

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-19

Subject: Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients
(Resolution 826-I-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

At the 2018 Interim Meeting, the House of Delegates referred Resolution 826, Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients, which was introduced by the Resident and Fellow Section. Resolution 826 asked that our AMA “work with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals.” The resolution further asked that our AMA reaffirm Policy H-270.962, Unfunded Mandates, and Policy H-130.940, Emergency Department Boarding and Crowding.

This report (1) explores how homelessness contributes to emergency department (ED) overuse and hospitalization, (2) outlines current regulatory requirements related to homelessness and discharge planning, and (3) describes the need for broader efforts to address the unique healthcare and social needs of homeless patients.

BACKGROUND

Homeless individuals are more likely than the general population to experience behavioral health disorders, acute and chronic conditions, and injuries resulting from assaults and accidents. This increased prevalence, in concert with lack of insurance or access to a usual source of medical care, leads homeless individuals to seek care at EDs at a high rate and increases their rates of hospitalization. Indeed, as many as two-thirds of homeless individuals visit an ED each year, as compared to just one-fifth of the general population, and the hospitalization rate for homeless individuals is as much as four times higher than that for non-homeless individuals.¹⁻⁶

Not only are homeless patients more likely to visit an ED, but they are also more likely to re-visit an ED. Indeed, an analysis of national ED utilization rates found that homeless patients were more than three times as likely as non-homeless patients to have been evaluated in the same ED within the previous three days, and were more than twice as likely to visit an ED within a week of discharge from the hospital.⁷

ED utilization is not uniform across the homeless population, with one study representative of the literature on the topic finding that a small proportion of frequent users (7.9%) account for an outsized proportion of total use (54.5%).⁵ Anecdotal accounts, which are not uncommon, cite cases of individual homeless patients with more than 100 ED visits in a year and total costs topping \$1 million.^{8,9}

DISCUSSION

Discharge planning and ED overuse

As suggested by Resolution 826-I-18, hospital and ED discharge planning plays a key role in ending the revolving door of ED visits, hospitalizations, and readmissions, especially among homeless frequent users. Specifically, evidence shows that well-coordinated case management (the development and initiation of which is a key outcome of discharge planning) may reduce ED use and costs, and improve both clinical and social outcomes for homeless patients.¹⁰⁻¹² Despite these findings, discharge planning for homeless patients remains rare: one analysis found that 64% of ED visits resulted in homeless patients being discharged back to the street, with only 4% having a discharge plan addressing their housing status.¹³

Current approaches to discharge planning also overlook important opportunities to improve the health of homeless patients in areas unrelated to their ED visits. For example, given that the CDC Advisory Committee on Immunization Practices now recognizes “homelessness” as an indication for hepatitis A vaccination,¹⁴ patient encounters in the ED present an excellent opportunity to assess immunization status and need for vaccination, and to administer vaccines or refer patients for vaccination.¹⁵ As an added bonus, this holistic approach ensures that homeless patients are immunized, which helps keep them well and out of the ED.

Hospital requirements for discharge planning

Recognizing the value of discharge planning in preventing hospital readmissions, the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) include comprehensive discharge planning requirements for hospitals participating in the Medicare or Medicaid programs. These requirements include:

- (1) Identifying inpatients for whom discharge planning is necessary;*
- (2) Providing a discharge plan evaluation to each identified patient, which “must include an evaluation of the likelihood of a patient’s capacity for selfcare or of the possibility of the patient being cared for in the environment from which he or she entered the hospital;”
- (3) Developing and “[arranging] for the initial implementation of the patient’s discharge plan;”
- (4) Transferring or referring the patient, “along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care;” and
- (5) Reassessing the discharge planning process “on an on-going basis;” which must include “a review of discharge plans to ensure that they are responsive to discharge needs.”¹⁶

The CoPs do not require discharge planning for ED visits without hospital admission, which are categorized as outpatient visits. However, in recent revisions to its interpretive guidelines for discharge planning, CMS observes that “many of the same concerns for effective posthospital care coordination arise [for outpatients] as for inpatients” and therefore recommends that “hospitals

* Note that “in the absence of a finding by the hospital that a patient needs a discharge plan, the patient’s physician may request a discharge plan...[and] the hospital must develop a discharge plan for the patient.”

might consider utilizing, on a voluntary basis, an abbreviated post-hospital planning process for certain categories of outpatients...and for certain categories of emergency department discharges.”¹⁷

At the state level, in 2018 California adopted regulations requiring more stringent discharge planning requirements and services for homeless patients. Set to take effect July 1, 2019, these new regulations require California hospitals to “include a written homeless patient discharge planning policy and process within the hospital discharge policy.”¹⁸ The law further requires hospitals to perform a variety of specific tasks and in a specific manner, including but not limited to:

- logging all discharges of homeless patients;
- providing a meal, clothing, medication, and transportation upon discharge;
- coordinating with social service agencies; and
- discharging homeless patients only during the daytime.^{19,20}

The California law was met with concern by many in the healthcare community, including the California chapter of the American College of Emergency Physicians and the California Hospital Association.^{20,21} While recognizing the importance of and supporting appropriate discharge planning and protocols, critics questioned the feasibility of many aspects of the law—for example, how exactly would a hospital go about maintaining a supply of clothing for homeless patients? They also pointed to severe unintended consequences of the law—for example, that prohibiting overnight discharges would further exacerbate ED overcrowding and constrain hospitals’ capacity to provide timely, lifesaving care to those patients who need it most. And, at the broadest level, they questioned why the societal costs of homelessness should be borne by hospitals, especially safety net hospitals that treat a disproportionately large share of homeless patients and are least able to comply with unfunded mandates.

Moving beyond discharge planning

Effective ED and hospital discharge planning constitutes just one component of what ought to be a more comprehensive approach to addressing the unique healthcare needs of homeless patients—one which, as stated by CMS in its interpretive guidelines for discharge planning, “moves away from a focus primarily on a patient’s hospital stay to consideration of transitions among the multiple types of patient care settings that may be involved at various points in the treatment of a given patient.”¹⁷

Central to these more comprehensive efforts is housing security, an area in which, in the absence of comprehensive state and local homelessness strategies, hospitals and health systems have been obligated to take action in recent years. In 2017, for example, the American Hospital Association published a guidebook, *Housing and the Role of Hospitals*, identifying how hospitals can address this particular social determinant of health. This resource outlines strategies and provides case studies on:

- neighborhood revitalization;
- home assessment and repair programs;
- medical care for the homeless;
- medical respite care; and
- transitional or permanent supportive housing.²²

The last of these strategies has received considerable attention, with hospitals and health systems investing an estimated \$75 to \$100 million in housing for homeless patients.²³ Insurers and local units of government also have contributed to these efforts, typically in partnership with hospitals

1 and health systems.²⁴⁻²⁶ Initial outcomes data on these endeavors suggest that providing housing for
2 homeless patients can decrease ED use and hospitalizations while yielding net savings on
3 combined expenditures for healthcare and social services.²⁷ Despite these outcomes, the long-term
4 desirability and feasibility of this approach is uncertain, as questions of appropriate resource
5 allocation (is there a better way to spend these monies?), cost-sharing (is it appropriate to ask
6 hospitals to cover the cost of social services for homeless patients?), and society's overall approach
7 to eliminating homelessness remain unresolved.

8 9 *AMA policy on discharge planning and care for homeless patients*

10
11 AMA policy recognizes the link between housing security and health outcomes, and supports a
12 coordinated, collaborative approach to care for homeless patients that combines clinical and social
13 services. For example, Policy H-160.903, Eradicating Homelessness, "supports improving the
14 health outcomes and decreasing the health care costs of treating the chronically homeless through
15 clinically proven, high quality, and cost-effective approaches which recognize the positive impact
16 of stable and affordable housing coupled with social services."

17
18 Furthermore, Policy H-160.978, The Mentally Ill Homeless, avers that "public policy initiatives
19 directed to the homeless, including the homeless mentally ill population, should...[promote] care
20 that is sensitive to the overriding needs of this population for food, clothing, and residential
21 facilities."

22
23 Finally, the AMA's comprehensive Evidence-Based Principles of Discharge and Discharge Criteria
24 (Policy H-160.942), while not explicitly addressing homelessness, "calls on physicians, specialty
25 societies, insurers, and other involved parties to join in developing, promoting, and using evidence-
26 based discharge criteria that are sensitive to the physiological, psychological, social, and functional
27 needs of patients."

28 29 **CONCLUSION**

30
31 Homelessness is an exacerbating factor in ED overuse, excess hospitalization, and preventable
32 readmissions. Hospital discharge planning for homeless patients, with a holistic focus on case
33 management that coordinates clinical and social services, has been shown to alleviate some of these
34 problems. Despite this evidence, focused discharge planning remains rare for homeless ED
35 patients. Our AMA should educate physicians about the importance of discharge planning for
36 homeless patients, and encourage the development of holistic, cost-effective, evidence-based
37 discharge plans for homeless patients who present to the emergency department but are not
38 admitted to the hospital.

39
40 While critical, discharge planning alone will not prevent unnecessary ED visits and hospitalizations
41 for homeless individuals. Instead, a more comprehensive approach to addressing the unique
42 healthcare and social needs of homeless patients is required, with efforts reaching beyond the
43 hospital and into the community. Our AMA should encourage collaborative efforts to address
44 homelessness that do not leave hospitals and physicians alone to bear their costs.

1 RECOMMENDATIONS

2
3 The Board of Trustees recommends that the following be adopted in lieu of Resolution 826-I-18
4 and that the remainder of the report be filed:

- 5
6 1. That our American Medical Association partner with relevant stakeholders to educate
7 physicians about the unique healthcare and social needs of homeless patients and the
8 importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role
9 therein, in addressing these needs. (Directive to Take Action)
10
11 2. That our AMA encourage the development of holistic, cost-effective, evidence-based discharge
12 plans for homeless patients who present to the emergency department but are not admitted to
13 the hospital. (New HOD Policy)
14
15 3. That our AMA encourage the collaborative efforts of communities, physicians, hospitals,
16 health systems, insurers, social service organizations, government, and other stakeholders to
17 develop comprehensive homelessness policies and plans that address the healthcare and social
18 needs of homeless patients. (New HOD Policy)
19
20 4. That our AMA reaffirm Policy H-160.903, Eradicating Homelessness, which "supports
21 improving the health outcomes and decreasing the health care costs of treating the chronically
22 homeless through clinically proven, high quality, and cost-effective approaches which
23 recognize the positive impact of stable and affordable housing coupled with social services."
24 (Reaffirm HOD Policy)
25
26 5. That our AMA reaffirm Policy H-160.978, The Mentally Ill Homeless, which states that
27 "public policy initiatives directed to the homeless, including the homeless mentally ill
28 population, should...[promote] care that is sensitive to the overriding needs of this population
29 for food, clothing, and residential facilities." (Reaffirm HOD Policy)
30
31 6. That our AMA reaffirm Policy H-160.942, Evidence-Based Principles of Discharge and
32 Discharge Criteria, which "calls on physicians, specialty societies, insurers, and other involved
33 parties to join in developing, promoting, and using evidence-based discharge criteria that are
34 sensitive to the physiological, psychological, social, and functional needs of patients."
35 (Reaffirm HOD Policy)
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37 7. That our AMA reaffirm Policy H-130.940, Emergency Department Boarding and Crowding,
38 which "supports dissemination of best practices in reducing emergency department boarding
39 and crowding." (Reaffirm HOD Policy)
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41 8. That our AMA reaffirm Policy H-270.962, Unfunded Mandates, which "vigorously opposes
42 any unfunded mandates on physicians." (Reaffirm HOD Policy)

Fiscal Note: \$5,000

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AMA POLICIES RECOMMENDED FOR REAFFIRMATION

H-160.942 Evidence-Based Principles of Discharge and Discharge Criteria

- (1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
- (2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
- (3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
- (4) The AMA promotes the local development, adaption and implementation of discharge criteria.
- (5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
- (6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
- (7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
 - (a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
 - (b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
 - (c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii)

Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care.

- (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and
- (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

H-160.978 The Mentally Ill Homeless

- (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.

H-160.903 Eradicating Homelessness

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;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.