clinical care
- Conducts baseline assessment of each patient to determine factors that will influence care, treatment and services
- Develops a care plan for each patient
- Conducts at least one wellness check for each patient every 24 hours

5 Medical respite program assists in healthcare coordination and provides wraparound support services
- Helps patients navigate health systems and establish an ongoing relationship with primary-care providers
- Provides wraparound services like helping facilitate housing or helping submit applications for aid programs

6 Medical respite program facilitates safe and appropriate care transitions from medical respite to the community
- Patients are given a minimum of 24 hours' notice prior to discharge
- Patients are provided options for placement after discharge

7 Medical respite care is driven by quality improvement
- Program establishes and annually updates a quality improvement plan
- Program has a written patient grievance policy and procedure
- Establishes an employee training plan providing necessary skills to maintain a safe environment

Enzian, director of the Edward Thomas House Medical Respite program at the University of Washington Medicine's Harborview Medical Center in Seattle. Edward Thomas House recently helped train the nurses of a new 47-bed shelter for COVID-19 patients without homes.

Enzian said individuals who go through the medical respite program often end up continuing their care within the larger primary-care system as regular patients. "It goes a long way toward their utilization of outpatient resources once they leave here," she said.

Setting a standard

Advocates have lauded how the governments of California, Chicago and other places have provided emergency medical respite programs during the pandemic. But some worry the speed at which those programs are being developed and implemented raises questions about how well those sites will be able to address and manage patients' multiple health needs.

"We've got these populations that are high-need and have very high rates of medical and behavioral health issues, and we are putting them very quickly into these makeshift spaces," said Barbara DiPietro, senior director of policy at the National Health Care for the Homeless Council. "We can't in any way attest to the quality of care that's being provided."

DiPietro said she has heard many emergency programs are staffed by volunteers with no experience or training in providing care for homeless patients. She is concerned many of those housed in such programs may end up with poorer health outcomes than if they were in an established medical respite-care program because their underlying health issues won't be addressed; such care would normally be offered in an established program. "As people get disconnected with care, I think you're going to see an outgrowth of poorly managed diabetes and asthma and hypertension and cardiovascular disease," DiPietro said.

But even for established medical respite-care programs, having a recognized standard of care has always been an issue, with many programs varying in the services they offer. Seeking to form a clearer definition of medical respite care, the council released a set of standards in 2016 with a goal of improving quality and consistency across programs.

The council is working with the Centers for Disease Control and Prevention and HUD to provide training materials for health workers at emergency medical respite-care sites so they can quickly develop skills on how to effectively provide care for such a high-need population.

"Our folks, if they're not managed well, then they'll leave," DiPietro said. "And then we risk both compromising their health and the public's health. That's a situation everyone would like to avoid."

THE BOULEVARD OF CHICAGO

Medical respite programs, such as the one run by the Boulevard of Chicago, are designed to help recently discharged homeless patients continue on the path of better health, which includes providing meals and generally 24-hour access.

Long-term role

While many cities and states are providing housing for the homeless during the pandemic, such programs could offer opportunities to identify longer-term solutions to homelessness and address those patients' healthcare needs.

One obvious approach would be for the federal government to help expand medical respite care, which faces a constant funding challenge. Medicare and Medicaid don't directly reimburse for healthcare services at such programs. Operators such as Boulevard and Edward Thomas House have negotiated individual rates for contracts with Medicaid managed-care plans.

Being able to bill Medicaid for medical respite-care services would potentially give more programs the opportunity to expand rather than just struggling to stay afloat, said Donna Biederman, associate professor at Duke University School of Nursing and research director of Durham Homeless Care Transitions.

"There have always been homeless people in our hospitals and in our health systems who need a safe place to recover," Biederman said. "Having Medicaid be a billable service would be incredibly helpful." ●