Whereas, The AMA recognizes that the growing crisis of poverty, homelessness, and decreased number of mental health facilities has led to increasingly more Medicaid patients visiting the Emergency Department for preventable and predictable conditions (AMA Policy H-160.903); and

Whereas, Current healthcare delivery to homeless patients contributes to poor health outcomes, increased healthcare spending, and increased medical provider frustration;¹,²,³,⁴ and

Whereas, Without a formalized post-hospitalization arrangement for homeless patients, a de facto process of care has emerged that leads to suboptimal discharge arrangements, provider burnout, poor patient outcomes, and an overall increase in cost of patient care;¹,⁵,⁶ and

Whereas, Medical Respite Care (MRC) is acute and post-acute medical care for homeless patients who are too sick to recover on the streets but not sick enough to be kept inpatient;⁷ and

Whereas, MRC centers are third-party organizations that provide homeless patients MRC, including access to nursing care, behavioral health services, substance abuse services, case managers, and primary care providers;⁷,⁸,⁹,¹⁰ and

Whereas, MRC is associated with fewer hospital readmissions, and a reduction in the total amount of time patients spend in the hospital across multiple parameters as compared to patients who were unable to access MRC care;⁷,⁸ and

⁸ Doran, KM, Ragins KT, Gross CP, et. al. Medical respite programs for homeless patients: A systematic review. J Health Care Poor Underserved. 2013, 24, 499–524
Whereas, MRC report overall cost-savings, particularly when compared with the cost of hospitalization, with demonstrated cost avoidance for hospitals ranging from $3.5 to $5.5 million annually;\(^8\),\(^1\) and

Whereas, As stated in the Standards for Medical Respite Care, MRC quality standards only require self-audits and do not promote standardization across facilities;\(^1\)\(^2\),\(^3\) and

Whereas, Because the vast majority of MRC centers do not receive funding from Medicaid, MRC programs utilize an unreliable patchwork of funding mechanisms across the public and private sector, leading to challenges of incorporating and streamlining MRC;\(^1\)\(^4\),\(^5\) therefore be it

RESOLVED, That our American Medical Association study funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (Directive to Take Action)

Fiscal Note: not yet determined

Received: 04/26/18

RELEVANT AMA POLICY

Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; and (2) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.
Citation: (Res. 401, A-15)

The Mentally Ill Homeless H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.
Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16;

See also: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

\(^1\) National Health Center for the Homeless Council, Inc. “Medical Respite Care: Reducing Costs and Improving Care” (2011)
\(^2\) National Health Care for the Homeless Council, Inc. “Standards for Medical Respite Programs” (2016).