



The Framework for an  
Equitable COVID-19  
Homelessness Response

#HousingEquity

# Expanding Options for Health Care Within Homelessness Services:

## CoC Partnerships with Medical Respite Care Programs

A brief to improve health care quality and outcomes for people experiencing homelessness during the COVID-19 response by strengthening partnerships between homelessness assistance systems and medical respite care (MRC) providers. This brief features the views of both Continuums of Care (CoCs) and MRC staff about how to best integrate operations at the systemic level, as well as featuring a community spotlight on the CoC-MRC partnership in Yakima, Washington.

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## Focus of this Brief

Beyond the lack of affordable housing, poor health, disability, limited access to care, and health-related debt can all cause homelessness. In addition, the traumatic experience of homelessness can cause new health conditions to develop and/or exacerbate pre-existing issues, while making it harder for people without homes to engage in needed treatment. Homelessness services providers are often challenged to serve people with significant health issues. To fill a common gap in community-based care, [medical respite care](#) (MRC) programs provide health care and support services for people without homes who do not need to be hospitalized, but who require further care that is not possible to deliver within traditional emergency shelter environments or in unsheltered settings. When people do not receive needed care, the consequences can be devastating to their health and daily functioning, their emotional and psychological well-being, and their ability to successfully exit homelessness.

**This issue brief illustrates how MRC programs and Continuums of Care (CoC) can effectively partner to improve systems of care and better meet the health care needs of individuals experiencing homelessness.**

It describes existing service gaps, perspectives from MRC and CoC program staff, and action steps that can be taken to improve collaborations. While all communities are unique in their own way, CoC staff, homelessness services providers, MRC program staff, as well as hospital systems and Medicaid payers should use this document as a guide for improving health and housing outcomes.



## The Problem: Health Care Conditions in the Homelessness Services System

The homelessness services system has long-struggled to address the significant health care needs of the population it serves. Chronic and acute illnesses, behavioral health conditions, injuries, and wounds, as well as functional/cognitive limitations are common among people experiencing homelessness, but most homelessness services providers are not health care providers. As a result, shelter staff often struggle to maintain a healthy environment for everyone while at the same time, vulnerable individuals do not receive needed care—resulting in high rates of 911 calls, emergency department/hospital admissions, and worsening health outcomes. For example, most shelters are not trained or staffed to care for those who have just been discharged from the hospital but still require ongoing care for wounds, IV antibiotics, post-operative recuperation, or COVID-19.

[Partnerships with Health Care for the Homeless programs](#) (or other federally qualified health centers/health care partners) are important to connect clients to a medical home, but these outpatient services do not include the residential component so critical to healing, nor are they able to provide the intensity of daily services often needed for stabilization.

To mitigate this problem, [MRC programs](#) provide medical care, support services, and short-term residential services (often in a shelter or stand-alone facility) to people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.<sup>1</sup> MRC programs help people safely recover, access outpatient care and support services, and improve their chances of successfully transitioning to permanent housing. To date, there are [120 known medical respite programs in the United States](#)—most rely on [hospitals or private donations](#) for funding—but more programs are needed to accommodate the rising demand for care.

### Medical Respite Care

- Medical care & case management
- Documentation & benefits
- Medication & disease management skills
- Housing assessments & search preparations
- Ongoing care plans & care coordination

<sup>1</sup>Some communities use the term “recuperative care” instead of “medical respite care” and these terms can be used interchangeably.

## The Vision of Medical Respite Care: “Hospital to Home” in Concept

[Federal law](#) requires hospitals to provide emergency care to everyone, and prohibits them from denying treatment based on insurance status, housing status, or other factors (although instances of “[patient dumping](#)” sometimes still occur). Because people experiencing homelessness often do not have a safe place to recover once they are ready for discharge, they often incur longer stays in the hospital at greater expense to hospitals and insurers.

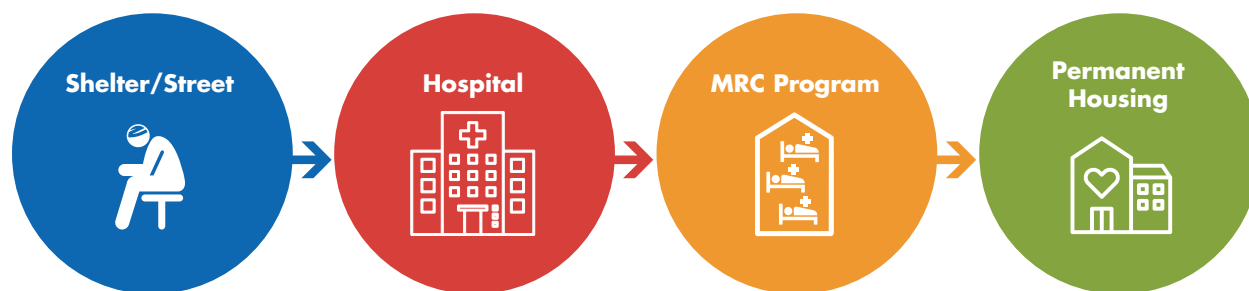
For people experiencing homelessness, MRC programs offer the time and space to heal; work on self-management skills (e.g., medication management, chronic disease management, and connection to primary care and specialists, etc.); develop longer-term care plans; and take the necessary steps to secure housing (e.g., gathering documentation, obtaining benefits, preparing applications, etc.).

For the health care system, MRC programs offer a safe discharge option and provide a secure space for people experiencing homelessness to

recuperate and receive further care—often for two to eight weeks (or more). During this time, clinical providers and support staff attend to medical needs, provide case management and health education, and develop a longer-term care plan. MRC programs can lower hospital lengths of stay, re-admission rates, and overall costs of care, while also improving health outcomes.<sup>2</sup>

For the homelessness services system, MRC programs work with recuperating clients to develop housing plans, which may include completing housing assessments for the coordinated entry (CE) system to determine eligibility for a potential housing placement. Moving clients directly from MRC into housing (see [Figure 1](#)) would help improve [outcomes and system performance measures for CoCs](#) by preventing shelter placements for very sick clients, [housing individuals more quickly](#), [increasing income](#), and preventing returns to homelessness.

Figure 1: The Vision of MRC in Concept



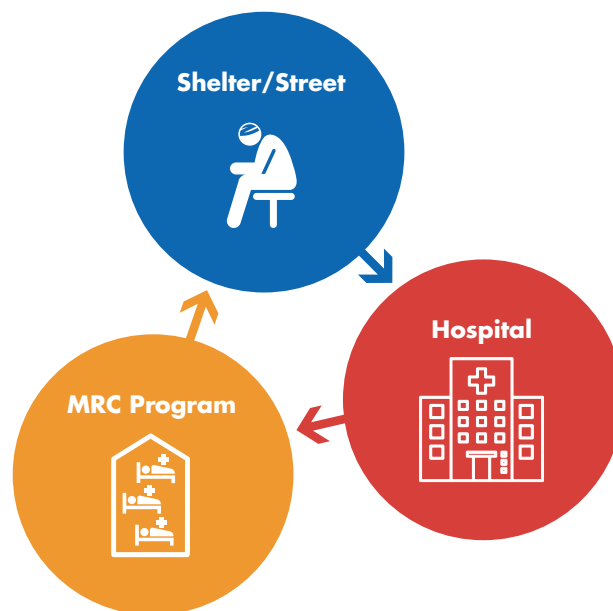
<sup>2</sup>Research demonstrating MRC outcomes can be found at [Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care](#) (March 2021).

## The Paradox: “Hospital to Home” in Reality

Unfortunately, the vision of a “hospital to home” housing placement is difficult to achieve. Many hospitals do not have an MRC program in their community, or if they do, not all hospitals partner with it. Hospitals already partnering with MRCs may have more patients being discharged without stable housing and in need of additional recovery than available respite beds ready to take them, and continue to discharge some patients directly to shelter (or even unsheltered settings). Likewise, it is not unusual for patients to be discharged from MRC programs back into emergency shelter or to an unsheltered location because a housing placement is not yet available. Further, MRC programs are generally only appropriate for those who can manage their own [activities of daily living](#) (ADLs, such as bathing, dressing, walking, eating, etc.), which may limit the number of patients eligible to be admitted to the program. Individuals who cannot conduct their own ADLs will also likely not be able to navigate the shelter system.

Hence, it is not unusual for there to be a cycle of shelter/street → hospital → MRC → shelter/street (see [Figure 2](#)). Although MRC programs offer short-term stability and intensive case management, without stable housing a person is likely to continue to struggle with chronic (and worsening) health conditions. Ongoing ill health can lead to more significant health events and a decline in functional abilities to the point where clients need a higher level of care than MRC programs can provide, such as a skilled nursing facility or nursing home. Unfortunately, accessing these higher levels of care is more difficult for homeless populations due to other gaps in the health care system (low reimbursement rates, stigma, lack of trauma-informed care, etc.). Hence, despite common goals and tangible efforts from both the MRC providers and the homelessness services sector, gaps in care for this population continue to be common.

Figure 2: The Common Reality of MRC



## Stakeholder Discussions: Shared Desires and Mutual Frustrations

Clearly there is a need to better understand this paradox and to identify successful strategies for incorporating MRC programs into homelessness services systems. To obtain direct input from the homelessness services and MRC field, we conducted a focus group with staff from 11 MRC programs, and a separate focus group with staff from seven Continuums of Care (CoCs) who were already partnering with an MRC program in their community. Their respective feedback reflected many shared goals and a strong desire to work together. At the same time, they also acknowledged mutual frustrations with systemic gaps, a common need for help from other vested stakeholders in the health care sector, a lack of adequate permanent housing options, and complex housing prioritization decisions. Below are key take-aways from these conversations, followed by action steps to take:

### **Shared desires and areas of agreement:**

All participants strongly agreed that people experiencing homelessness should get health care services in a setting that best meets their health needs and maximizes independence. They all agreed the ultimate desired outcome was a permanent housing placement coupled with support services as appropriate. Participants in both groups described how MRC staff participate in CoC leadership structures (e.g., member of Board of Directors, committees/task forces/workgroups, etc.) and brought welcome health care perspectives to the discussions and decision-making process. CoC participants cited numerous examples of sick or injured clients whose health declined in shelter, but were able to improve in MRC. The CoC group broadly recognized the value of MRC programs and the importance of partnering together, noting they fill a critical role in the larger system of care.

### CoC Quote

*"We had two people exit from shelter with behavioral health issues. The MRC picked them up because of their medical vulnerabilities, got them into a more appropriate place with medical resources, and prevented them from going back to hospital, getting worse, or becoming unsheltered."*

**Mutual frustrations:** Both CoC and MRC focus group participants expressed views that expose mutual frustrations with systemic gaps and a need for help from the greater health care sector to address the health care needs of people experiencing homelessness. Five areas of particular focus included the following:

- Admission criteria and program capacity
- Coordinated entry and program referrals
- Medical vulnerability and assessments
- Ongoing gaps in housing and health
- Responsible entities

**Q:** "Are we solving a medical problem or a homelessness problem?"

**A:** Both.

The views of CoC and MRC representatives are explored below across each of these five focus areas:

# 1

## Admission Criteria and Program Capacity

### CoC Views

CoCs want a better understanding of admission criteria and eligibility for MRC programs.

CoCs want more MRC beds because programs are often at capacity, resulting in more hospital discharges directly to the shelter (which are not equipped to meet the care needs of these clients). Having additional MRC capacity would likely strengthen coordination.

### Quotes

*"We're at the beginning of bringing an MRC program into the homeless response system, but there's some growing pains between the homeless system and the medical system. Aligning the language we use and getting a common understanding of each other's worlds will likely help."*

### MRC Views

CoCs often do not understand MRC admission criteria and the model of care being offered.

CoCs do not always understand health care issues or know how to be involved in these issues. There are times when the health care and homelessness services systems feel very separate from each other.

### Quotes

*"In our community, the CoC's perception is that these are our patients and we need to figure it out on our own."*

*"They [CoCs] don't realize the impact that not having these services has on their outcomes."*

## 2

## Coordinated Entry and Program Referrals

### CoC Views

CoC staff understand that MRC programs want their clients to be prioritized for housing and to discharge clients directly into a housing placement. However, the length of time from CE assessment to an available housing opening almost always exceeds the relatively short timeframe that MRCs can keep people.

CoCs try to ensure a consistent CE process for all the providers in the CoC. Because MRC programs are often small and comprise very few beds, it is difficult to justify workarounds, special priority status, or alternate processes just for MRC programs.

CoCs would also like an option to refer clients to the MRC. CoCs observe that hospitals are often the only referral source to MRCs, but there are many people in shelters and/or staying unsheltered with similar acuity and needs for MRC.

### Quotes

*"MRC clients [in my community] come through their own funnel to get into the system rather than the CE front door. It creates a problem because the MRC program wants us to house them, and they want to move people on [to housing] from their program without having to merge into other prioritizations."*

### MRC Views

While some MRC programs participate in CE, others do not. Many MRC programs would like to participate in the system, have their clients prioritized for housing, and discharge clients directly to a housing placement. They acknowledge the lack of adequate permanent housing resources makes that difficult given the typical length of stay at MRCs, but they would like to explore where flexibilities are possible.

At times, longer lengths of stay at an MRC can jeopardize an individual client's "chronic homelessness" status [depending on which category the CoC has listed the MRC beds in the housing inventory count (HIC)], which then can limit eligibility for some housing programs upon discharge.

### Quotes

*"The length of time between getting someone an assessment and them actually being housed is an incredibly long time. Open units sit because they're trying to find people or get paperwork together. We provide a lot of education and help clients get connected to more permanent supports so they have a team to help them with the journey."*



## 2

## Coordinated Entry and Program Referrals *continued*

### CoC Views

#### Quotes

*"MRC [in my community] can only take from hospital, but what if the person doesn't come from the hospital but clearly needs MRC? Why can't shelters refer? Some of this is case-by-case, but we're working through a clear referral process."*

*"We are focusing on CE access for MRC clients but the program stays are so short that people don't get a housing referral before their time is up."*

*"When we first integrated CE into the MRC process, it was challenging. But it does get better—the relationship will get better."*

### MRC Views

#### Quotes

*"In our community, if someone is with us, or hospitalized or in a SNF [skilled nursing facility] or anything besides a shelter and they are there for more than 90 days, it disrupts their chronic homeless status so they are not eligible for many housing programs."*

### 3

## Medical Vulnerability and Assessments

### CoC Views

CoCs would like to have more medical information to understand and assess vulnerability beyond the limited existing questions about disability in the CE assessment; however, they would like medical providers to verify information that is often self-reported.

CoCs struggle to balance consideration of medical vulnerabilities of people being served within MRCs with the need to prioritize a range of vulnerabilities and risks across the larger system for referrals to limited housing resources.

### MRC Views

MRCs provide care to a vulnerable population but the CE assessment process often does not consider much medical information. Hence, it can be difficult to demonstrate the vulnerabilities that would allow this group to be prioritized for limited housing resources.

The CE assessment tool should include a sufficient level of medical/health care information to better assess medical vulnerabilities within systems for prioritizing people for limited housing resources.

### Quotes

*"Many of the folks in MRC are the most medically fragile in our CoC. We take disability into account for CE, but in our community it's just a yes-no question on whether you have a disability. We want to add a medical fragility piece because we want to pull those folks out and refer to CE."*

### Quotes

*"The shelter and our MRC both have seats at the table to talk about clients. We use VISPDAT [an assessment tool] to triage, but we can discuss extenuating circumstances where mental health or other health conditions are important. Each group brings something to the discussion and can better evaluate different clients' needs. It's not just housing that's pulling names based on a score, but actually a lot more criteria and consideration."*

# 4

## Ongoing Gaps in Housing and Health

### CoC Views

CoCs agreed that MRC is vital for meeting short-term medical needs, but recognize that many clients have significant, long-term chronic illnesses and behavioral health conditions that are not able to be accommodated in most MRC programs. There are often no good options for such clients with these significant service needs.

Due to the housing shortage, there is frequently a gap in care between MRC discharge and housing placement where clients are in the shelter or on the street. CoCs would like to see MRCs and other health care stakeholders advocate for more housing options so that people could be connected to housing more quickly.

### Quotes

*"The challenge is that the acute ailment starts unraveling into chronic conditions and then there's no long-term option...even if they go to a nursing home, there's no beds available or money to pay for it. That's a gap between hospitals and CoCs—there's no options for the chronic long-term clients who need in-home medical care."*

*"MRC is a clear solution for hospitals, which saves their bottom line, which is why they should invest. But we'd also like to see solutions for longer-term issues."*

### MRC Views

MRC programs regularly observe shelter staff having difficulty managing the wide range of health care problems that are present. They want to help CoCs with the gap in the service-delivery system and demonstrate their value and cost-savings to the community.

MRC programs believe CoCs are primarily focused on HUD-related housing requirements and as a result, only see MRCs as outliers that do not "fit." They believe that CoCs may see little role for the intensive health care and case management services that MRC clients need in order to stabilize and be able to exit homelessness.

### Quotes

*"The biggest piece is that we aren't fully included and there's a big service gap. The opinion of our CoC is that people experiencing homelessness need to be in hospital or they need to be in shelter and there's nothing in between."*

*"In our community, there's no leeway or modification for a program [like MRC] that's not proscribed by the CoC. So yes, we're at the table, but we don't really fit in."*

# 5

## Responsible Entities

### CoC Views

CoCs expressed a need for the health care system to support longer-term solutions—not just crisis interventions. They want the health care sector (hospitals and insurance plans specifically) to take more responsibility for homelessness because the homelessness services system can't do it all.

CoCs understand that more hospitals, insurance companies/Medicaid, and health care providers want to be involved in connecting people to housing, but CoCs do not generally have those relationships, nor are they Medicaid providers. They would like these entities to pay more for the health services in supportive housing, invest in affordable/permanent supportive housing, and make a greater effort to support patients' transitions to appropriate care.

#### Quotes

*"Sometimes the medical community is used to the world adjusting to them and their needs, but that's not the reality. MRC are important and solve one problem, but there's so much more to do together and it's our collective responsibility to figure out how to address homelessness in this country. We welcome partnerships, but the CoC can't do it all."*

### MRC Views

MRCs provide care to a vulnerable population but the CE assessment process often does not consider much medical information. Hence, it can be difficult to demonstrate the vulnerabilities that would allow this group to be prioritized for limited housing resources.

The CE assessment tool should include a sufficient level of medical/health care information to better assess medical vulnerabilities within systems for prioritizing people for limited housing resources.

#### Quotes

*"It goes without saying that health systems including hospitals and MCOs should also be funding MRCs. If all of these entities shared the cost equitably, the return on investment would absolutely exceed the actual dollar amount, in my opinion."*

# 5

## Responsible Entities *continued*

### CoC Views

#### Quotes

*"It's not just the hospital. Who pays for the services? That's why insurance providers need to help with long-term needs and have things be Medicaid billable—like case management and housing services. It's a three-pronged piece and everyone has their own lane. We see more insurance companies are now paying because they see value in MRC also."*

### MRC Views

#### Quotes

*"Health care is just another entry point into homelessness services. We need to bring these respective frameworks together into a collective community investment model and share the responsibility. Different funders want to see different outcomes so we need to fit the narrative better to demonstrate how housing helps both homelessness and health."*

## Focus on Equity Still Developing

Understanding how these collaborations impact racial inequities is still evolving. While participants were clear they wanted to do more to assess and address racial inequities, few were able to point to specific steps they had taken to center racial equity within their discussions and decision-making. CoCs see MRCs as a small (but critical) program within the CoC, but acknowledge it is difficult to assess how MRCs might contribute to reducing overall disparities since the homelessness response system is so much larger. None of the CoCs represented described specific steps they had taken to include assessment of MRCs within a larger equity analysis of access and outcomes within their local homelessness response system.

MRC program representatives asserted that they provide the case management, care coordination, and health education that could help address common inequities that BIPOC clients experience within homelessness response systems, such as obtaining benefits/identification, connecting to primary care and other providers, etc. However, more analysis is needed to understand what impact such services actually have on racial inequities, and if more intentional efforts to reduce disparities would have a greater impact. This is especially important given that health care and social services delivery systems have historically fostered—or even worsened—such disparities. None of the MRCs represented reported performing specific assessments of access and outcomes within their

## Focus on Equity Still Developing *continued*

programs. As CoCs and MRCs pursue stronger collaborations—and address challenges and differing perspectives within those collaborative efforts—they will need to share responsibility for centering equity in their work.

### Quote

“We say that we house everyone, but when we do a deeper dive into the numbers, it takes twice as long for someone of color to get housing. We’re having a moment of reckoning. This is the beginning and not the end of the conversation and it’s long overdue.”

## The Way Forward: Systemic Changes Needed in Housing & Health Care

The prevalence of homelessness is evidence that public systems have fundamentally failed. Absent a sufficient supply of affordable housing units and a system of health care that ensures access to comprehensive care in appropriate venues for everyone, homelessness—as well as the health care conditions it creates and perpetuates—will continue to be pervasive in the U.S.

CoCs, homelessness services providers, and MRC providers (as well as other types of service providers) are all working to bridge existing gaps in the housing and health care systems, but are not given the resources or support needed to do so consistently. Instead, they struggle with insufficient funding, siloed approaches to public programs, and either indifferent or tediously incremental responses from policymakers. It is therefore understandable that these community partners struggle at times to partner as seamlessly as their respective missions would suggest.

There is common agreement, however, that greater support is needed from the larger health care system. Skilled nursing facilities, nursing homes, residential treatment programs, and other higher levels of care may be more appropriate if clients need help addressing ADLs and/or chronic, longer-term functional limitations. Unfortunately, long-standing barriers to appropriate levels of care for this population—driven by stigma, [insurance status](#), cherry-picking, and limited reimbursements—can put undue pressure on MRC programs to take higher acuity patients. **These health care partners, along with insurers, are vested stakeholders with greater resources and more political capital than those in the homelessness services system and should do more to fund and advocate for affordable housing as well as improvements in access to health care.**

## The Way Forward: Systemic Changes Needed in Housing & Health Care *continued*

### Quotes

“There’s no assisted living or home health care, they aren’t appropriate for shelter, and they can’t live on their own. We need the medical establishment to step up and set up transitional/medium-term and long-term settings to address chronic issues. Our case management is not trained as nurses or mental health or substance use disorder counselors. Ideally—we need short- medium-, and long-term placement options. We are just not trained to handle these issues.”

“We need more resources than the emergency shelter bed—we need more housing vouchers. If you are a hospital system and you can afford three vouchers, that’s a huge help. Please don’t expect us to take care of everything with the limited resources we have.”

## Managing in the Meantime: Action Steps at the Local Level

While expanding MRC programs has long been a strategy in the [Federal Strategic Plan to Prevent and End Homelessness](#), it is likely local community responses to COVID-19 that have best illustrated the vital importance of MRC. Many communities expedited housing placements, implemented isolation/quarantine and non-congregate protective housing programs, and delivered onsite health care and support services in these [alternate care sites](#). While existing MRC programs were a [key part of the response](#), these new approaches [often replicated](#) the MRC model of care. The [lessons learned](#) from these experiences show that [effective partnerships](#) between housing, homelessness services, and health care providers were key in helping contain virus transmission and deliver needed services.

While larger, systemic changes are needed to truly end homelessness, there are many important steps that local CoCs, MRC programs, and hospitals and Medicaid/MCOs can take to help establish better partnerships. These steps can help address many of the differing perspectives and concerns highlighted by CoC and MRCs. They can also lay the groundwork for expanding access to MRCs should future funding opportunities become available.

## Managing in the Meantime: Action Steps at the Local Level *continued*

| Local Level Action Steps to Improve Partnerships                    |  |  |   |
|---|--|--|---|
| Issues to Address   | Steps for CoCs   | Steps for MRCs   | Steps for Hospitals & Medicaid/MCOs   |
| <b>Understand each other and build relationships across systems</b> | Get to know MRC programs and others in the health care system. Better understand their systems and their models of care. Create opportunities to talk with one another at a systems level. | Get to know CoC programs and the range of service models at different homelessness services providers. Create opportunities to talk with one another at a systems level. | Get to know MRCs, CoC staff, and homelessness services programs and discuss shared roles and responsibilities for clients who are homeless. Consider engaging state hospital associations as key partners also. |
|   | Add MRC representation to CoC boards and/or other committee structures (to include planning and other needs assessments).  | Add CoC representation to MRC boards and/or planning structures.   | Add CoC and MRC representation to <a href="#">community health needs assessments</a> and other initiatives.   |
|   | Collaboratively assess how often clients are disqualified from housing based on length of stay, and discuss how changes to the categorization of MRC beds might be needed.                 |  | Train discharge staff on appropriate criteria for MRC admission and access to other community resources.  |
|   |  |  |   |
|   |  | Conduct an annual summit together to improve care and patient outcomes.  |   |



## Local Level Action Steps to Improve Partnerships

| Issues to Address   | Steps for CoCs  | Steps for MRCs  | Steps for Hospitals & Medicaid/MCOs   |
|---|---|---|---|
| <p><b>Allocate funding strategically to achieve broader goals</b></p>                     | <p>Consider where funding MRC programs (or specific services) may be appropriate, or policy changes/system improvements that would facilitate better collaborations.</p>                    | <p>Obtain greater funding from hospitals and payers; for shelter-based programs, pursue funding for beds and other services appropriate for <a href="#">HUD-ESG</a> or other funding sources.</p> | <p>Fund MRC programs, housing units, housing-related services, and other needed interventions for people experiencing homelessness.</p>   |
| <p><b>Clarify process for program referrals &amp; coordinated entry participation</b></p> | <p>Assess policies for prioritizing CES referrals from MRC programs and introduce flexibilities as appropriate.</p>   | <p>Assess and revise, as needed, policies for taking MRC referrals from shelters and other homelessness services providers.</p>   | <p>Allow for direct referral from shelters and unsheltered locations into MRC (especially to avoid ED/hospital re/admissions).</p>  |
| <p><b>Consider the information most needed for decision-making</b></p>                    | <p>Collaboratively determine what medical vulnerability information should be factored into CES assessment tools and how it should inform prioritization for limited housing resources.</p> |   | <p>Collect and share data relevant to homeless status and medical needs.</p>  |
| <p><b>Center racial equity measurement and evaluation</b></p>                             | <p>Establish, track, and regularly evaluate performance metrics related to equity, and link to MRC outcomes where appropriate.</p>  | <p>Establish, track, and regularly evaluate performance metrics related to equity, and link to CoC outcomes where appropriate.</p>  | <p>Establish, track, and regularly evaluate performance metrics related to equity, which may mean <a href="#">recording/tracking homelessness status</a> more consistently.</p> |

## Managing in the Meantime: Action Steps at the Local Level *continued*

| Local Level Action Steps to Improve Partnerships                  |   |   |   |
|---|---|---|---|
| Issues to Address   | Steps for CoCs  | Steps for MRCs  | Steps for Hospitals & Medicaid/MCOs   |
| <p><b>Advocate to address gaps in housing and health care</b></p> | <p>Assess the existing barriers to accessing crisis services, shelter, and housing for people with significant health care needs.</p> | <p>Assess patient acuity, service needs, and appropriate venues of care needed to ensure positive outcomes.</p>                                       | <p>Regularly evaluate the impact of homelessness on hospital re/admissions.</p>   |
|   | <p>Advocate for the health care system to be more vested in solutions to homelessness.</p>  | <p>Encourage hospital and MCO partners to advocate for housing and access to all appropriate venues of care for people experiencing homelessness.</p> | <p>Advocate for greater public funding for housing and to eliminate barriers accessing appropriate levels of care for people experiencing homelessness.</p> |

# One Community's Collaborative Approach: A Spotlight on Yakima, Washington

Some communities have made tremendous strides to effectively align homelessness services and MRC programs. This spotlight interview includes the housing, CoC, and MRC leaders in Yakima, Washington. They describe their MRC program, how it fits within their community's response to homelessness, their collective approaches to racial equity, and specific ways they have strengthened their system through their collaboration. Finally, they offer four bits of advice for others who are looking to align their homelessness and MRC programs. All communities—large and small—can make improvements in their systems of care.



## Spotlight on Yakima, Washington

Yakima is an agricultural community in the central region of Washington State. In September 2021, leaders of the Yakima CoC, the housing authority, and the federally qualified health center (FQHC) that operates the [medical respite care](#) (MRC) program convened to discuss their effective collaboration together:

- **Esther Magasis, Director, [Department of Human Services](#)**. As a part of the Balance of State CoC, this agency coordinates the CoC activities in Yakima County. The [2020 Point in Time report](#) counted 663 people in 524 households, and homeless services is tracked on a [public dashboard](#).
- **Lowel Krueger, Executive Director, [Yakima Housing Authority](#)**; which is tasked with providing safe, decent, and sanitary housing for low- and moderate-income residents of the City of Yakima.
- **Rhonda Hauff, CEO, and Annette Rodriguez, Director of Homeless Services, [Yakima Neighborhood Health Services](#) (YNHS)**. As a large FQHC offering primary care, behavioral health, and support services—as well as operating an MRC program—YNHS served 2,633 people experiencing homelessness in 2020.

### Medical Respite Care

Provides acute and post-acute medical care for people who are homeless and too ill to be on the street/in shelter, but not ill enough for hospital-level care.

## Spotlight on Yakima, Washington *continued*

**Purpose of this Spotlight Profile:** People experiencing homelessness need space to recover safely from illnesses or injuries, and receive support to access care. This “spotlight” interview illustrates how one community forged an effective partnership between its CoC, its public housing authority, and its FQHC-operated MRC program.

### Can you describe Yakima’s Medical Respite Care program and the services it offers?

Yakima Neighborhood Health Services (YNHS), an FQHC, operates the MRC program. The program currently has three locations—“The 101 House,” a wheel-chair accessible residence with five, single-occupancy rooms, and “The Bonlender House,” a three-bedroom house nearby that can accommodate up to five people (two rooms are double-occupancy). In order to accommodate greater client needs and to conduct more infection control during the COVID-19 response, YNHS contracted with the Department of Human Services to add 10 “COVID” rooms at a nearby motel using [CDBG funding](#) [Community Development Block Grant]. However, the contract was flexible enough to expand capacity according to need; hence, YNHS was able to shelter and care for as many as 26 COVID-19 respite patients at one time in the motel. Between all three sites, the MRC program in Yakima has served up to 40 people at any given time. Referrals to the program can come from either hospital discharge staff or YNHS providers. YNHS nurses at the MRC program evaluate referrals to ensure each patient is appropriate for the program.

**Services:** Daily case management and nursing visits, behavioral health care visits (if needed), medication management, care coordination to

specialty care and other services, connections to a housing specialist, enrollment in benefits such as health insurance, transportation to medical appointments, three meals a day, laundry, and housekeeping. Each client is screened for an assessment of social determinants of health, and a client-centered care plan is developed. The program focuses on support services and connections to care; most medical care is provided separately at YNHS (as an FQHC).

**Staff:** YNHS dedicates a registered nurse, a behavioral health specialist, an outreach worker, a medical case manager (who is a certified medical assistant), and a housing specialist to staff the MRC program.

### How does your MRC program fit within your community’s response to homelessness?

The MRC program is a critical part of the county-wide homelessness system response, especially during COVID-19, because it brings the health care lens to the entire continuum. Our MRC program is considered an “emergency shelter” so enrollments and transfers to other homelessness assistance programs are seamless.

The [Yakima Housing Authority](#) (YHA) has dedicated more than 100 housing vouchers to people experiencing homelessness, and has been a significant partner for the MRC program in order to house clients directly upon discharge from the program. These YHA vouchers, combined with YNHS’s support services, help provide supportive housing and supported employment to improve the health status and income status of our shared clients. One of MRC’s goals is to identify a housing option prior to discharge, but this is only able to happen for

## Spotlight on Yakima, Washington *continued*

approximately 25% of clients due to the lack of available, affordable housing units.

Importantly, the CoC's collaboration with the MRC helps improve CoC outcome measures. In [Yakima County's 5-year Plan to Address Homelessness](#), the MRC helps most directly with Goal 1 (identify and engage PEH) and Goal 2 (prioritize housing for people with the greatest need). Not only does the MRC receive referrals from hospitals and coordinate needed care using a warm hand-off, but once people are connected to the MRC program, they have a chance to recover, be assessed through the CE, and connect with a case manager and a primary care provider. Offering greater supports and medical care in addition to a bed and a meal has brought greater dignity to those who are genuinely suffering.

### How are you addressing issues of racial equity within your efforts?

More young adults (age 18-24) with behavioral health conditions are being housed, but we want to ensure that BIPOC and LGBTQ youth have equitable access to those housing opportunities. To that end, we are surveying our community so we know how best to reach this population. To help stretch housing opportunities and assist a greater number of youth, our CoC is also offering more diversion training in order to avoid longer-term involvement with the homeless services system.

To better serve the Native population, the Yakima County Department of Human Services met with the [Yakama Nation Tribal Council](#) to discuss the large group of Tribal members living outside in a field. Now all three of our coordinated entry access point agencies are building stronger

relationships with [Village of Hope](#), a family shelter for the Yakama Nation. This will help better connect those living unsheltered to housing and health care services.

### How have you strengthened your system and collaboration?

Four systemic changes our community has made to help further our collaboration include:

**Resumed MRC funding and reassigned as emergency shelter:** The MRC received CoC funding back in 2010, but that ended after several years because the CoC didn't consider the program a low-barrier emergency shelter. The CoC evaluation committee at the time believed the eligibility criteria of requiring an acute medical condition was a barrier to accessing a traditional "shelter." Just before the pandemic, however, a re-constituted CoC resumed funding MRC to cover the beds, meals, and support services because of its low-barrier approach, and reclassified the MRC beds to emergency shelter.

**Increased capacity to respond to COVID-19:** The CoC allocated additional COVID-19 funding to expand MRC beds and staff capacity. The additional funds allowed the MRC program to expand beyond 10 additional beds to using motel rooms to accommodate greater client needs and to conduct more infection control. The extra funding allowed the MRC program to add more clinical staff (to include night and weekend coverage), which increased the capacity to conduct more outreach at shelters and encampments to address outbreaks and provide public health education. Separate facilities are available for COVID and non-COVID patients.

## Spotlight on Yakima, Washington *continued*

**Revised assessment tool:** The CoC is revising its CE assessment tool to be [more equitable](#) and better prioritize those who are most vulnerable, especially BIPOC and LGBTQ clients. The [Statewide Diversity, Equity and Inclusion Council](#) reviewed and approved the new tool. Staff from YNHS chair the CE Committee, where providers meet twice a month to discuss the needs of clients who have not yet been housed, and ensure they are connected to a case manager and/or a health care provider, as needed.

**Added health information:** Care coordinators at YNHS conduct a [PRISM assessment](#) (Predictive Risk Intelligence System), which is a modeling system developed by the WA State Medicaid program. PRISM predicts the type, intensity, and costs of future health care services as well as likely barriers to care and assigns a score. While this type of assessment is new to housing providers, the health care sector is more familiar with this process. There is now additional information to add to the CE determination because PRISM scores are considered along with the score from the new prioritization tool to better determine vulnerability.

“Health care risk factors should drive more housing decisions.”

– **Annette Rodriguez**, Director of Homeless Services, Yakima Neighborhood Health Services (YNHS)

Because the health center is both the health care provider and the CE coordinator, there’s more information about the health status of clients.

### What advice do you have for other communities?

- Integrate MRC in a way that’s not a stand-alone medical program, but an integral part of your homelessness response system that can take and make CE referrals. Discuss how and why MRC qualifies as emergency shelter for the housing inventory count (HIC).

“Many communities just involve housing providers in their CoC, but here in Yakima, we’ve included housing AND health care, which is unique. As a housing provider, you need to build relationships with your health care providers because it’s difficult for clients to navigate both systems—they need help from us, and we need to be good partners for them.”

– **Annette Rodriguez**, Director of Homeless Services, Yakima Neighborhood Health Services (YNHS)

- Build partnerships with other shelters and housing providers to conduct CE intakes, provide warm hand-offs to needed services, and discharge clients to permanent housing as often as possible.

## Spotlight on Yakima, Washington *continued*

- Be responsive to one another when there's an urgent need to get clients into care.

"One of the great things about being in a medium-size town is that you know people and you know if you pick up the phone, they will likely help you—even at 6:00 on a Friday night."

– **Esther Magasis**, Director, Department of Human Services

- Set realistic boundaries, but be flexible enough to occasionally cross them. For example, we often say we are not a nursing home or a skilled nursing facility, yet sometimes we accept someone we otherwise would not.

### **Examples of How MRC Programs Respond Quickly to Medical Needs (September 2021):**

The hospital called our MRC to report a very fragile, terminally ill patient had just left AMA (against medical advice). When we found her on the street, she was very weak, but desperately did not want to be in the hospital. We got her into an MRC unit immediately, helped meet her dietary needs, and scheduled hospice services to help care for her. She regained her strength and is currently staying with friends for further recuperation (thus diverting her from the homelessness services system).

The church called because someone was resting in their yard and needed help. Our team found him malnourished and with a bad wound. He hadn't slept or ate in three days. We delivered urgent care and admitted him to the MRC program. We coordinated wound care for him and he is currently still healing in our program.

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### Medical Respite Care program participants:

1. **Ashley Brand**, MA, MPH, CPH , System Director, Community/Homeless Health, [CommonSpirit Health](#), Sacramento, CA
2. **Kelly Bruno**, President and CEO, [National Health Foundation](#), Los Angeles, CA
3. **Leslie Enzian**, MD, Medical Director, [Edward Thomas House](#), Seattle, WA
4. **Beth Graham**, Executive Director, [Joseph's Home](#), Cleveland, OH
5. **Elizabeth Kelly**, Executive Director/CEO, [HOPE, Inc.](#), Adult Shelter and Recuperative Center, Pontiac, MI
6. **Pamela Kerr**, MSW, Director of Resident Life and Employment Services, [The Boulevard](#) – The Road to Health and Home, Chicago, IL
7. **Susannah King**, MSW, LICSW, Social Services Manager, [Health Care for the Homeless](#), Minneapolis, MN
8. **Hilary King**, LMHC, SUDP, Clinic Manager, [Edward Thomas House](#), Seattle, WA
9. **Laurel Nelson**, CEO, [Center for Respite Care](#), Cincinnati, OH
10. **Miriah Nunnaley**, Director of Recuperative Care, [Colorado Coalition for the Homeless](#), Denver, CO
11. **Randy Pinnelli**, PA, Director, [Health Care for the Homeless, Care Link](#), Gleason House Medical Clinic, Stockton, CA

### Continuum of Care participants:

1. **Adam Cheshire**, Program Administrator for Homeless Initiatives, San Joaquin Valley/Stockton, CA.
2. **Colin Davis**, Community Development Manager, [Community Development Department](#), Durham, NC
3. **Beth Horwitz**, Vice President of Strategy and Innovation, [All Chicago](#), Chicago, IL
4. **Sally Lott**, Outreach Specialist, Nashville Outreach Team for Encampments, [Homeless Impact Division](#), Nashville, TN
5. **Leah McCall**, Executive Director, [Alliance for Housing](#), Pontiac, MI
6. **Tracey Schumacher**, Hennepin County-Minneapolis CoC Coordinator, CE Manager, Hennepin, MN
7. **Melissa Sirak**, Director, [Office of Homeless Services](#), Cuyahoga County HHS, Cleveland, OH

**The Framework for an Equitable COVID-19 Homelessness Response project is being collaboratively guided by the following partners:**

Center on Budget and Policy Priorities • National Alliance to End Homelessness  
National Health Care for the Homeless Council • National Low Income Housing Coalition  
Urban Institute • Barbara Poppe and associates • Matthew Doherty Consulting