

Many states and local communities are seeking cost-effective alternatives to inpatient hospital stays while at the same time trying to improve the health of vulnerable populations and reduce homelessness. People experiencing homelessness have significant health care needs and use hospitals at higher rates and for longer periods of time than their housed counterparts. Unfortunately, because they lack housing, hospital discharge planners often have difficulty finding a safe and appropriate venue for these patients to rest and recuperate after they no longer need acute care. Medical respite care programs can help solve this problem, and offer a better venue for more comprehensive case management and care transitions planning. While ensuring permanent and affordable housing is the ultimate goal for those experiencing homelessness, medical respite programs can provide the needed care transition point between hospital and home. This policy brief describes medical respite care, provides a rationale for creating/growing programs in local communities, outlines financing approaches, and suggests steps to consider for effective implementation of this model. Finally, this paper provides examples of currently funded medical respite programs.

What is Medical Respite Care?

Medical respite care is acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the street or in a shelter, but are not ill enough to stay in a hospital. While the term “respite” usually refers to caregiver support, “medical respite” refers to short-term residential care that allows homeless individuals to rest in a safe environment while accessing medical care and other support services. It is often used interchangeably with “recuperative care,” a term defined by the Health Resources and Services Administration (HRSA) as “short-term care and case management provided to individuals recovering from an acute illness or injury that generally does not necessitate hospitalization, but would be exacerbated by their living conditions (e.g., street, shelter, or other unsuitable places).” Medical respite care is not skilled nursing care, nursing home care, assisted living care, or a supportive housing program. Instead, it offers a safe and humane alternative when “discharge to home” is not possible for those without homes.

In 2016, there were 80 known medical respite programs providing 1,574 beds throughout the U.S. Defining characteristics of these programs include a focus on short-term residential care that allows rest and access to medical and support services, thus providing a bridge to a more stable discharge point.¹ At the same time, a directory of these programs indicates there is significant diversity among the programs regarding key demographic components:²

Medical respite care:
-- Provides acute and post-acute medical care for people who are homeless and too ill to be on the street or in a shelter, but not ill enough to be in a hospital.
-- Shortens hospital lengths of stay, reduces readmissions, and improves outcomes

- **Program size:** Average 21 beds, but range from five beds to over 100. Most programs have between 5 and 35 beds.
- **Facility type:** Medical respite programs are located in apartments/motels, homeless shelters, transitional housing programs, assisted living/nursing homes, substance use treatment programs, and can be stand-alone facilities.
- **Length of stay:** The median stay is 30 days, but program averages range from a few days to 1 year (though this is an extreme outlier). The vast majority of programs report average stays between 5 and 60 days. Programs usually determine length of stay by medical need and whole-person care, and by actively engaging participants in the process of their own recuperation.

- **Staffing:** Most programs have both clinical and non-clinical staff, with 81% utilizing a nurse, 63% a social worker, 48% a nurse practitioner, 48% a physician, 32% a community health worker, and 19% a physician's assistant.
- **Admission criteria:** Because programs differ significantly in the type of facility and services available, admission criteria vary widely. In addition to being homeless, most programs require patients to be medically stable, independently mobile, and able to perform their own activities of daily living (ADLs). Most also require patients to have a medical condition that can be addressed within a relatively short time. Most programs cannot accommodate IV lines, oxygen tanks, or severe mental health or addiction issues.

Standards for Medical Respite Care: Components

- Safe and quality accommodations
- Environmental services
- Safe care transitions into medical respite from other settings
- High quality post-acute clinical care
- Care coordination and wrap-around services
- Safe care transitions out of medical respite to the community
- Quality improvement

Find these standards at https://www.nhchc.org/wp-content/uploads/2011/09/medical_respite_standards_oct2016.pdf.

Because of this diversity, the National HCH Council developed standards that align with other health industry patient care standards, reflect the needs of patients being served in a medical respite setting, promote quality care and improved health, and are achievable for a range of programs with varying resources.³ These standards do not serve as a “one size fits all” approach to medical respite care. Instead, they serve as a framework to help programs operate safely, effectively, and seamlessly with local health care systems, and to promote program development and growth (see text box).

Rationale for Medical Respite

Various studies have shown longer lengths of hospital inpatient stays and higher readmission rates for people who are homeless, having a direct impact on total costs of care. One study found this population has a 30-day emergency department (ED) readmission rate 5.7 times higher and a hospital inpatient rate 1.9 times higher than their housed counterparts.⁴ Another study found patients without homes visited the ED six times per year compared to 1.6 times for those who had stable housing.⁵ Another found patients who are homeless stay in the hospital 4.1 days longer and cost \$4,094 more per admission than other low-income patients.⁶ When examining those experiencing a delay in discharge for non-medical causes, another analysis found patients experiencing homelessness had four or more “delay days” when compared to those who were not homeless.⁷ These disparities in utilization have implications for overall costs as well as available hospital resources to care for the broader community. They can also have implications for any financial penalties that hospitals incur because of excess readmissions. A recent study found just over half of all hospitals (52%) have been penalized each year over the past five years, with those serving a higher proportion of Medicare patients or socioeconomically disadvantaged patients more likely to be penalized.⁸

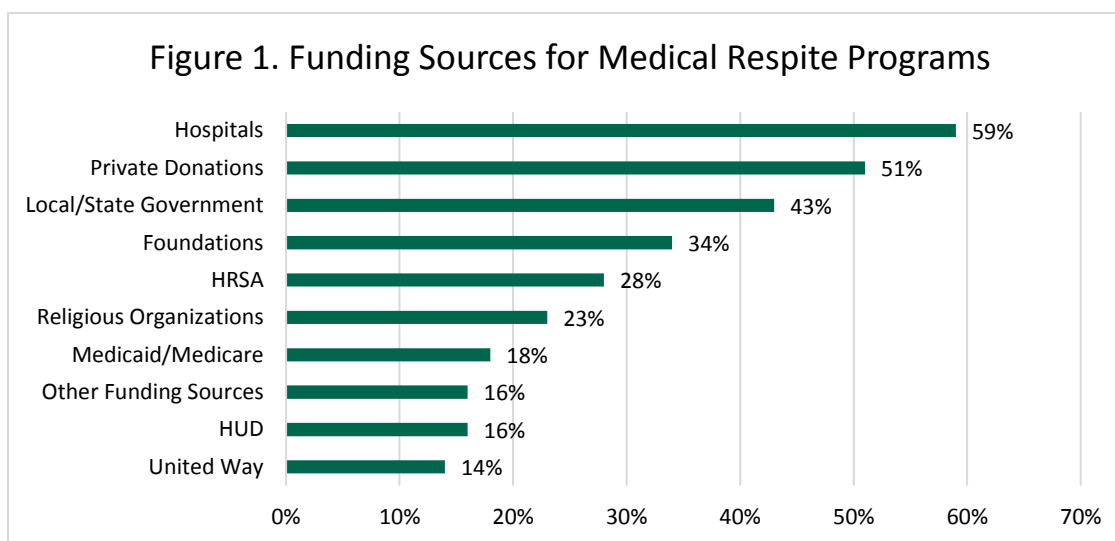
As health care systems seek ways to reduce ED and inpatient utilization and costs of care, they increasingly are looking to community-based providers and innovative models. Having access to medical respite programs can reduce lengths of stay as well as contribute to better overall outcomes. As an example, in Boston, patients who had access to medical respite care had a 50% reduction in the odds of readmission at 90 days post-discharge.⁹ In Chicago, patients who had access to medical respite care required fewer hospital days (3.4 v. 8.1) in the following 12 months compared to those released to usual care.¹⁰ One qualitative study found six features related to successful medical respite care: warm handoffs to outpatient providers, support navigating the system, the ability to address logistical barriers, the

Patients experiencing homelessness stay in hospitals 4 days longer and have readmission rates nearly twice as high than other patients, costing \$4,000 more per visit.

trusting relationships between clients and outpatient providers, clients' openness to receiving behavioral health treatment, and clients' limited prior outpatient service use.¹¹ Connecting to medical respite can help achieve multiple goals, but requires partnerships with community providers as well as adequate financing. It also serves as an effective bridge between hospitals and supportive housing programs.¹²

Financing Approaches

Over half of medical respite programs (57%) report having three or more funding sources, with hospitals and private donations being the most common (see figure 1). Only 23% of programs report one funding source, and the remaining 20% report two funding sources.¹³ Each funding stream has its own advantages, and combining several types of funding can help stabilize operations and expand the types of services offered. The most common funding sources are described in more detail below. As a range of examples, Appendix A includes a description of how seven existing programs are currently funded.



➤ Hospitals

Hospitals have an interest in reducing lengths of stay, preventing readmission, and ensuring a safe patient discharge. Having access to a medical respite program in the community can help achieve all of these goals, which likely explains why over half of all known respite programs are funded using hospital resources. Because hospitals have numerous sources of potential funding, there are a variety of ways to pursue support for medical respite services, which include community benefit resources, operations funding, and contributions from a foundation or charitable section of the hospital's work. Because federal law requires non-profit hospitals to conduct Community Health Needs Assessments every three years and adopt an implementation strategy to address those needs areas, this is a particularly advantageous approach.¹⁴

Payment arrangements or other support for medical respite programs can also vary. Contracts or memoranda of understanding (MOUs) can be established that pay in advance or be billed retrospectively based on utilization.^{15, 16, 17} Annual grants or a designated per diem rate can be established to cover the projected or actual cost of care, which can vary based on program size and type of services delivered. Sometimes beds are reserved exclusively for that hospital, but other arrangements allow access to the program pending availability. These arrangements may also depend on how many other hospitals may refer into the program, approved length of stay, or other factors that can be included in the contractual arrangement.

➤ Private & Philanthropic Institutions

Corporate, foundation or religious charities can provide a wide range of support from unrestricted funds needed to fill gaps in other funding, pay for one-time-only costs, facilitate renovations, and/or other program needs. The United Way is a lead funding partner for a number of respite programs (used in 14% of known programs), but

fundraising events and other approaches are also used to maximize private funding. The benefit of these funds is that they offer much-needed flexibility to respond to unanticipated needs or provide a bridge between other funding sources. However, they can also be short-term or variable absent ongoing negotiations for longer commitments.

➤ State and Local Government

Public health, social services, and behavioral health agencies looking to improve the health of chronically ill people who are homeless may want to consider annual grants to support medical respite programs. These arrangements can also take the form of in-kind salaried positions or covering administrative aspects of the program not included under other funding streams. The local authority that serves as the HUD Continuum of Care (CoC) coordinator can also consider how homeless services funds can be used to support aspects of a respite program, especially when coupled with other CoC providers (e.g., shelters).

➤ HRSA

Health centers that have recuperative care in their scope of work may be able to use part of their HRSA health center grant toward staff or services. While not all medical respite programs are affiliated with a health center, those that are can achieve some administrative efficiencies, especially when the respite is co-located with the health center's clinical services. These partnerships can also help connect vulnerable patients to a medical home and a broader range of care to support the longer-term care plan after the medical respite stay is completed.

➤ Medicaid/Medicare

Medical respite care is a model of care and generally not a discrete billable service (hence, there is no billing code for "medical respite care"). Physicians and other credentialed providers will often be able to bill for eligible medical and behavioral health services, though the support services critical to making the model work well are generally not reimbursable outside an agreement. Authorized care providers might be able to bill for care coordination (HCPCS code G9006), or home health visits (CPT codes 99342-99345 as a new patient, or CPT codes 99348-99350 for an established patient). Including these services in a state's Medicaid plan through a waiver can help ensure federal financial participation is maximized where possible.

➤ Medicaid Managed Care

At the MCO plan level, there may be an interest to enter into an agreement that includes flat monthly payments (usually less than a daily encounter), or allows for a set number of referrals per month for an approved set of days (e.g., 15 referrals a month for 30 days). Per Diem rates based on utilization can also be an arrangement that works well, enables plans to reduce inpatient hospital costs, and provides more flexibility between the plan and the medical respite program. There are a number of common goals between managed care entities and homeless health care providers that can be explored, to include ensuring case management and care coordination, quality outcomes, and an appropriate venue of care for people with chronic health care conditions.¹⁸ Medical respite programs can help meet those goals.

Steps to Consider Related to Financing

Meeting with the wide range of stakeholders described in this brief to establish need, collect data, and outline how a medical respite program would operate naturally leads to a discussion about financing. While each community's agreement will differ, below are some specific steps to consider when beginning those discussions:

1. Seek funding from the wide range of potential partners described in this brief, and consider starting with a small program that expands as needed over time.
2. Talk with those involved in the Community Health Needs Assessment to explore how Hospital Community Benefit funding may be used to meet the needs of people who are homeless.
3. Discuss with your state Medicaid director and/or Managed Care Organization (MCO) partners how best to use Medicaid dollars.
4. Talk with local philanthropic or grant-making organizations about their support for filling gaps in the health care system.

5. Ensure clinical providers are maximizing billing for all eligible health and support services to offset the need for additional funding.

Conclusion

Medical respite programs are an essential component of the continuum of care for vulnerable people. They bridge the gap between hospital and home, providing hospitals a safe discharge option and allowing patients a safe space to rest, recuperate, and work on next steps to achieve housing and health stability. Various financing arrangements are possible through a wide range of potential partners that will benefit providers, payers, and patients. As communities continue to look for ways to lower health care costs and increase positive patient outcomes, especially for those lacking housing, medical respite care is an innovative approach to implement.

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References

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- ¹ Respite Care Providers Network, Defining Characteristics of Medical Respite Care. Available at: <http://www.nhchc.org/wp-content/uploads/2011/09/RespiteDefiningFinal1.pdf>.
 - ² National Health Care for the Homeless Council. (2016.) 2016 Medical Respite Program Directory: Descriptions of Medical Respite Programs in the United States. Available at: https://www.nhchc.org/wp-content/uploads/2011/10/2016-MEDICAL-RESPITE-PROGRAM-DIRECTORY_FINAL2.pdf.
 - ³ National HCH Council (October 2016). *Standards for Medical Respite Programs*. Available at: https://www.nhchc.org/wp-content/uploads/2011/09/medical_respites_standards_oct2016.pdf.
 - ⁴ Crombie, P, et al. Columbus House Medical Respite Data Analysis Presentation. Paper presented at Opening Doors-Connecticut, Health and Housing Stability Workgroup; August 2016; Hartford, CT.
 - ⁵ Kushel, MD, Vittinghoff, E, and Haas, JS. (2001.) Factors associated with the health care utilization of homeless persons. *JAMA* 285: 200-206. Available at: <http://jamanetwork.com/journals/jama/fullarticle/193438>.
 - ⁶ Salit SA, Kuhn EM, Hartz AJ, Vu JM, Moss AL. Hospitalization Costs Associated with Homelessness in New York City. *NEJM* 1998, 338 (24): 1732-40. Available at: <http://www.nejm.org/doi/full/10.1056/NEJM199806113382406>.
 - ⁷ Feigal, J, et al. (2014.) Homelessness and discharge delays from an urban safety net hospital. *Public Health* 128:1033-1035. Available at: <https://experts.umn.edu/en/publications/homelessness-and-discharge-delays-from-an-urban-safety-net-hospit>.
 - ⁸ Thompson, M., et al. (May 2017.) Most Hospitals Received Annual Penalties for Excess Readmissions, But Some Fared Better Than Others. *Health Affairs* 36 (5): 893-901. Available at: http://content.healthaffairs.org/content/36/5/893.abstract?elq_cid=2648159&x_id=003C0000026n1TKIAY&cited-by=yes&legid=healthaff:36/5/893.
 - ⁹ Kertesz SG, Posner MA, O'Connell JJ, Swain S, Mullins AN, Shwartz M, Ash AS. (2009.) Post-hospital medical respite care and hospital readmission of homeless persons. *Journal of Prevention and Intervention in the Community*, 37(2): 129-142. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2702998/>.

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- ¹⁰ Buchanan D, Doblin B, Sai T, Garcia P. (2006.) The effects of respite care for homeless patients: a Cohort Study. *American Journal of Public Health* 96(7): 1278-1281. Available at: <http://ajph.aphapublications.org/doi/10.2105/AJPH.2005.067850>.
- ¹¹ Zur, J., Linton, S., and Mead, H. (April 2016.) Medical Respite and Linkages to Outpatient Health Care Providers Among Individuals Experiencing Homelessness. *Journal of Community Health Nursing* 33 (2): 81-89. Available at: <http://www.tandfonline.com/doi/abs/10.1080/07370016.2016.1159439?journalCode=hchn20>.
- ¹² Corporation for Supportive Housing (April 2017). *Improving Care for Medically Complex Patients: Medical Respite and Supportive Housing*. Available at: <https://www.nhchc.org/wp-content/uploads/2011/10/profile-y3-medical-respite-final.pdf>.
- ¹³ National Health Care for the Homeless Council. (2016.) 2016 Medical Respite Program Directory: Descriptions of Medical Respite Programs in the United States. Available at: https://www.nhchc.org/wp-content/uploads/2011/10/2016-MEDICAL-RESPITE-PROGRAM-DIRECTORY_FINAL2.pdf.
- ¹⁴ National HCH Council (May 2016). *Hospital Community Benefit Funds: Resources for the HCH Community*. Available at: <https://www.nhchc.org/wp-content/uploads/2016/06/policy-brief-hospital-community-benefit.pdf>.
- ¹⁵ National HCH Council (January 2010). FAQs: Negotiating Medical Respite Care with Hospitals. Available at: <http://www.nhchc.org/wp-content/uploads/2011/09/hospitalFAQ.pdf>.
- ¹⁶ National HCH Council (n.d.) Sample Memorandum of Understanding (for a post-hospitalization outpatient recuperation care program). Available at: <http://www.nhchc.org/wp-content/uploads/2011/09/MOUSample1.doc>.
- ¹⁷ National HCH Council (n.d.) Sample Hospital Contract for Medical Respite Program. Available at: <http://www.nhchc.org/wp-content/uploads/2011/09/RespiteHospitalContract.pdf>.
- ¹⁸ National HCH Council and UnitedHealthcare (March 2016). *Managed Care and Homeless Populations: Linking the HCH Community and MCO Partners*. Available at: <https://www.nhchc.org/wp-content/uploads/2016/03/mco-hch-policy-brief.pdf>.

APPENDIX A:

Financing at Work: Medical Respite Program Examples

<p>HOSPITALS</p>	<p>LifeLong Medical Care – Interim Care Program, Berkeley, California:</p> <p>Starting in 2014 with five beds at two sites, this program now operates 10 beds split between a residential hotel, a transitional housing program, and a women’s shelter/transitional housing. This respite model provides up to six weeks of onsite supportive services (meals, transportation, case management, and community health worker) with clinical services provided offsite at a separate location (home health nursing is available onsite when medically necessary). Funding is provided through an annual contract from the local hospital system largely using community benefit resources. This funding pays for all 10 beds at a pre-determined rate, 0.3 FTE care transitions nurse, and 1.0 FTE case manager.</p>
<p>CITY STATE PRIVATE MEDICAID</p>	<p>Convalescent Care Program, Baltimore, MD:</p> <p>Convalescent Care Program, Baltimore, MD: Established in 1995, this 25-bed homeless shelter-based program is a collaboration between the Health Care for the Homeless program (operates and staffs the respite program), Catholic Charities (operates the shelter), and Baltimore City government (owns the shelter building and is the local Continuum of Care). The model has limited medical services onsite (physician, physician assistant, nurse, and social worker) together with support services (meals, transportation and case management). Additional medical services are available at the HCH project two blocks away.</p> <p>While Baltimore City provides most of the operating costs for the shelter facility and funds food, bed linens and security staff, the State of Maryland (though a statewide hospital funding pool) funds about half of the medical respite program clinical costs, with about a quarter of the funding coming from the City CoC using HUD/Emergency Solutions Grant (ESG) funds, with the rest split between private funding through a grant from a regional insurance company foundation and Medicaid billing for eligible medical and behavioral health services.</p>
<p>MEDICAID/MCO INDIVIDUAL DONATIONS HUD FOUNDATIONS HOSPITAL</p>	<p>Circle the City Medical Respite Center, Phoenix, Arizona:</p> <p>Established in 2012, this 50-bed stand-alone facility has comprehensive services that include an onsite medical clinic, congregate dining spaces, a physical therapy room, and a salon. Clinical services include physician oversight, 24/7 nursing care, psychiatric care, physical therapy, social worker, hospice, and substance abuse support. Support services such as meals, transportation, and case management are also provided.</p> <p>About two-thirds of funding comes from Medicaid MCOs (66%) for eligible health care services. The rest of program funding comes from private donations (16%), public grants such as the HUD Community Development Block Grant (9%), in-kind donations (5%), local foundations (2%) and hospital community benefit funds (2%).</p>

<p>FOUNDATIONS IN-KIND/ CONTRIBUTIONS COUNTY</p>	<p>Durham Homeless Care Transitions Program, Durham, North Carolina:</p> <p>This is a new program in a small city that contracts with area sober houses and motels for medical respite care. A nurse case manager coordinates the care and oversees two community health workers who work with individuals over a 9-month period. A complex care coordinator inside the hospital system refers individuals into the program, which provides medical respite if needed and connection to primary, specialty, and mental health care, substance abuse services, benefits, vocational rehab, and other community support services, and family. The bulk of the funding (80%) comes from a private foundation that awarded the program a 3-year innovations grant to cover staff, services and operating costs. The County contributes an annual amount for the cost of housing (5%), and in-kind and other contributions account for the remainder (15%).</p>
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<p>HOSPITAL STATE COUNTY</p>	<p>The Daily Planet Community Medical Respite, Richmond, Virginia:</p> <p>The current 20-bed program has been operating since 2008 and is co-located with a health center. The respite model combines robust medical services (physician, nurse practitioner, psychiatrist, social worker, pharmacist, and health educator) with support services (meals, transportation and case management). Funding from the UnitedWay and agency underwriting allowed the program to be restarted in 2008, reviving an earlier community program that had closed. As the new program matured and established steady patient referrals from area hospitals, Memoranda of Agreement (MOAs) with participating local health systems were established on an annual basis to purchase a dedicated number of beds per health system, each with an option to purchase additional beds at a per diem rate.</p> <p>Currently, the program is funded by two hospital systems, the state Department of Housing and Community Development (DHCD), and a county Community Services Board (CSB), with very limited unrestricted health center funding. Each hospital has used different internal sources of funding (e.g., mission budget, community grants, marketing, etc.), though there is a goal to see these funds come more consistently from health system operating budgets to allow grants to be used for other community needs. As hospitals began paying for beds, funding from the UnitedWay phased out, stopping altogether in 2014. A local county CSB also has an MOA to purchase beds. State DHCD funding provides financial support for referrals from outside of the health systems, which allow homeless services community partners to refer into the medical respite program at no cost to the referring organization.</p>
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<p>MEDICAID/MCO HOSPITALS COUNTY HRSA</p>	<p>Edward Thomas Housing Medical Respite Program, Seattle-King County, Washington:</p> <p>Started as a shelter-based program in 1996, this 34-bed respite program has been based since 2006 on the 7th floor of a public housing high-rise building owned by the Seattle Housing Authority. Medical care is available onsite nearly 18 hours a day (nurse practitioner, nursing, social worker, psychiatric care) together with support services (meals, transportation, case management). Average length of stay is 21 days.</p> <p>Funding for this program consists of four main revenue streams. MCO contracts cover 26% of total program expenses using a per diem rate that includes all services provided (medical care, care coordination, chemical dependency and mental health care, etc.). Six hospitals cover 30% of the program expenses through individually contracted yearly contributions. One of these hospitals, owned by the county and administered by the University of Washington Medical Center, is contracted to provide services for the medical respite program (including staff as employees) and provides additional operational support such as IT, security, contract negotiations and coverage of past budget shortfalls. A further 26% of the funding comes from HRSA, while 14% of expenses are covered by a county tax slated for mental health and substance abuse services. The public health department is also central to supporting the program by assisting with soliciting grant support and offering contract management.</p>
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<p>FOUNDATIONS</p> <p>RELIGIOUS CORPORATIONS</p> <p>HOSPITALS</p> <p>MEDICAID/MCO</p> <p>HUD</p> <p>CITY</p> <p>VA</p> <p>FEMA</p> <p>PUBLIC HEALTH</p> <p>INDIVIDUAL DONATIONS</p>	<p>The Boulevard, Chicago, Illinois:</p> <p>Located in a large transitional housing facility that contains a wide range of services, this medical respite program has 64 beds and is able to provide onsite health clinic services as well as assessments, behavioral health care, support services (meals, case management, life skills, group education, etc.), and housing services (assess needs, identify options, and secure placement).</p> <p>Funding for this program is divided between private (56%) and public sources (43%). From the private funding, 15% is from over 20 local foundations that give between \$5,000 and \$65,000 annually to pay for assessments, case management, transportation, medication, room and board, and capital items. Another 15% comes from four MCOs where some contract on an annual basis and reserve beds in advance, while others contract on a quarterly or daily basis and do not have reserved beds. Another 6% from private funding comes from annual contracts with two hospitals that reserve beds. The rest of the private funding comes from individuals (16%), religious organization grants and donations (3%), and numerous local corporations (1%) who provide some annual funding for administrative and other operating costs.</p> <p>From public funding, 15% of the budget is from HUD McKinney-Vento homeless assistance grants that help pay for transitional housing and services such as case management, assessments, housing placement, food and clothing; 10% from the City to pay for transitional housing, moving supplies and assessments; 10% from the public health department (pass through HUD/HOPWA funding) to pay for assessments and case management, 8% from the Department of Veterans Affairs (VA) for respite care, and 1% from the Federal Emergency Management Agency (FEMA) to pay for meals.</p>
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