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3 Title: Availability of Medical Respite Centers
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5 Introduced by: Mara Darian, for the Medical Student Section
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11 Referred To: Reference Committee E
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13 House Action: **APPROVED AS AMENDED**
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16 Whereas, the 2018 State of Homelessness Annual Report cited there were more than 10,700
17 people that experienced homelessness in the Detroit continuum in 2018 with 2,231 of them being
18 chronically homeless, and

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20 Whereas, in a given year, homeless individuals are three times more likely to utilize
21 emergency room services than housed individuals and are more likely to be readmitted to inpatient
22 services, and

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24 Whereas, when persons experiencing homelessness are hospitalized, they have longer
25 lengths of stay than housed patients and thus have increased medical costs, and

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27 Whereas, homeless patients are often discharged into a setting, such as a homeless shelter
28 or back on the streets, where they cannot receive adequate care for their medical needs, and

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30 Whereas, medical respite programs are centers staffed by health care providers and nurses
31 that provide medical care and housing to homeless patients who are too sick to be in a shelter or
32 on the streets, but not sick enough to require an inpatient stay, and

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34 Whereas, there are a total of 65 medical respite programs in the United States and 3 respite
35 programs in Michigan located in Detroit, Pontiac, and Ann Arbor, with a total of only 45, 15, and 6
36 beds, respectively, and

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38 Whereas, access to care in a medical respite center is restricted by limited beds and
39 resources, as well as specific program eligibility requirements, including that patients must be
40 independently mobile, patients have a condition that can be addressed within a relatively short
41 time, and patients must be able to perform their own activities of daily living, and

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43 Whereas, the majority of medical respite programs receive funding from three or more
44 sources, the majority sourced from hospitals and private donations, and 18 percent of programs
45 receive public funding through Medicaid/Medicare, and
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47 Whereas, medical respite care for homeless patients has been shown to reduce hospital
48 re-admittance rates and length of stay, increase outpatient provider visits, and decrease health care
49 charges, and

50 Whereas, a program in Boston demonstrated that patients discharged to a homeless respite
51 program experienced an approximate 50 percent reduction in readmission rates at 90 days post-
52 discharge, compared to those discharged to streets and shelters, and

53
54 Whereas, a two-year study in Durham, North Carolina assessing health care utilization
55 among homeless patients following a homeless medical respite pilot program determined that
56 hospital admissions decreased by 37 percent, inpatient days decreased by 70 percent, and medical
57 system charges for participants decreased by 48.6 percent, and

58
59 Whereas, an \$800,000 investment in a medical respite program for homeless patients has
60 saved participating hospitals in Santa Rosa, California \$17 million in the first three years, and

61
62 Whereas, emergency department residents have reported being more likely to admit a
63 homeless patient than a non-homeless patient experiencing the same illness, leading to resource-
64 intensive hospital stays that could be handled at the level of care provided in medical respite
65 centers, and

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67 Whereas, our AMA supports “improving the health outcomes and decreasing the health
68 care costs of treating the chronically homeless through clinically proven, high quality, and cost
69 effective approaches” and “development of holistic, cost-effective, evidence-based discharge plans
70 for homeless patients who present to the emergency department but are not admitted to hospital,”
71 and

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73 Whereas, the Board of Trustees recommends that “our AMA should encourage collaborative
74 efforts to address homelessness that do not leave hospitals and physicians alone to bear their
75 costs;” therefore be it

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77 RESOLVED: That MSMS support policy to increase the availability of medical respite centers
78 and programs for use by the homeless population; and be it further

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80 RESOLVED: That MSMS support policy that local stakeholders secure increased funding for
81 medical respite programs, including but not limited to expansion of current facilities in urban areas
82 with large populations of homeless individuals.

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85 WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS
86 or AMA policy - \$500

STATEMENT OF URGENCY: In light of the COVID19 pandemic, the effect of deficiencies in transitional care are even more detrimental to those experiencing homelessness. The WCMS has supported this resolution and we ask that the MSMS do the same.

Relevant MSMS Policy:

None

Relevant AMA Policy:

Eradicating Homelessness H-160.903

Our AMA:

- (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;
- (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;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

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