Medical Respite:
Post-Hospitalization Support for Californians Experiencing Homelessness

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About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

"A lot of the folks we serve who are homeless — they don't want and/or need a lot. Sometimes they just want to be left alone. Sometimes they don't need expensive medical services. What they are looking for is connection and family and community. Our recuperative care program keeps people out of the hospital, and it's cost effective and that's great. What it really does is allows people to feel at home and comfortable. Recuperative care has allowed us to serve the folks that previously hospitals would have sent out to the street, or to skilled nursing or other institutional settings. It is a very human decision to try to find other ways to support people to live their lives with some autonomy. For many homeless folks, that is all they have left — what they choose to do with their bodies and where they are placed. I am hoping we can continue to foster and grow this out, because it is a benefit to the community."

— Isaias Acosta, Hospitality House Recuperative Care Program

Introduction

Medical respite programs are unlicensed organizations that provide acute and post-acute care for individuals experiencing homelessness who have recently been discharged from the inpatient setting. The programs are a growing part of the homeless services continuum throughout California. This paper surveys the California medical respite landscape and examines the variation in programs by program components, funding sources and mechanisms, and associated challenges.

Medical respite programs vary by type. Some have a largely medical model of care, while others strive to integrate a combined medical-social model. A few have yet to integrate clinical care, despite the pressing need. Where possible, most programs form partnerships with local health centers, hospitals, homeless service providers, and other entities to address the health of the whole person, including their physical, mental, spiritual, and social needs. These partnerships drive referrals and can facilitate continued care after discharge from medical respite. Many programs braid together funding streams from hospital community benefit dollars, county funds, and, increasingly, managed care plans.

As California drives toward implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative,[1] which aims to coordinate care for Medi-Cal recipients, who currently experience some of the most fragmented care, an opportunity exists to leverage promising practices and grow statewide capacity in medical respite. However, to succeed, such programs will need new billing and reporting functions and contracting arrangements with local managed care plans or centralized contracting entities.

National. Medical respite programs in the United States emerged in the 1980s. Today, approximately 100 respite programs exist across 29 states. Medical respite, also known as recuperative care, provides acute and post-acute care for individuals experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to require a hospital or skilled nursing facility (SNF) level of care. These programs typically offer short-term residential care that allows clients to recuperate in a safe environment, with access to medical care and other supportive services. Medical respite can be offered in a variety of settings, including freestanding facilities, homeless shelters, nursing homes, and transitional housing facilities.[2] In 2016, a task force

of medical respite experts for the National Health Care for the Homeless Council (NHCHC) released the following standards (PDF)[3] for medical respite programs:

- *Standard 1.* Medical respite program provides safe and quality accommodations
- *Standard 2.* Medical respite program provides quality environmental services
- *Standard 3.* Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings
- *Standard 4.* Medical respite program administers high quality post-acute clinical care
- *Standard 5.* Medical respite program assists in health care coordination and provides wraparound support services
- *Standard 6.* Medical respite program facilitates safe and appropriate care transitions from medical respite to the community
- *Standard 7.* Medical respite care is driven by quality improvement

Even with these medical respite standards established, it is unclear how many programs have adopted the standards in practice. Only a small number of the programs interviewed were aware of the NHCHC medical respite standards, and none of those programs cited these standards in conversation.

California. The number of medical respite programs has increased over the past several years, as both public and private funders have invested in expanding provider capacity to meet a growing need. Beginning in 2015, Medi-Cal seeded and supported several medical respite pilots under California's Whole Person Care program, authorized under California's Section 1115(a) Medicaid waiver, Medi-Cal 2020. Several county-led pilots chose to invest in medical respite services and infrastructure. Building on those learnings, in January 2022, the Department of Health Care Services (DHCS) will launch medical respite as an In Lieu of Services (ILOS) (PDF)[4] alternative under the CalAIM initiative. Under ILOS, Medi-Cal managed care plans (MCPs) in every county can opt to contract with medical respite providers and fund the care provided using Medicaid dollars in lieu of more expensive hospital or nursing facility care. While this option does not make medical respite a full Medi-Cal benefit, it will greatly expand the Medicaid funding available for this type of care across the state. Historically, California hospitals have been major funders of medical respite services, funding beds through direct staffing and community benefit dollars and grants. While ILOS may increase the quantity of medical respite services funded through Medi-Cal managed care, hospital funding will likely continue to be a core source of program financing.

CalAIM Initiative ILOS

The CalAIM initiative includes ILOS that MCPs can choose to provide. These services are provided in lieu of higher-cost services traditionally covered by Medicaid. Proposed by the Department of Health Care Services (DHCS), the following list includes the current 14 ILOS:

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Short-term post-hospitalization housing
- Recuperative care (medical respite)
- Respite services
- Day habilitation programs
- Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for elderly (RCFE) and adult residential facilities (ARF)
- Community transition services/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations (home modifications)
- Meals/medically tailored meals
- Sobering centers
- Asthma remediation

Value. Research on the value of medical respite programs demonstrates significant cost savings, improved health outcomes, and improved housing outcomes.[5] Medical respite programs have been shown to shorten hospital stays[6] and decrease readmissions by discharging clients to lower levels of care instead of to the street.

A 2009 study of Boston Medical Center's medical respite program found that discharge from a hospital to a medical respite program was associated with approximately a 50% reduction in the odds of readmission at 90 days post-discharge.[7] Another study published in *Journal of Health Care for the Poor and Underserved* found that a day spent in the hospital is nearly 10 times more expensive than a day spent in medical respite. Clients who receive respite care spend an average of two fewer days in the hospital, and their future emergency visits decrease by 1.8 days.[8] Further, the Illumination Foundation found that, in addition to cost savings, 92% of individuals who received medical respite experienced an increase in income. Seventy-four percent secured supplemental security income (SSI).[9]

Project Background

In collaboration with the California Health Care Foundation (CHCF), Aurrera Health Group (AHG) conducted a six-month survey and interview process to capture the current landscape of medical respite. AHG surveyed 40 service providers, received responses from 20 programs, and conducted follow-up interviews with 11 programs. Through both the survey and interview processes, programs provided details on their program models, clinical processes, external partnerships, funding, challenges, and preparation for upcoming policy changes (see Appendix A for a detailed breakdown of these programs). Partway through the interview process, it became clear that sustained funding, referral pathways, and funder requirements were common challenges for medical respite programs. To better inform these challenges and understand the benefits and constraints from a payer's perspective, AHG added interviews with Los Angeles County's Housing for Health program, Dignity Health, L.A. Care Health Plan, and National Health Foundation.

Findings

The process revealed significant variation statewide in medical respite program design, scope, and funding (see Appendix B for a detailed list of programs)

Model of care and staffing. Thirteen of the 20 responding programs identified as a combined medical-social model of care, three programs identified as a social model of care, and three others identified as a clinical or medical model of care.

Medical model. Programs following a medical model usually employ medical staff, including medical doctors, physician assistants, registered nurses, and licensed vocational nurses. These programs are focused more on providing required medical services and less on providing social services. Most of the medical programs are able to provide some on-site care, including post-acute and primary care, nursing care, medication reconciliation, disease management, and mental health services. These programs often have RNs or LVNs who conduct assessments and facilitate safe discharges from medical respite.

Medical-social model. The combined medical and social model is typically staffed with RNs, LVNs, and other clinicians who provide direct medical support as well as on-site care management services. These programs work in partnership with local hospitals and Federally Qualified Health Centers (FQHCs) to provide robust medical services. The medical-social model offers the same on-site care and services as the medical model, with added social services to help clients connect with programs and benefits for after discharge. Several medical-social models also include community health workers (CHWs) and social workers or other behavioral health staff.

Social model. Programs with a social model employ few clinical staff members. Several programs include licensed clinical social workers (LCSWs), case managers, and CHWs on their teams, but these staff members are not able to provide direct medical care. These programs are primarily located in smaller communities with fewer resources. Because the nonclinical programs are unable to provide medical services, they must send clients back to the hospital should a medical issue arise. While the social model programs described a strong need and desire to incorporate more clinical services to better serve clients, these programs face barriers of insufficient funding and staff. Notably, programs that are not able to provide high quality post-acute care may not meet all the standards outlined by the NHCHC unless they are able to establish clinical partnerships.

Other staffing considerations. On-site staffing coverage varies widely across programs. While some programs provide around-the-clock client support, many struggle to fund and find coverage for nights and weekends. The Illumination Foundation, which operates throughout Southern California, offers round-the-clock medical staff. In their interview, they noted that this staffing model helps them reduce emergency room visits after hours and on the weekends.

Many programs expressed the need to have more in-house mental health and substance use disorder (SUD) staff. Six of the responding programs reported having on-site mental health professionals; only three of the responding programs employ SUD professionals. In several organizations, behavioral health professionals are available only part-time. Santa Clara County Medical Respite Program is unique in its ability to offer a full-time psychologist funded through a Stanford community benefit grant. More than 90% of the clients seen in the program have some degree of undiagnosed or untreated mental health disorder. This capability is not common, however: Harder+Company's 2020 study of Los Angeles (funded by UniHealth Foundation) found that only 43% of medical respite programs in the county can accept clients with behavioral health concerns such as severe mental illness.[10]

Referrals. The majority of medical respite programs identified their primary referral source as local hospitals, many of which have a direct funding relationship with the medical respite program. Other common referral sources include shelters, health plans, homeless services agencies, and less commonly, street health programs, and mental health and SUD programs.

In Los Angeles County, the county-run Housing for Health program is a primary referral source for many medical respite programs. Referral processing can be labor intensive; many programs noted the need to bring on additional staff to support the high volumes of referrals.

Exits to the community. Every program described the difficulty of connecting discharging clients to permanent supportive housing (PSH) or long-term transitional housing. The majority of programs — some of which are able to provide services for only 10 to 14 days — discharge many clients to shelter beds. For some, colocation and partnership with a local shelter provides an opportunity for coordinated discharges.

All medical respite programs interviewed included housing navigation services in their service model, though the service intensity varied widely. Most programs have a pipeline to multiple housing options, including Section 8 vouchers, PSH, and temporary supportive housing. Several programs have found success in using the Homeless Management Information System, a community-based and client-level database, to collect and share information on their clients. Many providers conduct a Vulnerability Index - Service Prioritization Decision Assistance Tool as part of their standard practice and connect clients to the Coordinated Entry System (CES) whenever possible. For example, San Francisco Medical Respite and Sobering Center has an on-site case manager who helps navigate CES and ensures that every client receives a housing assessment.

In most cases, medical respite stays are intended to provide short-term residential care to clients recovering from an inpatient stay. California's limited affordable and subsidized housing inventory makes it

difficult for medical respite programs to identify temporary and permanent supportive housing options for clients at discharge. The exception to regions experiencing this pervasive challenge is Los Angeles County, where some programs have been able to leverage Measure H funds to serve clients for up to two years.

Partnerships. Several programs found clinical and programmatic support through a partnership with a local FQHC or hospital. Collaboration and even colocation of the two entities allowed for better coordination of primary care and social service needs. For some programs, FQHC partnerships led not only to better health outcomes for clients but also to the development of a strong referral source.

In Alameda County, LifeLong Medical Care, a local FQHC, operates a medical respite program under contract with Alameda County Health Care for the Homeless (ACHCH). The medical respite program collaborates with Alameda Health System, a county safety-net health care system, 14 ACHCH-funded street medicine teams, and LifeLong's Trust Health Center to identify people in need of medical respite and to coordinate referrals.

At Santa Clara County Medical Respite, the team uses the model of the Valley Homeless Healthcare Program to promote the medical model of care across all local homeless service providers, including medical respite. Unlike many medical respite programs that directly employ clinical staff, most of the members of the clinical team are employees of the county. The team provides interdisciplinary care by coordinating closely with their hospital colleagues and other local entities.

Funding. Because medical respite is not a Medi-Cal benefit and not typically covered by other sources of health insurance, the funding landscape is diverse and unstable. Programs are funded through four primary sources:

- *Community benefit dollars.* The Affordable Care Act allows nonprofit hospitals to utilize community benefit dollars to cover medical respite care. These funds are intended to strengthen connections to community health and help provide linkages to programs that address social determinants of health. To qualify for community benefit dollar use, the nonprofit hospital must conduct a community needs assessment to justify the funds and must submit a yearly plan identifying the programs that will be receiving the funds.[11] The majority of medical respite programs identified hospital community benefit dollars as a primary source of funding for their services. These dollars are often more flexible than other types of per diem financing models and can be used to finance both clinical and nonclinical staff.

- *Hospital per diem payments.* Many hospitals have programs that fund beds for short-term stays in medical respite, typically 10 to 14 days. An extended stay, which is often needed, requires additional approvals.

- *Grants.* A few programs have secured short-term grants, usually on an annual basis. Grant funding is reportedly difficult to obtain and not a sustainable funding source. Interviewees described some grants as too narrowly prescriptive, making it difficult for programs to invest in long-term infrastructure needs, such as electronic health records (EHR) or leasing property.

- *Whole Person Care (WPC) pilots.* Several county WPC lead entities provide medical respite funding through their WPC pilots, initially launched in 2016. Of the 20 medical respite programs surveyed in September 2020, 10 cited WPC pilots as a funding source. While the initial five years of WPC funding has been extended for a sixth year through the end of 2021, the funding will not be renewed beyond that time. The state's goal is to transition all existing WPC clients who are eligible for Enhanced Care Management (ECM) and ILOS to the new programs in January 2022. However, because medical respite is an optional ILOS, it is not guaranteed that the service will be offered by the MCP, so funding to programs that rely on WPC dollars may be lost. In Placer County, WPC funding allowed the Gathering Inn to open a second recuperative care program.

The WPC pilot partnered with the Gathering Inn to provide case management and other wraparound services to WPC medical respite clients.

- *Measure H.* Through a quarter-cent tax increase in 2016, Los Angeles County's Measure H has created a stable and reliable funding source for a variety of homeless services. Measure H funds are allocated annually based on the regional percentage of people who are homeless in Los Angeles County, and funds are administered by lead county agencies, such as the Department of Health Services (DHS) and Los Angeles Homeless Services Authority (LAHSA). The goal of Measure H is to combat homelessness through a variety of programs, including bridge programs such as medical respite, case management, and subsidized and affordable housing.[12] Both the Illumination Foundation and the Recuperative Care Center at the Martin Luther King, Jr. Medical Campus noted that Measure H funds allow them to extend the stay for clients who have ongoing medical needs, until they can be transitioned to housing. Notably, the MLK Recuperative Care Center has an unusually long length of stay, ranging from six months to two years, partly because of Measure H funding.

- *Medi-Cal health plans.* While not a widespread practice, several Medi-Cal health plans have begun funding medical respite programs. Some utilize community benefit dollars, others reserve beds on an ongoing basis, and still others pay a per diem rate to supplement a longer stay than hospitals will allow. The National Health Foundation has established partnerships with several hospitals and health plans to fund reserved beds on an ongoing basis or to pay per diem to support the plan's eligible members.

The need to braid multiple funding streams has also led programs to tailor their lengths of stay and eligibility criteria to the payer, creating complex administrative workstreams. For example, the Illumination Foundation, a large medical respite program that manages 200 beds across three different geographic areas — Los Angeles County, Orange County, and the Inland Empire region — must adhere to each region's medical respite program requirements. In Los Angeles County, the Illumination Foundation is funded through Measure H and the DHS, and the program must meet the guidelines and specific reporting requirements in the county. In Orange County, they are supported by the county and the local MCP, both of which have their own guidelines and reporting requirements. In the Inland Empire region, the Illumination Foundation submits claims directly to the local MCP.

Evaluation. Most interviewees discussed the lack of access to client information and outcomes, such as diagnostic and claims data, needed to conduct robust evaluations of their program's impacts; this information is typically housed with local MCPs and hospital systems. Because many are stand-alone programs, they typically do not have standing data-sharing agreements with these institutions. Santa Barbara's Cottage Recuperative Care Program is an exception; through their partnership with the county and their local MCP, they are able to track client utilization and health outcomes over time using managed care and hospital data sources. This analysis has proven useful for both program administrative purposes and for demonstrating cost savings and improved health outcomes to funders. In Contra Costa County, the Philip Dorn Respite Center can access their clients' EHR data through a partnership with the county's WPC program, but they are unable to access the financial data that would allow them to measure the cost savings associated with medical respite care. A wide range of evaluation measures are used across programs, depending on the level of data access and analytic capacity. Included in the list are the following measures:

- 30-day, 90-day, and 6-month hospital readmissions
- Inpatient psychiatric readmissions
- Client satisfaction
- Discharge site
- Emergency department utilization
- Inpatient utilization

- Chronic conditions
- Length of stay
- Bed days
- CES assessment
- Connection to primary care
- Cost savings

Promising Practices

During the interview process, a number of promising practices were identified as essential to the success of the program:

- 24/7 on-site staff
- Medical and social service staffing
- On-site behavioral health staff
- FQHC and hospital partnerships, colocation with clinical services
- Data exchange with health plan or public hospital system
- Connection to CES

Challenges

Even as medical respite programs advance innovations and promising practices, they face significant challenges.

Standardization. While there is a clear need for variation to meet local needs, many interviewees voiced concern at the lack of standardized expectations from various funders. Programs described the administrative burden of when funders differed in their requirements around eligibility, referral processing, length of stay, rates, reporting, billing, and programmatic elements. This inconsistency may also lead to challenges as MCPs attempt to set standard contracts and requirements under ILOS.

Billing. As an ILOS service provider, medical respite programs will be required to submit claims or encounters to MCPs. This requirement may prove especially challenging for programs that do not have an established relationship with their local MCPs and for those that do not have clinical staff with a National Provider Identifier to bill for services. As a solution to this problem, the Illumination Foundation has established a medical group that is now providing primary care services to this population. While this option is not available to most programs, it demonstrates the innovation occurring on the ground. Smaller programs may require different yet equally innovative billing solutions in the years to come.

Coordination with local partners. Acutely ill individuals experiencing homelessness interface with the health care and social services systems at multiple points, making essential the need for coordination among entities. Yet many barriers remain around data sharing and care coordination as medical respite programs try to manage relationships with hospitals, health plans, county behavioral health organizations, FQHCs, and homeless service providers.

Sustainable funding sources. For many programs, annual budgets vary widely from year to year, depending upon grant acquisition, community benefit dollars, and county funding resources. Funding instability leads to challenges in meeting the community need, attracting and retaining staff, and growing program capacity.

Exits to the community. Many programs discussed the challenge of securing permanent supportive housing options for discharging clients. The lack of housing options often drives up the length of stay in medical respite. In addition, the discharge process can be resource intensive and require coordination with many other entities to ensure that clients have the appropriate medication, care planning, and services arranged for a successful transition back into the community. While some programs have been able to hire discharge planners, many have struggled to identify funding streams for these roles.

Gaps in the continuum of care. Most programs noted the challenge of meeting the needs of clients

with acute or complex medical needs who do not meet criteria for placement in an SNF. For example, Providence St. Joseph's CARE Network medical respite program noted that they are unable to accommodate clients who require assistance with personal care or administer medication in their program, but these clients are often not accepted into SNF care locally. Additionally, programs discussed the challenge of providing services such as wound care and assistance with activities of daily living because of not having the appropriate staffing, facilities, or funding to fill the need. Programs with a close connection to a local hospital system or FQHC are better able to fill this gap, helping clients avoid emergency room visits and readmissions through strong primary care. Another gap occurs for clients who need palliative care or end-of-life care, including hospice services. Clients admitted to medical respite with advanced illness often do not wish to be moved to a new facility for end-of-life care, but programs struggle to fund the higher service level and extended lengths of stay these clients require. Some programs are striving to meet this need. In Humboldt County, St. Joseph's can refer clients to a hospice house, but the cost is often too great at $500 per night. While hospice and palliative care services are covered by Medi-Cal, medical respite programs face many barriers, including licensing requirements, costs, and the space needed to offer hospice or palliative care.

What's Next?

CalAIM. Assuming that the ECM/ILOS plan outlined in the CalAIM proposal is approved by CMS, beginning in 2022, MCPs will have the opportunity to cover the costs of medical respite services under the ILOS program. While a few MCPs are already funding these services in various ways, the ability to opt in to ILOS represents a significant shift in medical respite funding and oversight. To ensure the success of this new type of contractual partnership, MCPs will need support in understanding the value of medical respite programs, metrics of success, and the existing network across the state. Medical respite programs in California are not currently licensed or accredited; MCPs will be tasked with establishing the minimum required service level for ILOS contracting. Though not required, MCPs will need to collaborate to establish standardized expectations of medical respite programs, particularly within a given county, so as to avoid provider administrative overload. Medical respite programs will also need support in navigating managed care, including contracting, credentialing or vetting processes, billing requirements, reporting, prior authorizations, new referral processes, and program compliance elements. Programs that contract with multiple MCPs may have to navigate varying eligibility criteria, lengths of stay, reporting, and other administrative requirements. It is recommended that the state establish provider-focused learning communities that provide the hands-on, specialized support required to make the shift into managed care.

Counties may continue to play a significant role in supporting medical respite programs as independent funders, referral coordinators, and potential administrative and contractual hubs.

In an environment of increasingly sustainable funding, medical respite programs may have the opportunity to grow in capacity, partnerships, and program model. The integration of medical respite with managed care may also allow medical respite programs to develop new relationships and improve coordination with local providers, facilitating care and exits to the community.

Community benefit. An opportunity exists to expand upon the success of hospital community benefit programs by increasing the size of existing programs and building new programs. With a clear value statement and the growing statewide network, hospitals may see improved outcomes and returns on investment.

Evaluation. There is a distinct need to establish an evaluation framework for medical respite programs, particularly for those participating in the CalAIM program. Creating and adopting a statewide or national set of evaluation standards will assist in ensuring equal access to high-quality medical respite services.

Case Studies

Providence St. Joseph Hospital Medical Respite Program

HUMBOLDT COUNTY

The CARE Network program is part of Providence St. Joseph Hospital, which is a nonprofit, Catholic hospital in rural Humboldt County. The program uses funds from Care for the Poor, a community benefit program, to partially cover the costs of the medical respite beds and the staff who are provided through a partnership with the Betty Kwan Chinn Homeless Foundation. The foundation provides 24 onsite nonclinical staff and CARE Network provides a registered nurse and a social worker to support the discharge. The program has a total of 14 beds across three different locations – 10 at Betty's House, operated by Betty Kwan Chinn, three in a clean and sober living house, and one motel room that is usually reserved for those with mental health issues or for couples. The average length of stay at St. Joseph's is 21 to 30 days. Because the CARE Network team is part of the hospital staff, team members bring with them expertise to navigate a complex system. Access to basic medical records, including recent medical history, and access to information on chronic health conditions, has been key to helping clients transition from a hospital stay to the medical respite program.

The St. Joseph program leadership supports including hospice or palliative care in the medical respite center but has been unable to do so due to the lack of staff, licensing restrictions, costs, and availability of space.

The rural nature of Humboldt County limits the number of inpatient hospice and skilled nursing facility (SNF) beds in the area, and home-based hospice is not an option for clients experiencing homelessness. Including these services in the respite program would be valuable to the community. When local SNF beds are unavailable for qualifying clients, St. Joseph's often must look to nearby counties to seek out other options for the clients.

St. Joseph's current model is supported by local community benefit dollars. The changes in funding that may come with California Advancing and Innovating Medi-Cal's implementation may offer opportunities to further expand services.

Cottage Recuperative Care Program

SANTA BARBARA COUNTY

Led by Cottage Health in Santa Barbara County, the Cottage Recuperative Care Program is a 10-bed program co-located within PATH, a local shelter. The average length of stay at Cottage Recuperative Care is 77 days. The program is staffed by both a full-time and a part-time registered nurse. In addition to providing medical care, a community health navigator provides case management support, connecting clients to housing and social support services. Cottage Health also runs a shorter-term care program that serves as a landing place for potential recuperative care clients being assessed to ensure they are a good fit for recuperative care. Referrals come through Santa Barbara Cottage Hospital, as well as from community organizations and government agencies. Cottage Health supports the program through community benefit dollars. Other funding is provided by CenCal Health Plan, UniHealth Foundation, and other private funders.

Cottage Recuperative Care has the rare ability to access electronic health records (EHR) data to evaluate its services. Access to the Cottage EHR system, Epic, has allowed the program to chart progress notes while a client is in their care, track client outcomes, and understand the hospital's return on investment. Their standard tracking includes a 90-day pre-medical and post-medical respite program view of emergency room and inpatient service usage, which has shown a 45% to 65% decrease in emergency room and inpatient utilization 90 days following discharge. Tracking this data has aided in encouraging hospitals to join conversations about the benefit of medical respite services.

The main challenge Cottage Recuperative Care Program faces is the lack of post-respite housing options. Cottage Recuperative Care is looking to partner with a community organization on establishing housing and wrap-around services for medical respite clients who face limited options due to housing shortages and the cost of housing in Santa Barbara County.

Martin Luther King Jr, Medical Campus Recuperative Care Center

LOS ANGELES

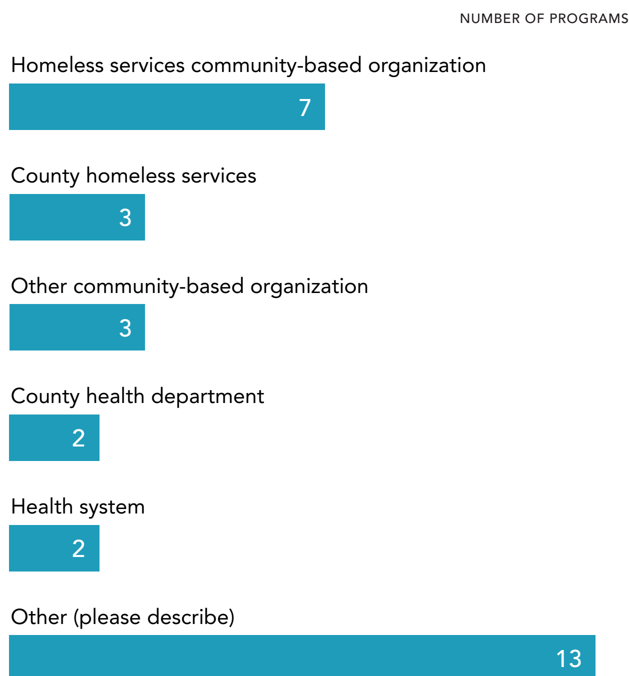
MLK Recuperative Care Center is a shelter-based program with 94 beds and two hospice beds. The program is funded through the allocation of Measure H funds administered by Los Angeles County Department of Health Services' Housing for Health. MLK Recuperative Care is a medical-social model program that employs medical providers, nurse practitioners and registered nurses; medical assistants; and nonclinical social support staff, such as case workers, social workers, and plainclothes security. Clients are referred to the program through Housing for Health and county hospitals. The length of stay in the MLK program is atypically long, varying from six months to two years. MLK's length of stay sits at the nexus of medical respite and interim housing and represents an innovation that communities may wish to explore for their highest-risk and most acute clients. Many clients are moved into transitional or permanent supportive housing (PSH) when they are discharged. To help support long-term success for those who transition out of the program, MLK offers educational classes, such as budget planning and household needs. The program invites "graduated" clients back for Thanksgiving, Christmas, and other holidays, especially if the client has no family within close proximity.

The MLK Recuperative Care program shared challenges related to the housing crisis in Los Angeles. While the goal of Measure H is to increase access to housing, it is not always easy or ideal to keep clients in the program until transitional housing or PSH becomes available. At times, it is also challenging to transition clients back to independent living because they have become accustomed to living in the program's facilities and being a part of MLK's community. To assist with this transition, MLK offers clients the opportunity to alternate spending nights in a new housing environment and at the medical respite facility until they are more comfortable living on their own.

Appendix A. Survey of Medical Respite Landscape in California

Aurrera Health Group (AHG) conducted a six-month survey and interview process to capture the current landscape of medical respite in California. AHG surveyed 40 service providers, received responses from 20 programs, and conducted follow-up interviews with 11 programs. Programs provided details on their program models, clinical processes, external partnerships, funding sources, and services provided. Programs were allowed to select more than one option. A selection of "other" allowed programs to add free text detail to their response.

Figure A1. Organization Type

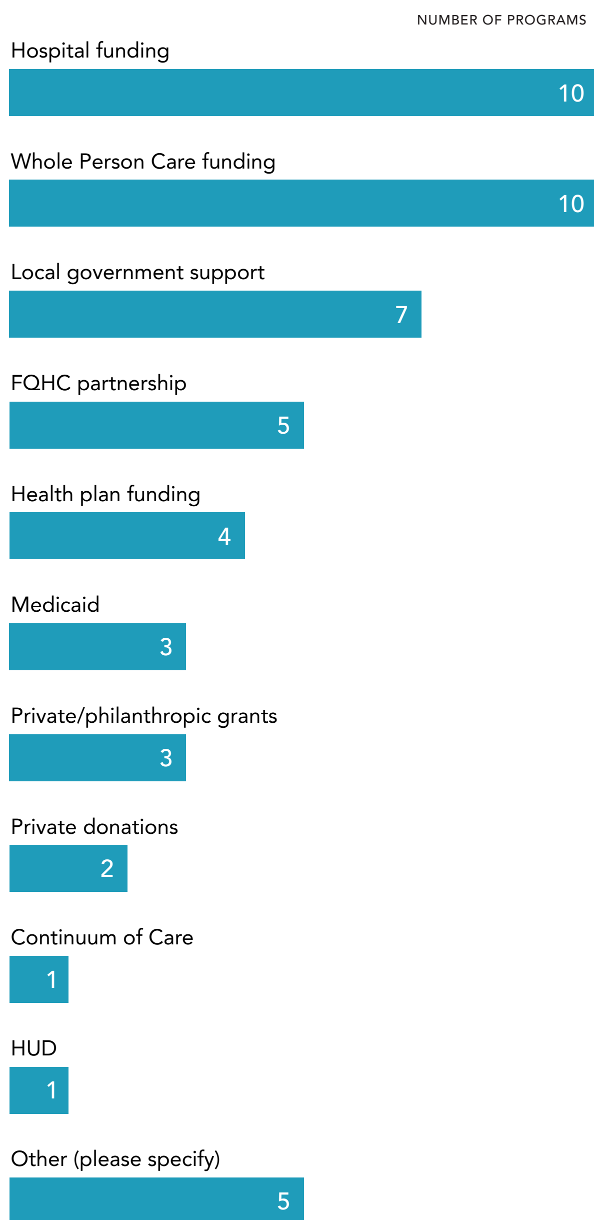


Note: All 20 programs responded.

"Other" responses included:

- Federally Qualified Health Center (FQHC)
- Nonprofit FQHC
- Combined service facility
- Recuperative care services program
- Recuperative care services for homeless population
- Recuperative care
- Community-based organization focused on serving underresourced communities
- Homeless recuperative care for patients being discharged from hospitals, skilled nursing facilities (SNF), etc.
- FQHC collaboration with shelter-based services
- County whole person care
- Partnership with heath system and homeless service organization

Figure A2. Program Funding Sources

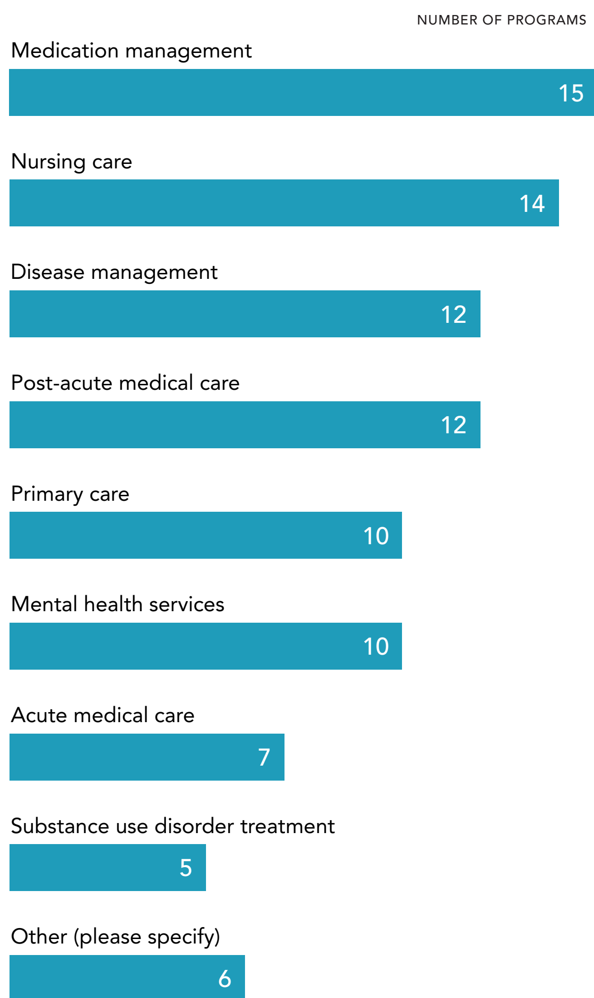


Notes: All 20 programs responded. *HUD* is US Department of Housing and Urban Development.

"Other" responses included:

- Veterans Health Administration contracts, AB 109 Counseling Services contracts, local hospitals, Federally Qualified Health Centers (FQHCs), county hospital
- Los Angeles County Department of Health Services – Housing for Health program
- Private company
- Private pay

Figure A3. Clinical Services Provided Onsite

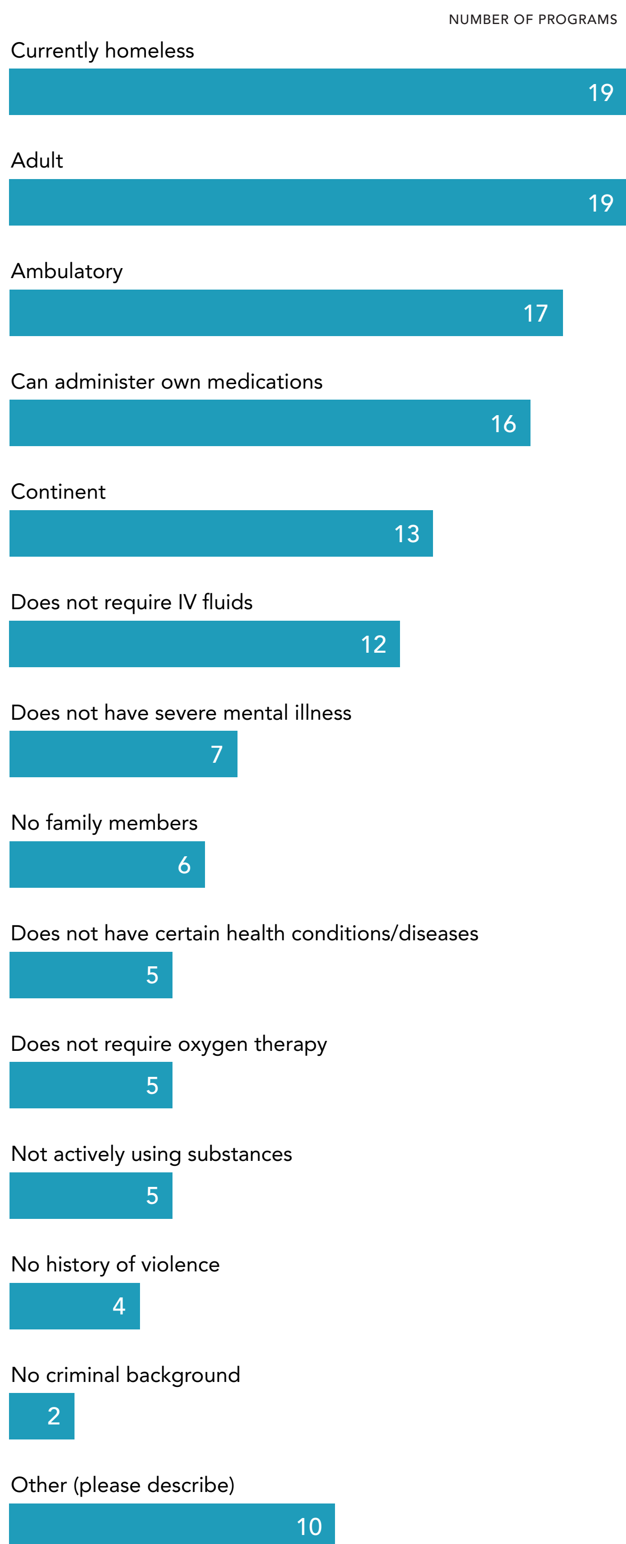


Note: Nineteen of the 20 programs responded.

"Other" responses included:

- All services are provided via home health or mobile physician, along with secured storage of medications, mobile psych, and assign staff to escort clients to medical appointments when client is in need of higher level of assistance (e.g., mobility issues, visual impairment).
- Cognitive testing, therapy
- Exam room is next to the recuperative area managed by Federally Qualified Health Center (FQHC). Occupational therapy / physical therapy visiting nurses are ordered through the hospital or primary care physician. Medications can be delivered or picked up by clinical staff. Med box fill is available.
- Non-24-hour nursing care, nurse assessment daily no direct nursing care such as wound care
- Nurse care under a clinic setting (immunizations, wound care, line care, EKG, nebulizer, etc.)
- We are partnered with a federally funded community clinic, who has office/clinic space within our facility.

Figure A4. Admission Criteria

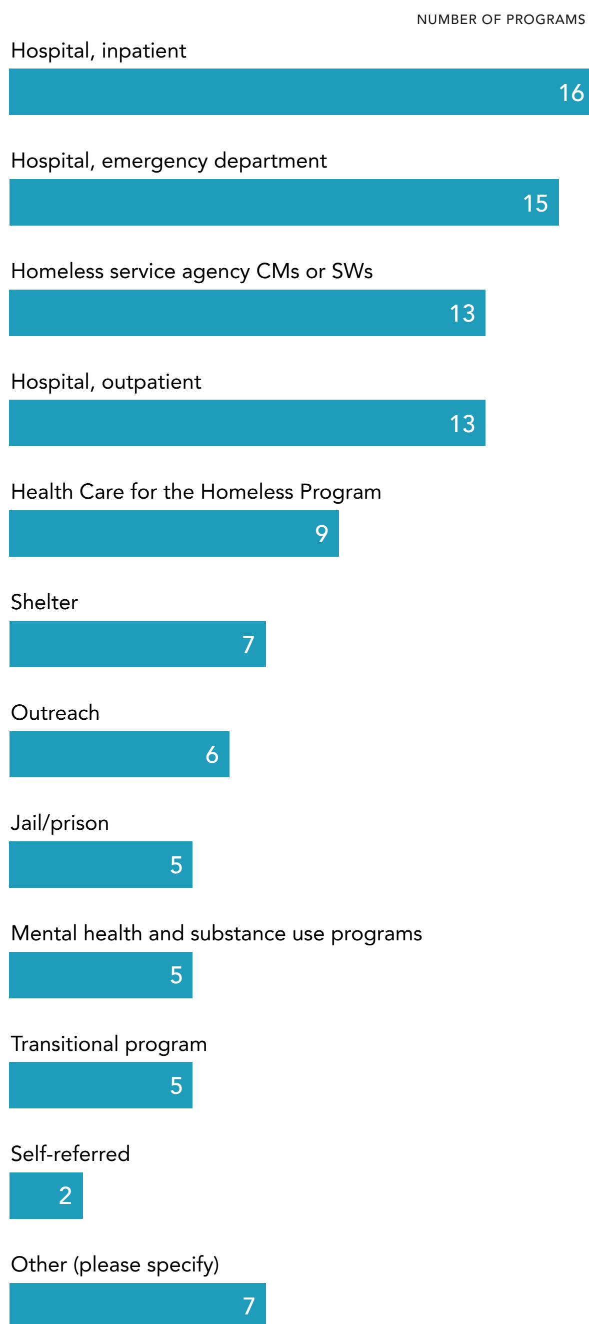


Note: All 20 programs responded.

"Other" responses included:

- CalOptima member and acute medical condition
- Domestic violence or arson history are not accepted. No active infectious disease. We have a community alternative site for COVID-19 positive. No active drug use, but outreach can offer a treatment program if interested.
- If briefs/diapers are used, independent with changing of briefs/diapers must be met.
- No EF, no MRSA, no TB, no C. diff
- No more than a one-person assist
- Others not marked are allowed, case by case
- Scabies, lice, C. diff, bedbound
- Terminal cancer
- We take those with serious mental illness who we believe can still manage in a group environment and care for themselves, practice a harm reduction model.
- Willing to participate in the program, willing to adhere to shelter's Good Neighbor Policy

Figure A5. Referral Sources

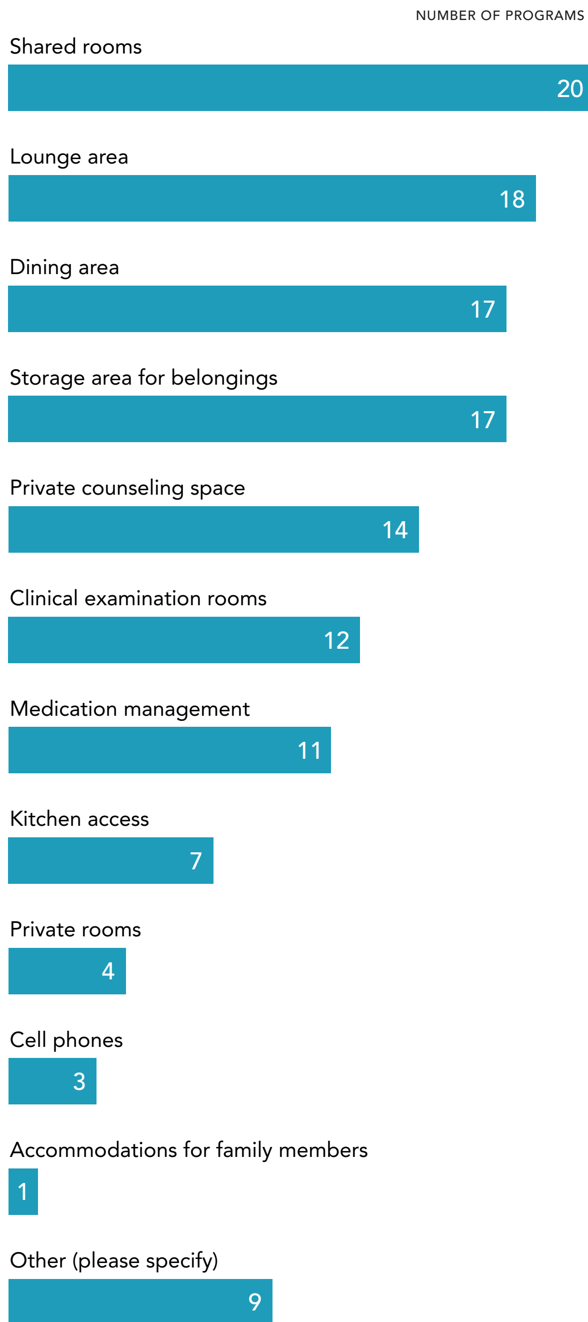


Note: Eighteen of the 20 programs responded.

"Other" responses included:

- All referrals come from Los Angeles County Department of Health Services - Housing for Health program (DHS HFH)
- Any community organization or agency
- DHS HFH
- Nursing homes, City Net
- Occasionally medical staff from the FQHC with speak to the patient at the hospital. Outreach worker will also speak to the patient about treatment options for substance use disorder if the patient is interested. (COVID-19 has made contact a little more complicated.)
- Some patients can be physically evaluated as needed.
- We seldom do bedside evaluations in the hospital, only if there is uncertainty if client is appropriate. For outpatient referrals, we often do a "meet and greet" to ensure program mutually acceptable for client and staff. Seldom take referrals from county jail, but have collaborated on a few occasions.

Figure A6. Onsite Accommodations

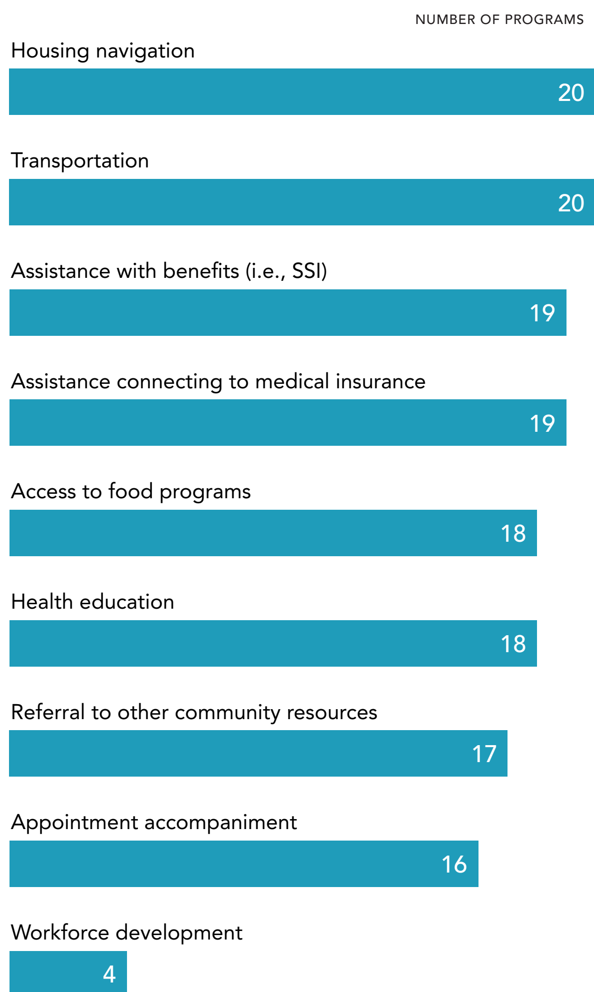


Note: All 20 programs responded.

"Other" responses included:

- Case management
- Do not distribute medication; coordination between primary care provider and pharmacy services, designated smoking area, outdoor courtyard
- Do not distribute medication; provider secure storage and access
- Laundry room: free; transportation van: free
- Outdoor space
- Personal lockers for medications. Med box assistance as needed. Lyft or staff transportation. Three meals a day are provided. Kitchen access suspended due to pandemic at this time.
- Private room for clinical calls
- Provide assistance with filling pillboxes. Will store and administer meds on rare occasions (e.g., withdrawal management).
- Semi-private rooms, semi-private restrooms

Figure A7. Social/Support Services Provided

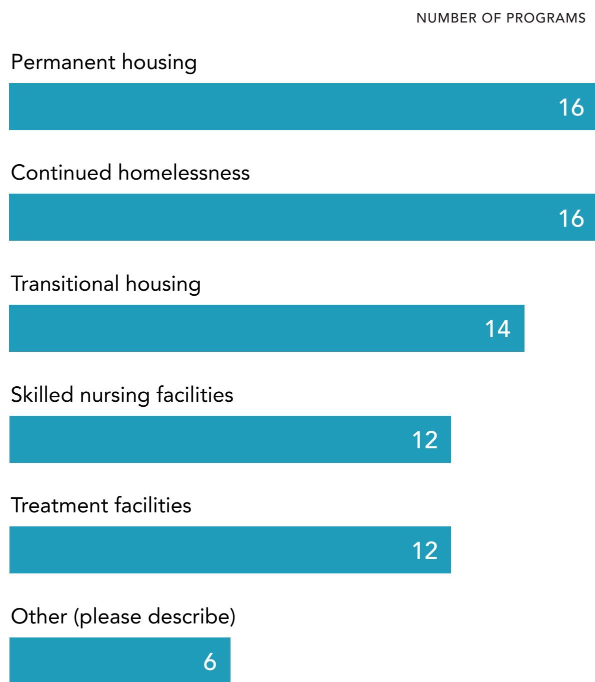


Note: All 20 programs responded.

"Referral to other community resources" responses included:

- Assist with SSI, GSR, DMV, birth certificates
- Assistance with becoming document-ready for housing and addressing any social needs the patient sets as goals
- Birth certificates, drug court, much more
- CBEST, Legal Aide, Public Counsel, ACESS, DPSS, Social Security, DMH, Veterans Programs
- Facilitate transportation, primarily through Veyo and public transportation; substance use disorder counseling; behavioral health services; TeleCare; shelters; back-to-work programs; medical supply services (e.g., wheelchairs, canes, diapers)
- Legal aide, share housing program, counseling through Petaluma Family Therapy, substance use disorder support, case management
- Mental health, substance use referrals
- Outreach and engagement, low income assisted living facilities, room and boards, Grandmas House of Hope, Adult Protective Services, ALW Program
- Outside appointments
- Specialty medical and dental referrals
- SSI, DMV, DPPS
- We refer out clients to whatever program they need to be placed in, be it board and care or skilled nursing facility, or addiction recovery, etc.
- We will refer to whatever resources are needed (e.g., Institute of Aging, Blind Center, VA if DD219 obtained, transitional housing programs, outpatient substance use treatment)
- "Whatever it takes" approach
- Workforce development, legal services
- Work to get folks connected to substance abuse treatment services and disability advocacy groups locally, as well as ongoing connections to mental health service providers

Figure A8. Discharge Location



Note: Seventeen of the 20 programs responded.

"Other" responses included:

- Family reunification
- Short-term procedures, deceased
- Clean-and-sober living
- Emergency shelter, same building
- Family/friends, board and care, room rental

Appendix B. California Medical Respite Programs – Program Detail

	LOCATION	SETTING	TYPE OF MODEL	STAFFING	NUMBER OF BEDS	AVERAGE LENGTH OF STAY
Cottage Recuperative Care	Santa Barbara	Shelter-based	Medical	1 RN (full-time) 1 RN (part-time)	10	90 days
Hospitality House	Nevada City	Stand-alone	Social	1 CM 1 Shelter manager 1 Program director 1 Grant manager 1 Outreach manager	14	60–90 days
Illumination Foundation	Orange, Los Angeles, and the Inland Empire	Stand-alone	Social-medical	1 LVN medical coordinator 1 CM 1 Therapist 1 SUD counselor support staff 24/7 Nonclinical staff*	200	LA: up to 1 year; Orange: 17 days; Inland Empire: 30 days
LifeLong Medical Care	Berkeley	Shelter-based	Social-medical	2 RNs (weekdays) 1 RN (weekend) 1 MD (1 day/week and on call) LCSW (1 day/week)* 2 CMs 1 Site manager	27	36 days
Petaluma Recuperative Care	Petaluma	Shelter-based	Social-medical	1 CM 1 RN	6	14 days
Philip Dorn Respite Center	Concord	Shelter-based	Social-medical	1 MD 1 RN 1 Dentist (2–3 times/week) 24/7 Nonmedical support staff*	24	42–56 days
Recuperative Care, Martin Luther King Jr., Medical Campus	Los Angeles	Stand-alone	Social-medical	1 MD 2 NPs 11 RNs Medical assistants* CNAs* CMs* Social workers* Nonuniform security* Housekeeping and food service	96	6 months–2 years

*Unspecified number of staff.

Note: *CHW* is community health worker; *CM* is case manager; *CNA* is certified nursing assistant; *LCSW* is licensed clinical social worker; *LVN* is licensed vocational nurse; *MD* is doctor of medicine; *NP* is nurse practitioner; *PA* is physician assistant; *RN* is registered nurse; *SUD* is substance use disorder; *WPC* is Whole Person Care pilot.

	LOCATION	SETTING	TYPE OF MODEL	STAFFING	NUMBER OF BEDS	AVERAGE LENGTH OF STAY
San Francisco Medical Respite and Sobering Center	San Francisco	Stand-alone	Medical	6 RNs 1 MD medical director 4.5 NP/PA 1 Nurse manager 3 Social workers 1 Behavioral health supervisor 7 CHWs 3 Medical assistants 1 Mental health resource specialist	75	14–56 days
Santa Clara Medical Respite Program	San Jose	Shelter-based	Social-medical	1 MD 3 RN/LVNs 1.5 Social workers 1 Psychologist 0.2 Psychiatrist 0.1 SUD counselor 1 CHW Street outreach team*	20	20–30 days
St. Joseph Health Humboldt Medical Respite Program	Eureka	Stand-alone	Social-medical	1 RN 1 CHW 1 Social worker 24/7 Nonclinical staff*	14	21 days
The Gathering Inn	Auburn	Stand-alone	Social	1 Site manager 1 Housing manager CM* 24/7 Nonclinical staff (WPC)*	12	42–90 days

*Unspecified number of staff.

Note: *CHW* is community health worker; *CM* is case manager; *CNA* is certified nursing assistant; *LCSW* is licensed clinical social worker; *LVN* is licensed vocational nurse; *MD* is doctor of medicine; *NP* is nurse practitioner; *PA* is physician assistant; *RN* is registered nurse; *SUD* is substance use disorder; *WPC* is Whole Person Care pilot.

Appendix C. Glossary

Activities of daily living (ADL). The tasks of everyday life. Basic ADLs include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet.

California Advancing and Innovating Medi-Cal (CalAIM). A multiyear initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program.

California's Section 1115(a) Medicaid Waiver, Medi-Cal 2020. The Medi-Cal 2020 Demonstration aims to transform and improve the quality of care, access, and efficiency of health care services for over 13 million Medi-Cal members.

Coordinated entry system (CES). Facilitates the coordination and management of resources and services through the crisis response system. CES allows users to efficiently and effectively connect people to interventions that aim to rapidly resolve their housing crises.

Electronic health record (EHR). A digital version of a patient's paper chart.

Enhanced care management (ECM). A whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and nonclinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person centered.

Federally Qualified Health Center (FQHC). Community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas.

Homeless Management Information System (HMIS). A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and those at risk of homelessness.

Hospital community benefit dollars. Initiatives and activities undertaken by nonprofit hospitals to improve health in the communities they serve.

In Lieu of Services (ILOS). Medically appropriate and cost-effective alternatives to services covered under the State Plan. These are optional services for Medi-Cal managed care plans to provide, and optional for managed care enrollees.

Measure H. The Los Angeles County Plan to Prevent and Combat Homelessness creates a one-quarter percent sales tax, which generates funds specifically for funding homeless services and short-term housing.

Palliative care. Specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness, no matter the diagnosis or stage of disease.

Permanent supportive housing (PSH). An intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and to connect people with community-based health care, treatment, and employment services.

Section 8 voucher. Rental assistance funded by the US Department of Housing and Urban Development and administered by a local public housing authority to help households with low income pay their rent. A tenant with a voucher pays a predetermined portion of rent, and the Section 8 program pays the remainder of the rent directly to the housing provider.

Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT). A "supertool" that combines the strengths of two widely used existing assessments. The Vulnerability Index, developed by Community Solutions, is a street outreach tool currently in use in more than 100 communities. Rooted in leading medical research, the VI helps determine the chronicity and medical vulnerability of people experiencing homelessness. The Service Prioritization Decision Assistance Tool is an intake and case management tool in use in more than 70 communities. Based on a wide body of social science research, the tool helps service providers allocate resources in a logical, targeted way.

Endnotes

1. California Department of Health Care Services (DHCS). "California Advancing and Innovating Medi-Cal." Last modified May 5, 2021.

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3. National Health Care for the Homeless Council, *Standards for Medical Respite Programs* (PDF), October 2016.

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5. Kelly M. Doran et al., "Medical Respite Programs for Homeless Patients: A Systematic Review," *Journal of Health Care for the Poor and Underserved* 24, no. 2 (May 2013): 499–524.

6. National Institute for Medical Respite Care, *Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care* (PDF). March 2021.

7. Stefan G. Kertesz et al. "Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons." *Journal of Prevention and Intervention in the Community* 37, no. 2 (2009): 129–42.

8. Dan Shelter and Donald S. Shepard. "Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage." *Journal of Health Care for the Poor and Underserved* 29, no. 2 (May 2018): 801–13.

9. "Providing Medical Respite for People Experiencing Homelessness During the COVID-19 Crisis," webinar, Center for Health Care Strategies, August 11, 2020.

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11. Lori Solomon, "Fast Fact: Hospital Community Benefit Dollars Can Benefit Community Development," *Building Healthy Places Network*, September 6, 2016.

12. Los Angeles County Homeless Initiative. "History." n.d. Accessed March 2021.