ISSUE BRIEF

Barriers to Accessing Higher Levels of Care: Implications for Medical Respite Care Programs

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People experiencing homelessness (PEH) consistently experience higher rates of chronic conditions, mental health and substance use disorders, and traumatic brain injury than the general population.[1,2,3] The high prevalence of these conditions and co-morbidities results in an increased risk for functional impairment, and often experienced at a younger age.[1,4,5] Barriers to care, such as lack of health insurance and stigma, prevent people experiencing homelessness from accessing both preventative and rehabilitative health services.[6, 7, 8] These barriers often result in conditions going unaddressed until they are emergent and require hospitalization for treatment. Once a person experiencing homelessness is hospitalized for an acute medical need, discharge planners are often faced with difficult decisions and a lack of resources for safe transitions from the hospital. Numerous and consistent barriers to accessing various levels of health care for this population puts a significant strain on hospitals and homeless services and prevents vulnerable people from receiving appropriate medical care.

There is a significant tension throughout the continuum of health care services because of systemic barriers to accessing appropriate levels of care that align with a person's functional and medical needs. For PEH, this often means discharges from hospitals to unsafe venues. When a person is excluded from appropriate levels of care, the alternative is returning to the street or shelter where there are even fewer supports available. While medical respite care programs offer a post-acute venue for this population to stabilize, these programs are not replacements for higher acuity venues and are generally not staffed or equipped to provide higher-level care. In addition, the health care system also relies on caregivers and an individual's resources (such as housing and out of pocket expenses) to fill gaps in medical services not available or covered by insurance. Those without a home or these other resources are too often left with no alternatives for care.

This issue brief describes the different levels of care within the health care service continuum a person may need following acute care hospitalization and highlights the admission barriers commonly encountered by people experiencing homelessness. It also illustrates the role of medical respite care programs within this continuum, and outlines action steps that communities can take to improve access to higher levels of care for people experiencing homelessness.

Medical respite care programs should use this issue brief to develop a common language on levels of care, identify appropriate expectations of different discharge venues, and illustrate barriers to care that policy makers should address.

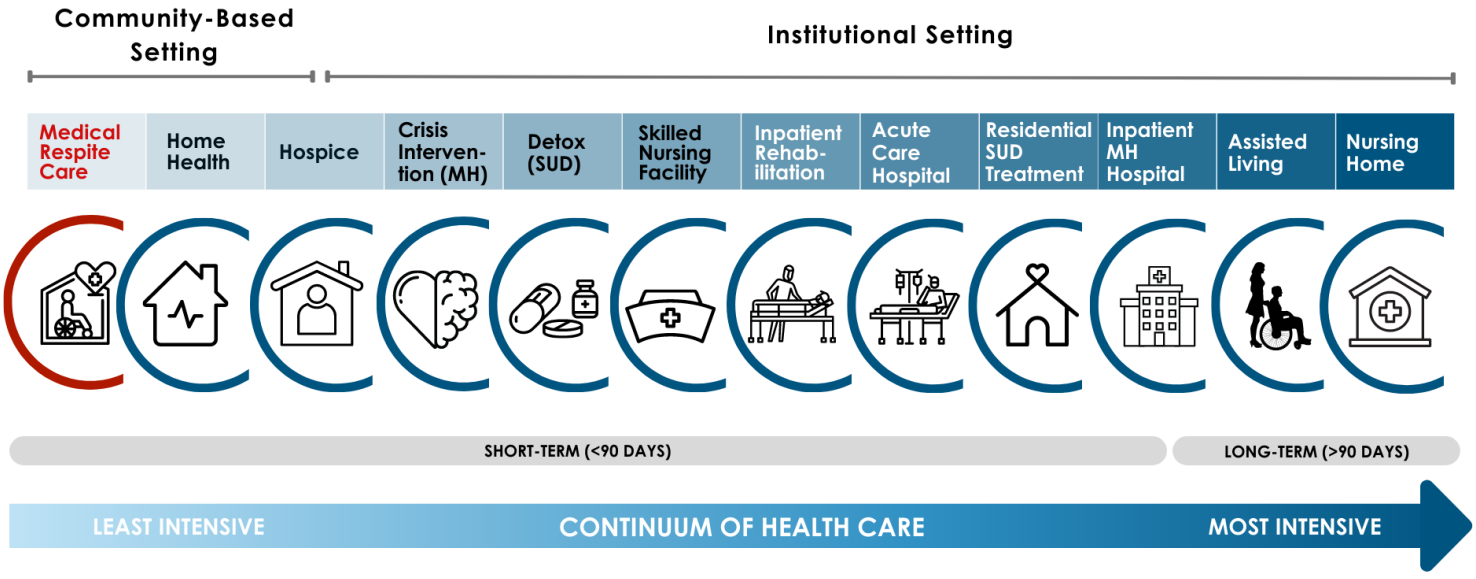
What are Levels of Care?

A level of care describes the intensity of health care services required to manage or resolve a health condition, often following acute-care hospitalization. **Figure 1** provides an overview of the continuum of health care services, including behavioral health. These levels of care may happen in a variety of venues, which can be informed by the person's eligibility for services (due to condition or insurance coverage), available community and caregiving supports, and personal economic resources. Some of these venues, such as nursing homes, may provide multiple levels of care within one facility.

While there are numerous levels of care across the health care continuum, this document focuses specifically on skilled nursing facilities, inpatient rehabilitation facilities, assisted living, long-term care, and medical respite care, because these are the most common discharge settings after an acute-care hospitalization. Future publications will focus on the other venues depicted in **Figure 1**.

Housing status is separate from a person's needed level of care. However, for people experiencing homelessness, a lack of safe, stable, and accessible housing often prevents them from being able to receive appropriate levels of health care. This may be due to stigma associated with being unhoused, health care providers not being willing or able to deliver care in a shelter or public space, or other factors preventing a referral or admission to a facility.

Figure 1: Health Care Continuum depicts the multiple levels of care that fall within the health care continuum. Need for each level of care is dependent on the acuity of the medical or behavioral health condition.



Note: This graphic only shows venues of health care that include a bed/residential component. It does not include primary care or other outpatient-based medical care services.

MH= Mental Health; SUD= Substance Use Disorder

Skilled Nursing Facility

"Skilled care" is nursing and therapy care that can only be safely and effectively performed by (or under the supervision of) professionals or technical personnel, to treat, manage, and observe health conditions, and evaluate care.[11] A person is eligible for care in a skilled nursing facility (SNF) if they meet all of the following criteria 1) ordered by their physician; 2) requires skilled services such as nursing or therapy; 3) requires the skilled nursing or rehabilitation services (or both) on a daily basis; 4) for a condition that meets established criteria; and 5) requires the daily skilled services that can only be provided in a SNF or an inpatient basis.[12]

Skilled services provided within a SNF include: medical care, nursing care, physical therapy (PT), occupational therapy (OT), and speech therapy. These skilled services address medical needs, rehabilitation to be able to complete activities of daily living (ADL), mobility, and communication and cognitive skills. SNFs are a time-limited stay to address the medical conditions present at referral.

Inpatient Rehabilitation Facility

Inpatient rehabilitation facilities (IRF) are licensed facilities that provide intensive rehabilitation and physician oversight when the person requires more care than could be provided within a SNF. Inpatient rehabilitation facilities are typically part of acute or specialty hospitals/hospital networks, and most individuals who receive care in an IRF are first hospitalized for an acute medical issue (such as a stroke or traumatic brain injury). To qualify for an IRF, it must be deemed medically necessary by 1) requiring 24-hour access to a physician; 2) 24-hour access to a registered nurse; 3) ability to participate in intensive therapy (OT, PT, speech) for 3 hours/day; 4) and require a coordinated team of providers.

Assisted Living

Assisted Living (AL) facilities provide long-term housing and support for activities of daily living and independent activities of daily living (IADL) for those that do not require 24-hour nursing care. The availability of AL facilities is variable by community, and each state has its own licensing process and criteria. The supports provided will vary by facility (such as transportation, meal preparation, or medical care), and those that offer a higher level of services are typically more costly. State Medicaid plans will not cover the cost of assisted living or room and board unless these are provided through a waiver program, and the number of Medicaid approved facilities may be limited.[13]

Long-Term Care

"Long-term care" (LTC) is defined by the Centers for Medicare and Medicaid Services[14] as "health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical

condition." For individuals insured by Medicaid, long-term care services are provided to an individual who requires a level of care equivalent to that received in a nursing facility, such as 24-hour nursing care.[15] Long-term care services can be provided in the community (such as someone's home) or within an institutional setting (such as in a nursing home). Individuals who are part of a state's Home and Community Based Waiver Programs may be able to receive long-term care services, but eligibility and available resources varies by state.

The majority of institutional long-term care is provided through nursing homes. For those who do not have stable housing, lack community supports, or whose homes are unable to support their functional needs, institutional long-term care often becomes the only service option. These facilities may have residents receiving both skilled nursing care and long-term care. Long-term care services indicate the person will be residing in the facility for an extended duration (often until end-of-life), versus addressing a health need and returning to the community. The higher rates of physical and mental health conditions along with functional impairment at younger ages contributes to individuals experiencing homelessness moving into institutional long-term care facilities earlier than their housed counterparts.[4]

A Note on Institutional Levels of Care

- The goal of any treatment plan is to deliver care in the least restrictive setting appropriate to client needs.
- However, an acute medical issue may require a higher level of medical care in order to rehabilitate and/or stabilize.
- Institutional settings are clinically appropriate venues to treat a range of specific conditions.
- While home-based care is often the least-restrictive level of care, it is generally completely unavailable to those who without a home.
- The availability of safe, stable, and accessible housing at discharge would ease transitions of care and allow for continued medical stability for PEH.

Common Barriers to Accessing Higher Levels of Care

There are common barriers to accessing each of the four levels of care described above. Some of these barriers are systemic and impact the general population, while others are more specific to people experiencing homelessness. **Table 1** illustrates these common and specific barriers that may be encountered by each venue.

Table 1. Common Barriers to Accessing Levels of Care

Barriers to accessing care for the general population:	SNF	IRF	AL	LTC
Insurance status and type of insurance will determine whether or not the person can be accepted into the facility or venue of care. Those in states who have not expanded Medicaid eligibility will not likely be able to access services.	X	X	X	X
Reduced bed capacity after the onset of Covid-19.	X	X	X	X
Individuals may not be ready or comfortable with transitioning to more congregate or institution-based settings.	X	X	X	X
The community or local hospital system may not have a facility to provide the level of care , and admission may require going into another town or area.	X	X	X	X
High costs of care are prohibitive for those with low or limited income, especially when insurance does not cover certain services.	X	X	X	X
Availability of beds may be limited in some communities, resulting in long-wait lists or limited access.	X	X	X	X
Care provided may be focused primarily on physical health needs and equivalent, specific services for mental health- or substance-use may not be available.[16]	X	X	X	X
Insurance coverage is required in order for care to be affordable.	X	X		X
Facilities are not required to take individuals insured by Medicaid or have a limited number of beds for Medicaid recipients because the reimbursement rates are often lower than other payers.	X	X		X
The person may not be eligible due to previous admissions.	X	X		
The facility may require the person has a representative payee or pay the majority of their income, resulting in the person no longer having autonomy over their finances.			X	X
Available beds or facilities may not provide the needed or specific type of support the person requires.			X	X
Eligibility varies state-by-state, including scope, amount, duration of services, and populations served.			X	X

Barriers accessing care more common to PEH:	SNF	IRF	AL	LTC
Lack of approaches to care such as trauma-informed care and harm reduction impacting effectiveness of care while at the facility.	X	X	X	X
Providers at facilities may not want to prescribe or manage medications for substance/ opioid use disorders or psychiatric diagnoses.	X	X	X	X
Stigma and bias regarding PEH or with mental health conditions may prevent a facility from accepting someone who is or formerly homeless.	X	X	X	X
Individuals who use alcohol/other substances or have mental health diagnoses are ineligible for care depending on facility regulations or criteria.	X	X	X	X
The facility may not be considered a discharge option due to the person's age (especially if younger), despite medical needs often being similar to those of older adults.	X		X	X
The federal definition of homelessness does not include SNFs or IRF; hence, patients may become ineligible for many housing programs that require ongoing "homeless status."	X	X		
May not accept PEH due to concerns of difficulty in discharge planning.	X	X		
Individuals who are younger, but have more significant health needs, may not want to move into communities that are primarily developed for older adults.			X	X
Those needing a lower level of care within these venues may be declined on the assumption they could receive the same support through home health care and caregiver support.	X			X
Medicaid does not cover room and board for AL and community-based long-term care, making out-of-pocket costs unaffordable to low-income people.			X	X

Role of Medical Respite Care in the Health Care Continuum

Medical respite care (MRC) provides acute and post-acute care specifically for people experiencing homelessness who are too ill or frail to recover from an illness or injury on the streets or in shelter, but who do not require hospital-level care or skilled nursing services.[9] Due to the demonstrated evidence of improving outcomes and reducing costs, many communities have (or are developing) MRC programs.[10]

Medical respite care is not an equivalent alternative to inpatient rehabilitation facilities, skilled nursing facilities, assisted living, or long-term care. Primarily, MRC programs serve those who have an acute or post-acute medical need for recovery but are able to independently manage their ADL. Simply stated, most people are discharged home to rest and recuperate, but those without a home have no such option. Medical respite care programs fill this essential role in the recovery process and provide a safe and stable place to address continued health needs for those that do not require or no longer need a higher level of care. These programs also provide client-centered care coordination, access to health care assessments and services, and case management to address social service and housing needs.

MRC programs often receive inappropriate referrals for admission because higher-level facilities have denied entry, often due to the barriers described in Table 1. This then presents an ethical conflict for both hospital discharge planners and medical respite care providers: **Do you admit a client with very high needs the program is unable to meet, or do you allow the client to be discharged back to the shelters or the streets with no care whatsoever?** Since MRC do not generally provide the rehabilitative or 24-hour services provided by higher levels of care, accepting those with these needs presents a safety risk both for the staff and individual, and precludes an admission for someone who is more appropriate for MRC-level care. Instead of placing the burden and medical risk on medical respite care programs, health systems should address the barriers to accessing higher levels of care that are commonly needed for people experiencing homelessness.

Recommended Actions

Improve health care for people experiencing homelessness across the entire health care continuum by taking the following advocacy actions:

- If the state has not already done so, expand Medicaid to all low-income people and ensure a wide range of services are included in the state Medicaid plan.
- Collect data on the number of people denied entry to appropriate, higher levels of care, and document the impact of admission denials on client recovery and well-being.
- Work with policymakers to remove access barriers at skilled nursing facilities and long-term care facilities for those who are homeless and/or insured through Medicaid.

- Create safe, high-quality alternatives to appropriate levels of care for those who are uninsured. This may be through public grants to SNF/NH providers, or other funding sources.
- Develop a more streamlined continuum of care and discharge process for people experiencing homelessness by encouraging greater collaboration among hospitals, IRF, SNF, long-term care facilities, home health, and medical respite programs.
- Train staff in all venues of care in trauma-informed and harm reduction practices, as well as strategies for better accommodating for individuals experiencing homelessness.
- Provide affordable and accessible housing options for safe, independent community living, inclusive of independent and permanent supportive housing units, group homes, and assisted living facilities.

Conclusion

People experiencing homelessness, like anyone with an acute medical need, may require a variety of discharge options following hospitalization for rehabilitation and recuperation. Unfortunately, many of those experiencing homelessness often confront barriers to accessing care in settings such as skilled nursing, inpatient rehabilitation, assisted living, and long-term care facilities. Subsequently, medical respite care programs are pressured to accept individuals whose needs are beyond their scope of services and ability to address. Increasing access to all levels of care requires better understanding of the role of each of these services, collaboration to develop a more effective continuum for transition, and advocacy to address structural barriers to care.

Resources for Community Support

The following resources are recommended to further understand the role of medical respite care in the health care and housing continuum:

- Defining Characteristics of Medical Respite/ Recuperative Care
- Clinical Issues in Medical Respite/Recuperative Care: Addressing ADL Webinar and Clinical Guidelines
- Expanding Options for Health Care Within Homelessness Services: CoC Partnerships with Medical Respite Care Programs

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