MEDICAL RESPITE CARE: REDUCING COSTS AND IMPROVING CARE

POLICY BRIEF **APRIL 2011**

What is medical respite care?

Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. These programs are housed in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. Medical respite care meets the post-hospital recuperative care needs for people who are homeless while reducing public costs associated with frequent hospital utilization.

Homeless patients discharged to a medical respite program experience 50 percent fewer hospital readmissions within 90 days of being discharged compared to patients discharged to their own care.

Why do we need medical respite care?

People experiencing homelessness have high rates of physical and mental illness, increased mortality, and frequent emergency department visits and hospitalizations. Indeed, homeless persons are three to four times more likely to die prematurely than are their housed counterparts. These deaths are most often associated with acute and chronic medical conditions exacerbated by life on the streets or in shelters. Frequently, people who are homeless are discharged from hospitals with care instructions that are difficult to follow while living on the streets; moreover, their lack of a stable home environment diminishes the effectiveness of their hospital care. Homelessness exacerbates health problems, complicates treatment, and disrupts continuity of care. Medical respite care is an alternative to discharging patients to the streets while continuing hospital-recommended care, and has been shown to reduce inpatient length of stay, emergency department visits, and outpatient clinic visits (see Figure 1).

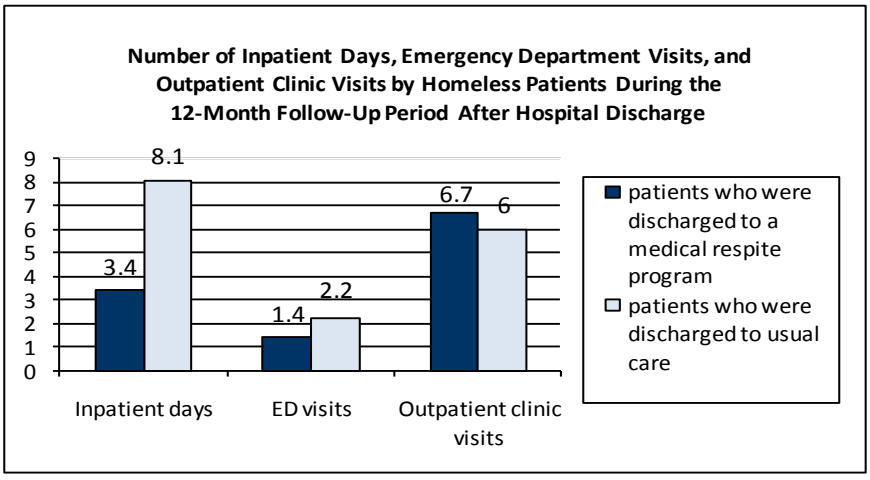

Figure 1: Hospital and clinic utilization before and after medical respite program participation

Source: 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.

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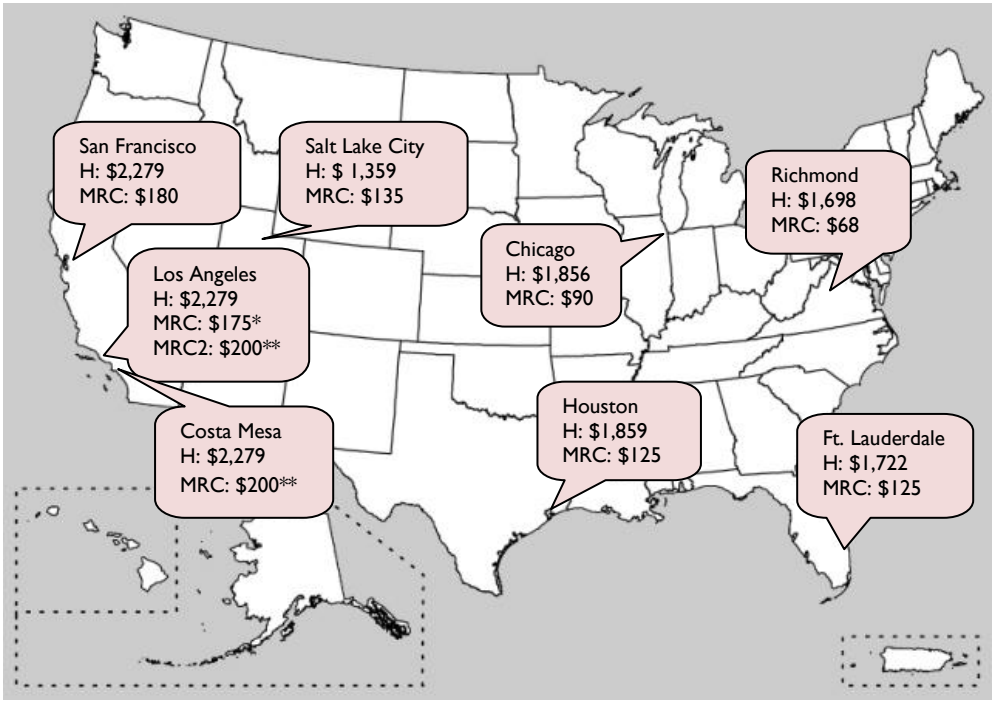
Demonstrated cost avoidance for hospitals partnering with medical respite programs

- **Los Angeles, CA** — **$3 million** total annual cost avoidance for hospitals[1]
- **Portland, OR** — **$3.5 million** total cost avoidance over three years for one hospital[2]
- **Cincinnati, OH** — **$6.2 million** total annual cost avoidance for three hospitals and the community[3]
- **San Diego, CA** — **$800,000** total annual cost avoidance for 20 patients studied over the course of a year[4]
- **Atlanta, GA** — **$185,000** total cost avoidance based on length of stay reductions for 154 patients[5]
- **Sacramento, CA** — **$1.07 million** total annual cost avoidance for 119 patients[6]
- **Richmond, VA** — **$11.2 million** total cost avoidance over 2 years for 3 health systems[7]
- **Salt Lake City, UT** — **$5.5 million** total annual cost avoidance[8]

Figure 2: Demonstrated cost avoidance for hospitals partnering with medical respite programs

Hospital stays contribute to costs

Nationwide, the average hospital stay for most patients is 4.6 days, but those facing homelessness average a stay nearly twice as long.[9, 10] Certainly these averages reflect a wide variance in the needs of many different patient groups, but a lack of safe and appropriate discharge options (due to lack of housing) and a dearth of community resources for medically recommended recuperation will lengthen overall stays. The costs associated with these increased lengths of inpatient stays can be substantive for both hospitals and the larger health care system, but medical respite care can offset the impact of these expenditures (see Figures 2 and 3). In addition to the reduced length of stay upon referral, studies find that homeless patients discharged to a medical respite program experienced 50 percent fewer hospital readmissions at 90 days and 12 months of being discharged compared to patients discharged to their own care.[11, 12]



Key:

H: Average hospital adjusted expenses per inpatient stay (at the state level).

Source: Kaiser Family Foundation State Health Facts (figures reflect 2008 data, the most recent data available as of March 2011)

MRC: Cost per day to stay in a medical respite program. Total program costs vary depending on level of services, partnerships, staffing, and facility-type.

Source: National Health Care for the Homeless Council Survey of Medical Respite Programs (March 2011)

Figure 3: Average daily hospital inpatient cost for select states compared to the daily cost in a medical respite program in that state.

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**National Health Foundation/Hospital Association of Southern California/Illumination Foundation

Medical respite care and health reform

The changes contained within the health reform law encourage the system to shift toward a more coordinated service delivery model, which is expected to increase quality of care and decrease overall costs. As such, incentives are available to health care providers to implement innovative models of care such as health homes, expanded home and community-based services, and discharge planning programs that provide 24-hour care management and support during transition in care settings.

Health homes

Health homes link primary and behavioral care and community supports in order to address the "whole person."[13] Health Homes can be a team of providers within the same facility or within partnering facilities working together to coordinate care. The provisions of the Patient Protection and Affordable Care Act (PPACA) establish a number of criteria for health homes including:

- Comprehensive care management,
- Care coordination and health promotion,
- Comprehensive transitional care from inpatient to other settings, including appropriate follow up,
- Individual and family support, which includes authorized representatives, and
- Referral to community and social support services, if relevant.

Medical respite programs are ideally suited to meet these criteria. The average length of stay for medical respite programs is two weeks, which provides ample time for comprehensive care management, care coordination, health promotion, and comprehensive transitional care. Partnerships with medical respite programs will increase primary health care providers' ability to meet health home criteria for their patients who are experiencing homelessness.

Home and community-based services

The provisions of PPACA also provide states with more flexibility to offer home and community-based services to people who might otherwise utilize more costly institutional care (e.g., inpatient hospitalizations). The 1915(i) Home and Community-Based Services (HCBS) Program allows states to amend their state Medicaid plan to include services and supports to low-income individuals before they need institutional care. It can also be a mechanism for states to provide services to people who have mental health and substance use disorders.[14] States can target benefit packages to specific populations – for example – one 1915(i) HCBS benefit package could be created for people facing homelessness and in need of medical respite care. States can also propose that additional services be covered beyond the traditional set of Medicaid home and community-based services (i.e., case management, homemaker/home health aide, personal care, adult day health, habilitation, and caregiver respite), or create a new Medicaid eligibility category for people who become eligible for the 1915(i) program, which would not only allow uninsured individuals to receive 1915(i) services but would also make them eligible for the full Medicaid package.

Comprehensive discharge planning

PPACA includes a number of provisions to improve discharge planning programs at hospitals. For example, insurers will be required to report on coverage benefits and reimbursement structures for comprehensive programs for hospital discharge that prevent hospital readmission.[15] Beginning January 1, 2015, qualified insurers who offer a plan through a state Exchange can only contract with a hospital that has more than 50 beds if the hospital implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional.[16] For people facing homelessness, comprehensive discharge plans must include access to appropriate discharge environments, which would include medical respite programs.

Recommendations & conclusions

- People facing homelessness have longer hospital lengths of stay compared to their housed counterparts; this is primarily due to lack of housing or other appropriate discharge options.
- Medical respite programs are proven to reduce future hospital readmissions by half.
- Hospitals should be investing in medical respite programs as part of health home initiatives for patients who are facing homelessness.
- States have a number of options to receive a federal match for the provision of medical respite care. These options include reimbursement for medical respite services provided by Federally Qualified Health Centers and implementation of an 1115 demonstration waiver. The Patient Protection and Affordable Care Act adds another state option, the 1915(i) Home and Community-Based Services Program, which allows states to expand the set of traditional home and community-based services and target specific low-income populations who may be at risk of institutional care, including those as risk of costly in-patient hospitalizations.
- Hospitals should be integrating medical respite care into comprehensive discharge planning programs for people facing homelessness.
- Insurers need to assess the comprehensiveness of hospital discharge planning programs by evaluating whether appropriate discharge options, such as medical respite care, are offered to people facing homelessness.

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[14] PPACA, Section 2402(b)

[15] PPACA, Section 2717(a)(1)(B)

[16] PPACA, Section 1311(h)(1)(A)(ii)

ACCESS MORE MEDICAL RESPITE RESOURCES ONLINE

- National Health Care for the Homeless Council | 2011 Policy Statement: Medical Respite Services & Homelessness | www.nhchc.org/Advocacy/PolicyPapers/2011/MedicalRespite2011.pdf
- Respite Care Providers' Network | www.nhchc.org/Respite