MODELS OF CARE FOR HIGH-NEED, HIGH-COST PATIENTS

How a Medical Respite Care Program Offers a Pathway to Health and Housing for People Experiencing Homelessness

Douglas McCarthy
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The Commonwealth Fund

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AUTHORS

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TOPLINES

The National Health Foundation provides comprehensive recuperative care to people experiencing homelessness, helping improve their health outcomes and reduce hospital readmissions

Despite growing evidence that medical respite care is a cost-effective way to help people experiencing homelessness recover after a hospital stay, it remains an underutilized service.

When Maureen was faced with the loss of her income, she found herself unable to pay rent and was evicted from her apartment. She moved into her car with her dog, Trenor, on the streets of Ventura, California. Living with diabetes made it difficult to manage her health and she landed in the hospital. Her situation was complicated by memory loss and the risk of COVID-19. Maureen's condition stabilized after several days and hospital staff recommended that she receive ongoing care. She needed somewhere to recuperate until she could find a permanent place to live.

To meet Maureen's needs, the hospital connected her to National Health Foundation (NHF), which offers recuperative care in Los Angeles and Ventura counties. She stayed for close to a month in a home-like facility that provided her with social support and intensive care management, paid for by the hospital. At the end of her stay, she transitioned to a sober living facility and was happily reunited with Trenor.

Unfortunately, stories like Maureen's remain the exception because many areas lack an appropriate place for homeless patients to recuperate after a hospitalization.

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Maureen, a National Health Foundation guest.

People experiencing homelessness often live with chronic illnesses that may be complicated by mental health or substance use disorders as well as unmet social needs, yet many receive inadequate health care. [1, 2] Consequently, many have repeated and prolonged hospital stays [3] make frequent emergency department (ED) visits [4] incur high health care costs [5] and experience poor health outcomes [6].

To address this gap in transitional care for homeless patients, community stakeholders across the country have developed more than **100** posthospital medical respite programs since the 1980s, with more under development. [7] In addition to promoting improved recovery and reduced costs of care, medical respite programs can play an important role in a continuum of services to prevent homelessness [8] which has taken increased urgency during the COVID-19 pandemic. This case study — the latest in a series describing models of care for high-need, high-cost patients — describes how NHF has developed a sustainable business model and attracted strong community support to help end the homelessness crisis in southern California. [9]

WHAT IS MEDICAL RESPITE CARE?

Medical respite programs offer hospitals an alternative to keeping homeless patients longer than medically necessary or discharging them to the street or to shelters that aren't equipped to support their recovery. [10] While shelters may require people to vacate the premises during the day, medical respite programs offer a supportive environment for people experiencing homelessness to recover during a stay that may last from two weeks to 90 days.

Medical respite programs vary in scope, depending on local resources and needs, and are provided in many kinds of places including capable shelters, apartments, motels, assisted living facilities, nursing homes, transitional housing, and stand-alone facilities such as those operated by NHF. Programs may be sponsored and supported by nonprofit organizations, health centers, hospitals, and government agencies. [11]

The National Institute for Medical Respite Care defines this care model as "acute and postacute care 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."

"**Unlike 'respite' for caregivers, 'medical respite' is short-term residential care that allows individuals experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services**," says Julia Dobbins, director of programs and services for NIMRC.

The term recuperative care also is commonly used to refer to the same set of services.

A virtual tour of the Pico-Union facility and guest testimonials can be viewed on the NHF website.

NATIONAL HEALTH FOUNDATION'S RECUPERATIVE CARE PROGRAM

Founded in 1973 by the Hospital Association of Southern California, NHF's mission is to improve the health of underresourced communities by addressing food access, education, housing, and the built environment. After news stories in the early 2000s cast local hospitals in a negative light for discharging homeless patients to the streets [12] the hospital association asked NHF to help find a better way to manage their discharge and reduce readmissions. Drawing on the experience of other programs, NHF in 2008 established a 25-bed recuperative care program in Los Angeles in partnership with hospitals and the county. [13]

When California expanded Medicaid under the Affordable Care Act in 2014, many low-income adults experiencing homelessness became eligible for enrollment in Medicaid managed care plans participating in the state's Medi-Cal program. With a financial incentive to reduce hospital admissions and improve outcomes of care for these new members, health plans took an interest in contracting with NHF for recuperative care beds. To meet the growing needs of partnerships with hospitals and health plans, NHF now operates four recuperative care sites with a total of 117 beds. [14] (A fifth site, with 148 beds, will open later this year.)

Program Enrollment: More than 60 hospitals refer patients to NHF's recuperative care program using an online form. Enrollment criteria are straightforward, assuring a 99 percent acceptance rate. Guests need to be able to function independently and manage their own activities of daily living. They can be reliant on wheelchairs and walkers if they can transfer themselves for sleep and other needs. Upon receiving a referral, NHF staff arrange for transportation and communicate with hospital discharge planners for instructions on follow-up care.

Hospitals face daily dilemmas in discharging homeless patients, and they have very few options. We could use a lot more recuperative care beds in Los Angeles county. Models such as NHF's provide hope for an ongoing, sustainable, and viable solution for us.

Adam Blackstone
vice president for external affairs and strategic communications, Hospital Association of Southern California

Accommodations: NHF seeks to provide a welcoming environment where homeless individuals will want to come and stay because they receive the respect and comfort they deserve. They are referred to as guests, rather than as patients or residents. Guest services coordinators ensure that their needs are being met throughout their stay.

In 2018, NHF opened a renovated 61-bed facility in the Pico-Union neighborhood of Central Los Angeles, where guests stay in semiprivate bedrooms and have private showers. Warm meals are served three times a day, with fresh food available on a "grab-and-go" basis throughout the day. Guests have access to WiFi as well as computers in a common room.

Supportive Services: Within 24 hours of arrival, each guest meets with a social worker who assesses their needs, helps them determine eligibility for benefits, and links them with community social services. They also help guests obtain identification, arrange transportation to appointments, and reconnect with family. Using the county's Coordinated Entry System, social workers plan a pathway to stable housing that may include permanent supportive housing, interim housing, shared housing, or family reunification. Guests typically move two points along a housing path scale (Appendix B) toward the goal of an identified housing option by the end of their stay, when NHF supports their transition. To ensure individualized care, social workers have a small caseload of 15 guests each.

We give guests a place to stay where they feel safe, respected, and comfortable, so they want to be here. That makes a huge difference. Our goal is to help them heal and help them get the services available to them.

Kelly Bruno
president & CEO, National Health Foundation

A National Health Foundation social worker consults with a guest. Photo courtesy of National Health Foundation.

Medical Oversight: A team of medical coordinators (licensed vocational nurses) assists guests with medication management and appointments with health care providers. Home health care agencies provide onsite nursing care, such as surgical wound care or intravenous antibiotic administration, when arranged in advance by the discharging hospital. At the end of a guest's stay, referring hospitals and health plan funding partners receive a discharge summary of a guest's progress, services received, and housing status on discharge.

Service Quality: Many homeless people have experienced trauma and perceived disrespect in their interactions with the health care system. To help overcome these challenges, NHF embraces the principles of trauma-informed care and a harm-reduction philosophy aimed at reducing both the negative consequences associated with substance use disorders as well as the stigma associated with homelessness and mental health issues. There are no security guards or metal detectors, for example. "*We don't want our guests to feel that we are afraid of them,*" says Kelly Bruno, NHF's president and CEO. Honoring their independence and autonomy encourages guests to remain at the facility until they have recovered.

Consistent with this philosophy, NHF does not perform sex offender background checks or substance use testing as a condition of enrollment. If staff learn that a guest has drugs or alcohol onsite, they ask the guest to remove them from the premises, but they don't search personal belongings. If someone has a history of violence, staff will assess their ability to safely stay at the facility; if a guest becomes violent while onsite, they are removed immediately.

Program Statistics and Outcomes: NHF served **1,129** recuperative care guests in 2020, among whom **44 percent** transitioned to stable housing and **15 percent** were reunited with family following a 14-day average stay.

They're 100 percent in what they do in terms of the caring and they meet your needs. I don't know what I would have done if this hadn't been here.

NHF Recuperative Care Guest

About 10 percent leave before completing a two-week stay, the minimum that NHF requires of funding partners. Some Medicaid managed care plans will pay for longer stays (e.g., 30 to 60 days) based on their decision criteria, such as ensuring that their members find housing before discharge.

An analysis by a hospital system showed that, among 64 patients discharged to NHF recuperative care, rates of hospital readmissions and ED revisits to the system's facilities were 9 percent and 23 percent, respectively, which is lower than typically experienced by homeless patients. [15]

FINANCING MEDICAL RESPITE CARE

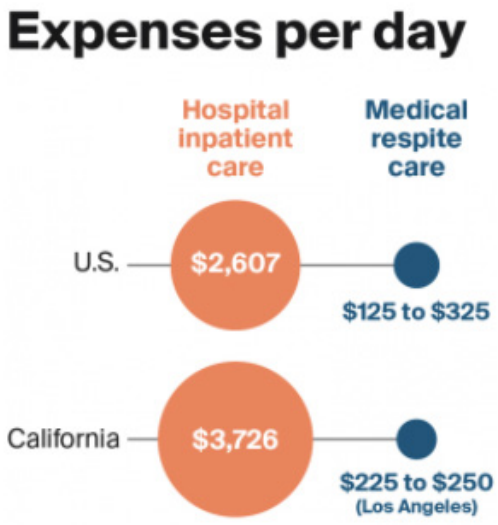
Since there is no dedicated funding mechanism for medical respite programs, they often braid together financing from multiple sources including hospitals, governments, foundations, faith organizations, and private donors.16 Stand-alone facilities operated by nonprofits such as NHF, which do not directly provide clinical care, are not usually licensed by the state or recognized as Medicare or Medicaid providers.

NHF funds its recuperative care program primarily through contracts with partnering hospitals and Medicaid managed care plans, which now pay for almost two of five NHF guest stays. Payment is made either on a per diem basis or on a prepaid basis for a specified number of dedicated beds. Reserving beds can be mutually beneficial by ensuring a reliable referral site for hospital discharge planning and a reliable revenue stream for NHF. (As an incentive for efficiency, NHF offers tiered discounts tied to the number of reserved beds.) Contracts with health plans are structured around the provision of intensive care management, which promotes accountability for program outcomes.

Grants and donations, which make up only about 6 percent of NHF's recuperative care program budget, provide a financial cushion to ensure the sustainability of the program through periods of reduced demand for services such as during the COVID-19 pandemic.

COST AND OUTCOMES OF MEDICAL RESPITE

Medical respite care is less expensive than other forms of residential health care. [17] Daily expenses for these programs range from about $125 to $325, depending on their location and scope of services. [18] Hospitals in Los Angeles report that they pay $225 to $250 per day for private medical respite programs. [19] For comparison, average reported expense per day of inpatient care was $2,607 among hospitals nationally and $3,726 among hospitals in California in 2019. [20]



The impact of medical respite care has been assessed in a variety of settings, some of which are similar in scope to NHF's program (Appendix C). Reviews of the literature find consistent evidence that medical respite programs reduce hospital admissions, days spent in the hospital, and 90-day readmissions, with promising evidence for reduced ED visits and improved housing outcomes. [21] An evaluation of 10 programs found that their guests experienced improvements in health status and in access to primary care, housing, and income supports. [22]

Hospitals may lose money caring for homeless patients, especially if their stays are prolonged. [23] By reducing the length of hospital stays and subsequent hospital use, medical respite care can reduce costs to hospitals as well as spending by payers such as Medicaid and health plans (Appendix C). NHF estimates that its recuperative care program has saved the health care system more than $20 million by preventing prolonged hospital stays. [24] At a societal level, savings from reduced use of health care because of medical respite programs could help offset the cost of preventing homelessness. [25]

INSIGHTS AND LESSONS LEARNED

Integrating health care and social services supports a coordinated approach to transitional care and homelessness prevention. [26] Safe and comfortable accommodations, intensive care management, and supportive services are the building blocks of NHF's approach to help homeless individuals recuperate and move toward independence. The ability of medical respite programs to fulfill this role depends on broader state and community efforts to make housing available to people experiencing homelessness. [27] *"We want to find our guests a bed that we ourselves would be willing to sleep in and food that we would be willing to eat, but not every interim housing facility provides this,"* says Bruno. During the COVID-19 pandemic, NHF leveraged charitable funding to ensure that guests found housing rather than see them return to living on the streets.

A medical respite program can help "localize and humanize" the homelessness crisis. Having witnessed the effects of a "Not in My Back Yard" mindset that derailed other programs, Bruno and her team are determined to foster a "Yes in My Back Yard" relationship with NHF's neighbors by engaging the community in efforts to end homelessness as a matter of local pride. This appeal spurred local builders to participate in renovating the Pico-Union facility, neighbors to sew window curtains and help paint the walls, and college students to outfit a shed where guests can "shop" for donated clothing. *"This facility is health equity in motion,"* says Bruno.

It takes time to translate the need for medical respite care into referrals for services. The number of hospitalized homeless patients who could benefit from medical respite care typically far exceeds the availability of medical respite beds in a community. [28] Yet, it can take time to establish routine referral relationships between hospitals and a new medical respite program, which requires educating staff and patients about this option as well as developing contractual payment processes including data privacy protections.

Because of these dynamics, one health plan initially overestimated the number of members who would use recuperative care, which diluted the advantage of contracting for a dedicated number of beds. The health plan has since seen increased use of medical respite care by its members as NHF's increased capacity became known and hospitals stepped up referrals.

> **Recuperative care has become a core piece of our strategy for population health management of people experiencing homelessness.**
>
> **Ben Hennemann**
> **director of special programs, Anthem**

Medicaid and managed care plans can play a vital role financing medical respite care in states that expand Medicaid under the Affordable Care Act. Relying on hospitals alone to pay for medical respite care does not offer a sustainable financing model, according to Bruno. Medicaid coverage of homeless adults in California has made it possible for NHF to contract with Medicaid managed care plans to shore up its business model. It does so by structuring contracts around a recognized Medicaid service — intensive care management — wrapped around a respite care bed, says Pamela Mokler, a consultant to NHF. Additionally, NHF guests insured by Medicaid can receive covered services such as home health care, which would be an unreimbursed expense if they were uninsured — as is typically the case in states that have not expanded Medicaid.

Federal Medicaid waivers can help overcome financing challenges for medical respite care programs. Current Medicaid payment rules may discourage managed care plans from paying for medical respite care, which cannot be counted as a medical expense in their medical loss ratio (box). Moreover, the decreased medical utilization brought about by medical respite care could lead to reductions in the health plan's capitation rate in subsequent years, according to Beau Hennemann, director of special programs for Anthem. These policies may prevent a plan from recouping its investment in paying for medical respite care.

California is preparing to implement a federal Medicaid waiver, known as California Advancing and Innovating Medi-Cal (Cal-AIM) that will allow managed care plans to pay for medical respite care — and other housing supports for homeless beneficiaries — as "in lieu of" services (box) that can be counted as medical expenses in their medical loss ratio. [29] The state will define eligibility criteria and core services for medical respite care, which should make it easier for managed care plans to contract with these programs statewide, according to Hennemann. This experience should be of interest to other states and the federal government to inform decisions about financing medical respite care.

CONCLUSIONS AND IMPLICATIONS

By integrating medical care and social services, postdischarge medical respite care helps people experiencing homelessness along the path toward better health and stable housing. With growing evidence that medical respite care is a cost-effective intervention, it remains an underutilized service with the potential for expansion across the country. Payers and policymakers may wish to identify the kind of evidence needed to make a business case for dedicated financing of medical respite care, either as a stand-alone transitional care service or as part of a continuum of services to prevent homelessness.

For more information on medical respite care, contact Julia Dobbins, director of programs and services for the National Institute for Medical Respite Care. The institute — a special initiative of the National Health Care for the Homeless Council — focuses on expanding access to medical respite/recuperative care programs in the United States by advancing best practices, delivering expert consulting services, and disseminating state-of-field knowledge in medical respite care.

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NOTES

1 Rishi K. Wadhera et al., "Trends, Causes, and Outcomes of Hospitalizations for Homeless Individuals: A Retrospective Cohort Study," Medical Care 57, no. 1 (Jan. 2019): 21–27.

2 Margot B. Kushel, Eric Vittinghoff, and Jennifer S. Haas, "Factors Associated with the Health Care Utilization of Homeless Persons," JAMA 285, no. 2 (Jan. 10, 2001): 200–6.

3 Kelly M. Doran et al., "The Revolving Hospital Door: Hospital Readmissions Among Patients Who Are Homeless," Medical Care 51, no. 9 (Sept. 2013): 767–73; and Jacob Feigal et al., "Homelessness and Discharge Delays from an Urban Safety Net Hospital," Public Health 128, no. 11 (Nov. 2014): 1033–35.

4 Bon S. Ku et al., "Factors Associated with Use of Urban Emergency Departments by the U.S. Homeless Population," Public Health Reports 125, no. 3 (May 2010): 398–405.

5 Katherine A. Koh et al., "Health Care Spending and Use Among People Experiencing Unstable Housing in the Era of Accountable Care Organizations," Health Affairs 39, no. 2 (Feb. 2020): 214–23.

6 David S. Morrison, "Homelessness as an Independent Risk Factor for Mortality: Results from a Retrospective Cohort Study," International Journal of Epidemiology 28, no. 3 (June 2009): 877–83.

National Institute for Medical Respite Care, State of Medical Respite/Recuperative Care Programs (NIMRC, 2021); and Suzanne Zerger, Bruce Doblin, and Lisa Thompson, "Medical Respite Care for Homeless People: A Growing National Phenomenon," Journal of Health Care for the Poor and Underserved 20, no. 1 (Feb. 2009): 36–41.

7 United States Interagency Council on Homelessness, "Integrate Health Care," USICH, last updated Aug. 15, 2018.

NOTES

8 United States Interagency Council on Homelessness, "Integrate Health Care," USICH, last updated Aug. 15, 2018.

9 California has a disproportionate share of the nation's homeless population, and Los Angeles has the greatest concentration of the state's homeless population. As of January 2020, 63,706 people were homeless in Los Angeles County, a 13 percent increase from January 2019. Among these individuals, 72 percent were unsheltered, 22 percent had severe mental illness, and 24 percent had chronic substance use disorders. See: U.S. Department of Housing and Urban Development, "HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations Reports," HUD, 2021.

10 California Senate Bill 1152, enacted in 2018, requires hospitals to provide appropriate discharge planning and assistance for homeless patients to transition to the community. This includes identifying a postdischarge destination, with priority given to a sheltered destination with supportive services.

11 Personal communication with Julia Dobbins, director of medical respite care, National Institute for Medical Respite Care.

12 Richard Winton and Cara Mia DiMassa, "L.A. Files Patient 'Dumping' Charges," Los Angeles Times, Nov. 16, 2006.

13 NHF initially contracted with a provider to operate its program in leased motel rooms to minimize startup costs. At that time, Los Angeles County operated the only medical respite program, with limited capacity to meet the needs of area hospitals.

14 During the COVID-19 pandemic, NHF also operated a 90-bed site for Los Angeles county's Project RoomKey initiative, which made motel rooms and health care available to people experiencing homelessness. For example, a study of hospitalizations among homeless patients at an urban academic medical center found that 51 percent resulted in a readmission and 48 percent resulted in an ED visit within 30 days; see: Doran et al., "Revolving Hospital Door," 2013.

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15 For example, a study of hospitalizations among homeless patients at an urban academic medical center found that 51 percent resulted in a readmission and 48 percent resulted in an ED visit within 30 days; see: Doran et al., "Revolving Hospital Door," 2013.

16 Health centers that operate a medical respite program can use their federal funding and seek reimbursement from Medicaid and Medicare for services provided to beneficiaries enrolled in the program. See: Sarah Ciambrone, Sabrina Edgington, and Marsha McMurray-Avila, Medical Respite Services for Homeless People: Practical Planning (Health Care for the Homeless Respite Care Providers Network, June 2009). Also see: Barbara DiPietro, Medical Respite Care: Financing Approaches (National Health Care for the Homeless Council, June 2017); and National Health Care for the Homeless Council and United Healthcare, Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care (NHCHC & UHC, Apr. 2020).

17 Nationally, hospitals were paid $1,870 per day on average for patients covered by Medicaid from 2015 to 2017, while skilled nursing facilities were paid $446 per day on average for residents covered by Medicare in 2016; see: Commonwealth Fund, Average Cost & Utilization Data, Tables 2b and 4.

18 Personal communication with Julia Dobbins, director of medical respite care, National Institute for Medical Respite Care.

19 Harder+Company Community Research, Recuperative Care in Los Angeles County (UniHealth Foundation, July 2020).

20 Data are from the American Hospital Association annual survey of registered U.S. community hospitals. Source: State Health Facts, "Hospital Adjusted Expenses per Inpatient Day: Timeframe: 2019," Henry J. Kaiser Family Foundation, n.d.

21 Kelly M. Doran et al., "Medical Respite Programs for Homeless Patients: A Systematic Review," Journal of Health Care for the Poor Underserved 24, no. 2 (May 2013): 499–524; and National Institute for Medical Respite Care, Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care (NIMRC, Mar. 2021).

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22 Suzanne Zerger, An Evaluation of the Respite Pilot Initiative (Health Resources and Services Administration, Mar. 2006).

23 One study found that homeless patients had 36 percent (4.1 days) longer length of stay on average than other patients, even after adjusting for differences in clinical and demographic characteristics. See: Sharon A. Salit et al., "Hospitalization Costs Associated with Homelessness in New York City," New England Journal of Medicine 338, no. 24 (June 11, 1998): 1734–40.

24 The estimate accounts for the average cost of a recuperative care stay and assumes that patients referred to recuperative care will have a four-day shorter average length of hospital stay. The estimate does not count the potential for additional savings from reductions in subsequent hospital use.

25 Anirban Basu et al., "Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care," Health Services Research 47, no. 1, pt. 2 (Feb. 2012): 523–43.

26 Catherine Stapleton and Julia Dobbins, "To Address the Homeless Crisis, We Need to Adopt a Systems-Level Approach Centered on Outcomes" (blog), Quantified Ventures, Apr. 8, 2021.

27 California Governor Gavin Newsom has proposed spending $12 billion on homelessness prevention over five years, including creating 46,000 new homeless housing units and programs to increase housing stability for 300,000 people.

28 NIMRC, Medical Respite Literature Review, 2021.

29 Michelle Carrera, Coverage of Housing Services in Medi-Cal: Policy Recommendations for 'In Lieu of Services' (California Initiative for Health Equity & Action, 2020).Catherine Stapleton and Julia Dobbins, "To Address the Homeless Crisis, We Need to Adopt a Systems-Level Approach Centered on Outcomes" (blog), Quantified Ventures, Apr. 8, 2021.

The following appendices are part of a Commonwealth Fund case study, Douglas McCarthy and Lisa Waugh, *How a Medical Respite Care Program Offers a Pathway to Health and Housing for People Experiencing Homelessness* (Commonwealth Fund, Aug. 2021), https://www.commonwealthfund.org/publications/case-study/2021/aug/how-medical-respite-care-program-offers-pathway-health-and-housing.

APPENDIX A

Standards for Medical Respite Programs

Standard 1	Medical respite program provides safe and quality accommodations	Medical respite programs provide patients with space to rest and perform activities of daily living (ADLs) while receiving care for acute illness and injuries. As such, the physical space of medical respite programs should be habitable and promote physical functioning, adequate hygiene, and personal safety.
Standard 2	Medical respite program provides quality environmental services	Like other clinical settings, medical respite programs must manage infectious disease and handle biomedical and pharmaceutical waste. Medical respite programs should follow applicable local or state guidelines and regulations related to hazardous waste handling and disposal, disease prevention, and safety.
Standard 3	Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings	Care transitions refer to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change. Care transition initiatives aim to improve quality and continuity of care and reduce the chances of medical errors that can occur when patient care and information is transferred to another provider.
Standard 4	Medical respite program administers high-quality postacute clinical care	In order to ensure adequate recuperation from illness and injury, medical respite programs must provide an adequate level of clinical care. Medical respite programs need qualified medical respite personnel to assess baseline patient health, make ongoing reassessments to determine whether clinical interventions are effective, and determine readiness for program discharge.
Standard 5	Medical respite program assists in health care coordination and provides wraparound support services	Medical respite programs are uniquely positioned to coordinate care for a complex population of patients who may otherwise face barriers to adequately navigate and engage in support systems. Case managers can improve coordination of care by brokering linkages to community and social supports to help patients transition out of homelessness and achieve positive health outcomes.
Standard 6	Medical respite program facilitates safe and appropriate care transitions from medical respite to the community	Medical respite programs have a unique opportunity to influence the long-term health and quality-of-life outcomes for individuals experiencing homelessness. A formal approach to the transition of care when patients are discharged from medical respite will optimize the chances for success.
Standard 7	Medical respite care is driven by quality improvement	Quality improvement consists of systematic and continuous actions that lead to measurable improvement in the services provided in the medical respite program. The integrity of a medical respite program rests on its ability to provide meaningful and quality services to a complex population.

Data: National Institute for Medical Respite Care.

APPENDIX B

National Health Foundation Housing Path Scale

	**Guest does not have a CES* score**
	**CES status has been assessed and/or updated**
	**Potential housing option(s) guest qualifies for have been identified.**
	**Shelter bed is best qualifying option.**
	**Guest has been accepted to an interim housing option.**
	**Guest has been accepted to a permanent housing option.**

* CES = Coordinated Entry System for the Los Angeles Homeless Service Authority.

Data: National Health Foundation, Impact Report 2021.

APPENDIX C

Select Evidence for Medical Respite Care Outcomes

The following studies were selected from the literature to highlight the potential of medical respite programs to impact health care utilization and spending and homelessness prevention.

A randomized controlled trial assessed the Chicago Housing for Health Partnership, which enrolled chronically ill hospitalized patients who had been homeless for more than 30 days. The intervention combined postdischarge medical respite care with supportive housing placement and case management.

Participants had 29 percent fewer hospitalizations and 24 percent fewer ED visits during the following 18 months.[1] The intervention yielded a net societal benefit of $6,300 per participant. Extrapolating the findings nationally suggests potential savings to society of $5.5 billion over 10 years if the intervention were made available to 100,000 chronically ill people experiencing homelessness each year.[2]

Cohort studies compared hospitalized homeless patients who received postdischarge medical respite care to similar patients who did not (the studies also adjusted for differences in patient characteristics).

- Guests of a Chicago medical respite program had 49 percent fewer hospital admissions and spent 58 percent fewer days in the hospital during the following year. The cost to avoid one hospital day was calculated to be $706, based on an average respite stay of 42 days at a cost of $79 per day.[3]
- Guests of a Boston medical respite program, which provided 24-hour onsite nursing care, had 46 percent lower odds of being readmitted to the hospital within 90 days. Guest stayed an average of 31.3 days in respite care at a cost of $253 per day.[4]

A business case study of two hospitals, in Connecticut and Florida, found that they incurred financial losses of 26 percent and 48 percent, respectively, on the cost of inpatient care for homeless patients. The authors estimated that the hospitals would reduce their losses by $11,076 per patient referred to medical respite care. This estimate assumed that those referred would have a two-day shorter hospital length of stay as well as 45 percent fewer hospitalizations and 35 percent fewer ED visits. Assuming a 45-day average stay in medical respite care at a cost of $136 per day, hospitals and payers together would realize a return on investment of $1.81 for every dollar spent on medical respite care.[5]

Another study estimated that hospitals in Washington State's Puget Sound area avoided $18,000 to $48,000 in *charges* per patient referred to a medical respite program, based on diagnosis-specific reductions in hospital length of stay for referred patients. Guests had a 39-day average stay in the medical respite program, which was provided at a cost of $157 per day.[6]

An analysis of homeless patients admitted to Yale-New Haven Hospital showed that rates of 30-day readmissions fell from 25.4 percent to 16.7 percent over three years among those discharged to a medical respite program while remaining at 31 percent of those not using medical respite care. The authors estimated that each patient completing at least two weeks in the medical respite program reduced Medicaid spending by $12,000 to $25,000 in the following year.[7]

NOTES

1. Laura S. Sadowski et al., "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Trial," *JAMA* 301, no. 17 (May 6, 2009): 1771–78.

2. The study was not powered to detect a statistically significant effect; net savings were attributed primarily to reduced hospital use. See: Anirban Basu et al., "Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care," *Health Services Research* 47, no. 1, pt. 2 (Feb. 2012): 523–43.

3. David Buchanan et al., "The Effects of Respite Care for Homeless Patients: A Cohort Study," *American Journal of Public Health* 96, no. 7 (July 2006): 1278–81.

4. Cost per day of medical respite care was calculated based on reported average charges of $7,929 per respite stay. Although the intervention did not appear to be cost saving, the cost analysis did not account for savings from reduced readmissions. See: Stefan G. Kertesz et al., "Post-Hospital Medical Respite Care and Hospital Readmission of Homeless Persons," *Journal of Prevention and Intervention in the Community* 37, no. 2 (Apr. 2009): 129–42.

5. The analysis assumed that medical respite care would be used by 8 percent of homeless inpatients. See: Dan Shetler and Donald S. Shepard, "Medical Respite for Persons Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage," *Journal of Health Care for the Poor and Underserved* 29, no. 2 (May 2018): 801–13.

6. Actual cost savings may be less than those represented by charges. Average length of stay was calculated based on the reported total 901 days in respite care among 23 people included in the study. See: Lauren Valk Lawson, Bonnie Bowie, and Melanie Neufeld, "Program Evaluation of a Recuperative Care Pilot Project," *Public Health Nursing* 38, no. 1 (Jan./Feb. 2021): 93–97.

7. Paula Crombie, Michael Ferry, and Alison Cunningham, "Medical Respite Care: Reducing Readmissions, LOS, and ED Visits of People Experiencing Homelessness," presentation to the Connecticut Coalition to End Homelessness (Yale NewHaven Health, n.d.).