Bridging the gap for unhoused people: Medical respite care programs
AMA MAKING THE ROUNDS
Making the Rounds

Bridging the Gap for Unhoused People: Medical Respite Care Programs

Aug 16, 2022

- Listen on Simplecast
- Listen on Apple Podcasts
- Listen on Spotify

Featured topic and speakers

In this episode of Making the Rounds, medical respite programs care for unhoused people who are not sick enough for inpatient care but are too sick to return to a shelter or the streets. Hear from experts David Munson, MD, David Woody, PhD, and Barbara DiPietro, PhD, about how these lifesaving programs improve health while protecting our health care system and how medical students can make an impact. This episode was moderated by Shad Yasin, a medical student at Rutgers New Jersey Medical School and a member of the Committee on Legislation and Advocacy.

Speakers

- **David Munson, MD**, medical director, Boston Healthcare for the Homeless
- **David Woody, PhD**, president and CEO, Bridge Homeless Recovery Center
- **Barbara DiPietro, PhD**, senior director of policy, National Health care for the Homeless Council

Hosts

- **Shad Yasin**, medical student, Rutgers New Jersey Medical School and member of the Committee on Legislation and Advocacy
- **Todd Unger**, chief experience officer, American Medical Association

Listen on the go to the full episode on Apple Podcasts, Spotify or anywhere podcasts are available.

Transcript


Copyright 1995 - 2021 American Medical Association. All rights reserved.
DiPietro: And so, I think one of the barriers as a medical student or as a clinician coming into this space is, how can you champion within your organization, the moral approach to why we are here delivering this care and bringing the dignity and the respect to patients that are not just overlooked, they're actively discriminated against. I think there's really a role for that being at the front of us participating in a system that demonstrates that it cares for all of its patients, particularly those that are most vulnerable and most often overlooked or ignored.

Unger: That was Barbara DiPietro, senior director of policy at the National Health care for the Homeless Council. In this episode of Making the Rounds, Rutgers medical student Shah Yasin interviews Barbara DiPietro and two other experts—David Woody, President and CEO of the Bridge Homeless Recovery Center in Dallas, Texas, and Dr. David Munson, medical director at Boston Healthcare for the Homeless program in Boston, Massachusetts. They talk about how these lifesaving programs improve health while protecting our health care system and how medical students can make an impact.

This virtual panel was part of AMA’s 2022 Annual Meeting. If you're a resident or medical student, you can gain access to more great events like this one by becoming an AMA member. Visit the [AMA website].

Yasin: First of all, thank you all for joining us, so much. Today, we're going to just start off really quickly with you, Dr. DiPietro. First of all, can you tell us a little bit about just what are medical respite care programs?

DiPietro: Sure. Medical respite programs are post-acute venues for people experiencing homelessness who no longer need to be in the hospital but don't have a place to rest and recuperate like you and I would. Medical respite programs offer a residential component for short-term healing after a hospitalization for those don't need a higher level of care, like skilled nursing.

Yasin: Great. Dr. David Woody, can you tell us a little bit about how these programs are managed? How do they work? What exactly are the inner workings of these programs?

Woody: Sure. Dr. DiPietro was able to really describe the overall desire, purpose of them. What I think goes along with them is, especially in respect to working with homeless individuals, is the ability to have a combination of access to services. Individuals who are comfortable working with the homeless, but also that there is some internal workings. How is it that a homeless citizen can get appropriate assessment, get their medical needs addressed?

And then in terms of the aftercare, the respite care experience, what kind of model is in place to ensure that patient’s needs are addressed, that they're addressed in a situation that is not like a
medical facility? And how is it that both employees of that facility and the homeless individual, that they're both on the same page in terms of the specific needs that are needing to be addressed?

**Dr. Munson:** Shad, can I just highlight one thing that Dr. Woody said, which I think is so important in respite programs, is the patient-centeredness of the program? I think so often, our patients, they really struggle interacting with the larger health care system, in part because of stigma and the fact that a lot of medical training doesn't involve taking care of homeless people. And so, folks don't realize, don't appreciate the trauma that patients have experienced and things like that. And so, they don't bring that into the care. Not intentionally but they don't bring that into the care that they provide as residents or later on in training.

And so, respite programs are beautiful in that the care is provided by people that are really passionate and interested and understand this work. And so, you can create an environment in which folks who aren't comfortable in hospitals, who have unplanned discharges all the time from hospitals, really settle in and feel comfortable in a medical respite program. And that's really a neat aspect of these sorts of programs.

**Yasin:** Dr. Munson, can you tell us a little bit more about what types of models exist around medical respite? There's a lot of different models that exist around this type of program. So what, how?

**Dr. Munson:** Yeah. I think the council, the National Health care Homeless Council and the Medical Respite Network has defined four types of models. The coordinated care model, the coordinated clinical care model, the integrated clinical care model and the comprehensive clinical care model. But the thing that I would say is that respite programs are designed to meet the needs of the communities in which they exist. And so, they have varying levels of clinical care and how intensive the clinical care is, or how intensive the case management services or care management services might be. There's a whole spectrum, from very intensive daily nursing visits that are provided by the same community health center that runs their respite program, to maybe once a week or every other day visiting nurse services that are provided.

So there's a whole spectrum and it's based on what the community needs are. And often payers, whether that be health insurers or state governments, are willing to recognize. And so there can be a wide variety of services that are provided. There are some standards that we recognize as what the baseline are for all programs, in terms of transportation and some clinical access, some food, those sorts of things, access to a bed. But the intensity of clinical services really varies from location to location.

**Yasin:** Great. And in terms of the types of programs that exist, are there large advantages to one specific type or disadvantages to different types?
Dr. Munson: I'm not sure what David or Barbara think but I really think that it's really what the community needs are. And so, I practice in Boston, we have a very clinically intensive model in Boston. Boston's a very clinically intensive place. Hospitals everywhere. That's what Boston seems to need but there's other communities that may not need that. And so, the respite programs look quite different but Barbara and David, I'm curious what you guys think about that.

Woody: I know here in Dallas, there is basically, like in many communities, a hospital role kind of thing but unfortunately there is not the access to the resources that many homeless individuals need. The challenge in some of those institutions is though, that there are homeless individuals who will try to use hospital emergency rooms for shelter. And that too often, there may not be as robust a communication strategy between hospitals and our local sheltering system to ensure that the respite needs for a homeless citizen, once they have gotten their priority medical needs taken care of, that there's not a good communication system in place.

I know here at the shelter that we have, Parkland Hospital, which is the county hospital for the indigent here in Dallas, we have a clinic of theirs right on our campus. And so that gives us access to the respite resources that a citizen who may be leaving the hospital, they have access to those resources here. But even here within our situation, I would say that we don't have the ideal communication strategy to feel fully comfortable with the timing and the responsiveness, in terms of medical needs that a guest would have. So our care management team, our team of social workers are really critical to ensuring that a guest's needs are taken care of.

DiPietro: And Shad, I would follow up that by saying that I think every community needs a medical respite program, simply because every community has people experiencing homelessness. That said, you are also in every community, going to have, people who are homeless have got pretty, very significant clinical needs. And so, I would argue that every community could support various models of medical respite service.

And to that point, even where Dave is, in Boston, they have different types of models of medical respite programs to meet different levels of need. At the same time, most communities just don't have the partnerships yet in place to support multiple levels of medical respite. So I think right now it's a lot of, what can you cobble together as a program, given the financing and the partnership that you have at the table, to do the best you can? And unfortunately, I think when it comes to homeless health care, doing the best you can is generally the best you can.

Yasin: That makes a lot of sense. Dr. Munson, you mentioned payers when you were talking about how medical respite programs may be financed. Dr. DiPietro, can you tell us a little more about how these programs are financed? Are they federal dollars, state dollars? Where does the money come from?
DiPietro: Sure. This is always the $10 million question, right? How does it get paid? I will say the good news here is that health care systems are increasingly looking at interventions that address social determinants of health. So, 10 years ago, even five years ago, I would say, that we were in a really different space with regard to financing. And so now you have more managed care plans. You have more state Medicaid systems. You have hospitals. You have community homeless systems, homelessness services providers, who are all looking to either, on their own or together with partners, come together and finance medical respite.

So, we're seeing increasingly, Medicaid payments and reimbursements on a per diem level. We're seeing more and more hospital grants given to programs, so that they've got a safe discharge plan. You've got homelessness services programs that can use HUD dollars for services and for beds.

And often people will be using multiple funding streams to be able to put together; someone pays for the bed, others pay for the staffing and services. Others might be able to cover food or housekeeping or security. So, there's different elements that need to come together.

Again, I think the real key for an individual community is thinking through, who are your partners that you've got available? And what funding can they bring to this conversation? So what Dave is able to do in Boston would be very different than what Dr. Woody can do in Texas. For example, in particular, a state that has not expanded Medicaid to single adults. So what Dave is able to bill the Medicaid, pretty pervasively in his program is not going to be available to you, Dr. Woody.

So, I think that's obviously another issue that we can talk about for a long time. But I think the financing here, I think we have never been in a more promising space because you've got health care leaders right now that are saying housing is health care. And the residential component that comes with medical respite is often that stepping stone to a more permanent housing placement.

Yasin: Given that some of the dollars might come from Medicaid, does that mean that a patient coming in who's uninsured would have a different experience than a patient coming in who is insured?

DiPietro: I would argue that a well-run respite program, that patient will not see any difference in the care that they receive based on their insurance status. I think that's for us on the administration, is to make sure that's transparent to the client. However, you always will have people who, for whatever reason, and it may be that they are insured but, perhaps, if Dave's working in a reimbursement model, for example, maybe the plan for some reason refused to approve medical respite. So, you might not be getting paid for that day for that patient, for example.

This is on us as administrators to make sure that we financed the program in a way that allows for us to serve the population without regard to insurance status. Now, putting that together with regard to insurance mixed and cost, obviously is financially solvent. But again, that's the challenge. That's the challenge to making it work.
**Dr. Munson:** Just to highlight, we didn't really say this explicitly but medical respite is not recognized by Medicare as a billable entity. And so, it's not like a colonoscopy, for example, where there's a set price and different plans figure out what they're going to reimburse, so you end up with this patchwork of reimbursement models depending on the location or maybe you have a relationship with a hospital here that's different than there. So, it really trickles down to the complete individual level, which is good on some levels but it's challenging on other levels in terms of having a standard of recognition and a standard of compensation for the work that's being done.

**DiPietro:** And if I could, again, mention too, I think where insurance status is really important, particularly clinically, and for medical students who are listening to this, your care options are often going to be dictated by your client's insurance status. And so, what insulins you have access to may even depend on the specific formulary of the managed care plan that your client is on. And so, whether they're on one plan or another might dictate what medications that are covered in that plan that you're able to prescribe.

And so, I think this is where again, I'd love to have another conversation completely about how we need to have a health care system that responds to you as clinicians. But I think often that's where your insurance is going to make a difference, is the care plan that you're able to put together, and what your client is going to have access to and what's covered, in terms of medications or treatments.

**Yasin:** That's definitely a much larger conversation to have, but Dr. Woody, I did have a question about the community resources. You had mentioned that the community in Dallas specifically was working with people experiencing homelessness. You all work with Parkland Hospital and I'm wondering what other community resources are integrated into these programs and how do community resources get integrated into these programs for medical respite?

**Woody:** Well, for me, I think, certainly advocacy is a huge part of the work. Here in Dallas, just structurally, we have a significantly higher percentage of the homeless population that is African American that may be seen across the United States. Here at our center, 65% of our guests are African American. And a lot of the reason why folks come to us is because of a lack of access to the critical resources that would prevent homelessness. They don't have access to those things in their communities, communities that they come from here in Dallas. Poverty rate here is nearly 26% across the city and Dallas County. And so, when folks come to the Bridge, they have free access to basically all of these resources that most folks were craving over a significant period of time and contributed to their homelessness. And so, we continue to advocate for access to the resources.

And one of the things in our model here is that we try to have all of those resources right here on the campus. We even have representatives from the VA for example, who are right here on the campus. There may be a service member, previous service member who feel some kind of way about their service that they were part of. And so, to have two caseworkers available to bridge the gap here and to connect those folks with the resources that the VA has available to them at the local VA hospital.

Copyright 1995 - 2021 American Medical Association. All rights reserved.
here in Dallas and that we can provide transportation to them for their resource needs, physical health, mental health needs there, and then transportation for them to come back here for night shelter, respite is really important.

And again, to have care managers, we call our case workers here care managers, who have crafted a plan, caring housing plan with folks that prioritizes the kind of needs that they didn't have access to in their local community, trying to get those issues taken care of here, and ultimately, craft an opportunity for them to acquire an affordable or workforce housing solution for them. That's really important.

And ultimately, that's what I think all of the respite care programs are about. Who is it that's going to orchestrate and prioritize in relationship with that homeless citizen? Who is involved in doing that? And to have a purpose in a respite program that is about, as Dr. Munson said, putting the client-centric experience first and is engaging, understanding, crafting a relationship, that then allows them with the homeless client, to prioritize what their needs are. That's really important. And I think that's one of the essential aspects of the various types of medical respite care models that's out there.

Yasin: I think we've created a very clear argument for how medical respite care programs are extremely useful for our clients. But unfortunately, we don't see them in every community. And Dr. DiPietro, you mentioned that you think that every community could benefit from a medical respite program.

Dr. Munson, could you tell us a little bit about the barriers that exist to preventing these programs from being integrated into the community in the first place?

Dr. Munson: Yeah, there's a lot of places to start. We could think about some of the financial barriers, just linking to the conversation we had before. The lack of universal health insurance in the United States and the fact that there's not a clear mechanism to pay for these things, these types of programs, is one where you have just some communities where there's just no infrastructure. The programs, the health care wellness programs or the shelter programs, they want to do this but the funding is just not there. Also, I think sometimes, some of these programs require buildings and infrastructure, and that costs money, and you have to have those buildings or you have to create space. Maybe you have a shelter that's already bursting at the seams. And then the question is, do we carve out some space in the shelter? Those are some challenges.

And then, I think, staff. There's a lot of burnout amongst service providers right now. Respite was amazing during COVID, I think, and showed a lot of what respite can do. But COVID has burned a lot of people out. And so now to ask people to work in a role or maybe they're working overnight or there's some issues that come up with some of the residential type aspect of respite care that could be a barrier. But those are just some ideas. I'd be curious for Barbara and David, what your thoughts are on that.
DiPietro: I would certainly say, one of the biggest structural barriers is just stigma against people who are homeless. And so, when you think about asking your hospital, your health center, other partners in the community to put time, resources and staff, toward addressing a medical need of people experiencing homelessness, you will be told at least 12 different reasons why this isn't a population that's worth your time or our money or our resources. Or and I think, one of the biggest things.

And there's a lot that gets wrapped into stigma, too. There's racism that goes into that and not deeming a population worthy of appropriate care. And there's lots of things that we can point to that have created homelessness to begin with, through those same racist or structural barriers that are put in place of a deserving versus an undeserving population. And so, I think one of the barriers as a medical student or as a clinician coming into this space is, how can you champion within your organization, the moral approach to why we are here delivering this care, and bringing the dignity and the respect to patients that are not just overlooked, they're actively discriminated against.

And so, I think there's really a role for that being at the front of us participating in a system that demonstrates that it cares for all of its patients, particularly those that are most vulnerable and most often overlooked or ignored.

Woody: I would add to that, again, in this country, to be able to ask for help is taboo. And it's this stream in terms of how it is that folks, especially folks with leverage, folks with power, decision-makers, can minimize the significance of the homeless experience. I know in our community, having the political will, for example, to commit resources to organizations who are collaborating, who are prioritizing the physical health and mental health needs of individuals experiencing homelessness, has been an incredible challenge.

And so, a large body of the work going on here at the bridge is about educating the community, talking about, as Dr. DiPietro said, dignity and worth or worthiness for the resources. And ultimately, that if an individual experiencing homelessness is not in a good place in terms of their physical health, their ability to manage or sustain housing, that's going to be terribly compromised. So, folks have to be working together in terms of this outcome.

Yasin: I think those are all incredible points. And I want to bring us to a close with our final question. Medical students, they're advocates, they're going to be entering clinical spaces, they're going to be entering policy spaces within the AMA and within their local communities. What advice do you have for them about getting into the space of medical respite care? Whether that be just the student who is working on a discharge for their patient or whether that's a student creating programs in their community. Dr. DiPietro, can I start with you?

DiPietro: I would say that the number one thing you can do is use your privilege and use your credibility to the utmost. Particularly as new doctors coming in, people will listen to you in a way that they might not listen to others raising these issues, particularly because you are newer in the field.
And we talk a lot about how older clinicians are burned out, and they're tired and having new, fresh eyes and new fresh spirit come into a department and say, “This is important. These patients are important, and we can be delivering better care.”

We need your spirit, we need your energy, we need your vision. And above all, we need a value structure in medicine that really pushes the boundaries of where all of these blind spots have been created consciously and they consciously need to be pulled down as well. So having just new people in this space is really welcome and needed.

**Woody:** Having individuals who are enthusiastic, having individuals who really, as Dr. DiPietro says, who are really committed to this. Probably one of the major challenges, again, it's one thing to have knowledge and skills and comfort, confidence in the medical aspect but also thinking about, how is it that I engage a homeless citizen? How do I talk to that person? There are some great evidence-based models. For example, trauma-informed care. There are some very specific techniques and skills that a medical student can layer on top of that knowledge, that will facilitate your connecting with an individual experiencing homelessness and engaging them in building a care plan.

And I think things go much better when you see your patient actively involved in understanding what's going on and understanding, how is it that they could own part of their healing experience.

**Dr. Munson:** All I would maybe add, those are tough acts to follow but I would say as a student, learn who's providing the care for homeless people in your community. Somebody's doing it, somebody's doing it on some level, so ask around. And then go out and spend some time with those people, shadow with them and see what it's like to care for somebody after a discharge from a hospital when they're on 12 medicines, and they return to the shelter and they still have a wound.

Hang out on the street. Spend some time with providers and people experiencing homelessness with medical issues in the community, so that you understand what the need is. And then go back. And as Barbara said, you have a lot more privilege and power than you even recognize you do. The letters after your name are going to open a lot of doors, so use that experience to advocate for what's needed.

**Yasin:** Thank you all so much for your incredible responses. Thank you to the AMA staff for all of your hard work on this and thank you to my committee, the Committee on Legislation and Advocacy. Have a good day, everybody.

**Unger:** You can subscribe to Making the Rounds and other great AMA podcasts anywhere you listen to yours or visit ama-assn.org/podcasts. Thanks for listening.

**Disclaimer:** The viewpoints expressed in this podcast are those of the participants and/or do not necessarily reflect the views and policies of the AMA.