HOMELESS NEW YORKERS NEED A SAFE PLACE TO RECUPERATE - NOT THE STREET

A REPORT EXPLAINING THE EFFECTIVENESS OF A MEDICAL RESPITE MODEL FOR THE MEDICALLY HOMELESS AND WHY IT'S NEEDED IN NEW YORK CITY

NYLAG New York Legal Assistance Group

LegalHealth A Division of NYLAG

ACKNOWLEDGEMENTS

MANY PEOPLE & ORGANIZATIONS GENEROUSLY GAVE THEIR TIME TO PARTICIPATE IN THE DEVELOPMENT OF THIS MODEL FOR MEDICAL RESPITE:

Thank you to the Altman Foundation for bringing together the stakeholders involved with the medically homeless to identify challenges and potential solutions. Thank you to LegalHealth, a division of New York Legal Assistance Group, and to the Coalition for Housing and Health for their work over the years and in particular for providing leadership during this past year to finalize a model for medical respite.

Thank you to the people and organizations who participated in our Planning and Work Groups including LegalHealth, the Coalition for Housing and Health, the Department of Homeless Services, the Department of Social Services, Legal-Aid, the Immigrant Health and Cancer Disparities Center at Memorial Sloan Kettering Cancer Center, the Coalition for the Homeless, Care for the Homeless, NYC Health+Hospitals, Montefiore Medical Center, BronxCare Health System, BronxWorks, and the Bronx Health & Housing Consortium.

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EXECUTIVE SUMMARY

There is a pressing need in New York City to address the issues and challenges of homeless New Yorkers with cancer, renal disease, diabetes, chronic heart disease and other serious medical conditions. Many of these conditions require long-term solutions and others can be addressed in the short-term. Studies have shown and experience has confirmed that housing is inextricably connected to health and there is a hospital-homeless cycle for homeless patients. When these patients who have temporary post-hospitalization needs are discharged from hospitals to shelters or similar places, they cannot safely and effectively convalesce. Their need for IV antibiotics, wound care, medication regimens, special diets, etc. cannot be met in unstable housing situations. Their condition deteriorates and they are often re-admitted and the cycle begins again.

For those whose medical conditions can be addressed in the short-term, medical respite is an approach that has been successfully developed and implemented around the country. National Health Care for the Homeless Council ("the Homeless Council") defines medical respite as "recuperative care", providing "a safe and humane alternative when 'discharge to home' is not possible for those without homes."[1] Medical respite can also include additional services such as case management, meals, and support in finding and transitioning into permanent housing.

Many stakeholders in the City and State are interested in finding a solution to this problem but until recently, these groups operated in silos. In December, 2017, The Coalition for Housing and Health, led by LegalHealth, a division of the New York Legal Assistance Group ("NYLAG") and the Immigrant Health and Cancer Disparities Center at Memorial Sloan Kettering Cancer Center ("Immigrant Health"), brought together those key stakeholders, including but not limited to City and State government, hospitals, managed care organizations, housing providers and legal advocates, to address this issue as a community. A Planning Group was organized from these diverse stakeholders and four work groups were created to focus on particular issues, with the goal of making preliminary recommendations to the Planning Group. Recommendations for our model of medical respite in New York City were finalized in the fall of 2018.

The eligible population for this respite model will be single adults who are homeless, have medical needs that can be addressed in the respite setting in a relatively short time (typically within three months) and are generally able to perform their Activities of Daily Living (ADLs) but need extra support to become healthy enough to move to shelter or permanent housing. The admission process will include a mutually agreed upon understanding about post-respite discharge and, while ideally that would be to permanent housing, it could also include shelters, family/friends and nursing homes or assisted living facilities for those with greater needs. The length of stay is determined jointly between the payer and the program based on the patient's medical needs and housing prospects. In some cases, a longer stay in the program may be preferable in order to move the patient into permanent housing.

Populations outside the scope of this project include OPWDD eligible[2]; people with

developmental disabilities not known to OPWDD; homeless families with children and individuals who are HASA eligible.

Based on a needs-assessment conducted at various hospitals, the proposed model uses a conservative recommendation that a respite facility is needed in each borough with at least 15 beds in four boroughs and three in Staten Island. Respite programs could be sited either within a building housing a shelter, with a housing program (transitional or permanent), or as a stand-alone program. Bedside care, similar to that provided in institutional settings like hospitals, will not be available in respite settings, however the program should be in close proximity of health care services to support access to care. Those health care services can be off-site with access to providers in the community; on-site via a dedicated respite clinic facility or a shared clinic with a shelter site; or on-site via visiting nurse, home care, and therapy services. The non-medical services that will be provided include: program management, case management to help people connect to medical services and appointments, medications monitoring (observing the self-administration of medications), appropriate meals; entitlement and housing assistance; linkage to legal services and security.

The initial pathways through which people will enter these respite programs would include hospital discharges and pre-hospitalization surgery. In the future and depending on the payer, if the program expands, people could be referred from city homeless shelters, hospital emergency departments, outpatient clinics, supportive housing, the NYC Department of Corrections, and from the community. Depending upon the extent of medical and non-medical services available, the annual cost for a medical respite program described above, and based on 2018 figures, ranges from approximately $870,000 to $1.35 million per site, plus a start-up cost of $78,000 for each site. The per diem would range from $175-$265. The cost-effective analysis from both existing sources and new research makes it clear that the savings for the hospitals and managed care organizations would justify the expenditures needed to create a medical respite program both at the outset and for on-going costs. A 15-bed respite program serving only Medicaid recipients could save more than $2 million per year.[3] In addition medical respite programs have been found to reduce subsequent emergency room visits and hospital inpatient admissions.[4]

Financing the costs could come from a variety of sources, both government and private. The remaining challenge is to identify the legal/regulatory structure for medical respite in New York City; that challenge is being addressed with the assistance of the Governor's office in Albany.

BACKGROUND & OVERVIEW OF THE PROCESS

In 2014, LegalHealth and the Immigrant Health and Cancer Disparities Center, as well as other advocacy groups, began to notice an increasingly vulnerable segment of the homeless population identified as medically homeless. These homeless individuals, who were ready to be discharged from the hospital but needing recuperative care, were determined by the NYC Department of Homeless Services to be medically inappropriate for the single adult shelter system or were inappropriately returned to the streets. To address the needs of this population, the Coalition for Housing and Health ("the Coalition") was formed in 2015 by representatives from LegalHealth, BronxWorks, the Bronx Health & Housing Consortium, Memorial Sloan Kettering Cancer Center, Montefiore Medical Center and, for a time, Susan G. Komen Greater New York City and New York Lawyers for the Public Interest. This multi-disciplinary group of medical, legal, and housing professionals has as its mission the development of actionable steps to address the pressing needs of homeless New Yorkers with serious medical conditions.

Early initiatives included assessing current resources, conducting a literature review, examining programs in other states, developing needs assessments, collecting case stories, publishing articles, testifying before members of the New York City Council (November 2016), and drafting a Council bill to address this need.

In July, 2017, after a meeting with the Medical Director of the NYC Department of Homeless Services, the Coalition formed a Planning Group to set the agenda for a December 1st, 2017 city-wide multi-organizational/ institutional working meeting of key stakeholders, including City and State government, hospitals, social service agencies, managed care organizations, housing providers and legal advocates; more than 70 people attended. Four working groups ("Work Groups") were created to meet over the course of several months to make findings and develop preliminary recommendations

to the Planning Group. The Work Groups were: Needs Assessment and Evaluation, Pathways into and out of Respite, Models of Respite, and Legal/Regulatory/Financial Challenges.

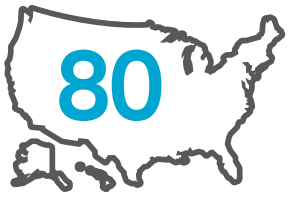
From January 2018 through the end of 2018, with support from the Altman Foundation, the Planning Group and Work Groups met consistently and reported their preliminary findings and challenges as well as recommendations to a broader group of stakeholders during two additional convenings held in April and July of 2018. By the fall of 2018, reports from each of the Work Groups were finalized.

The Work Groups' findings and recommendations for a model of medical respite are described below.

FINDINGS

NATIONAL LANDSCAPE OF MEDICAL RESPITE CARE

OVERVIEW



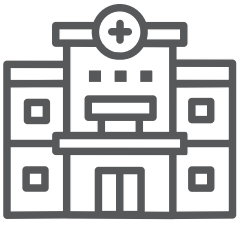
MEDICAL RESPITE CARE PROGRAMS IN THE U.S. (AS OF 2016)

1,574 BEDS

AVERAGE LENGTH OF STAY

FUNDING

(MORE THAN HALF OF THE NATIONAL PROGRAMS HAD THREE OR MORE FUNDING SOURCES, THE LARGEST OF WHICH ARE SHOWN BELOW.)



57%
HOSPITALS

51%
PRIVATE DONATIONS

43%
LOCAL/STATE GOVERNMENT

Based on information from the Homeless Council, which maintains a directory of medical respite programs around the country, as of 2016, there were 80 such programs in both large and small cities providing 1,574 beds throughout the U.S.[5] The policy brief issued by the Homeless Council entitled "Medical Respite Care: Financing Approaches" June 2017,[6] provided an overview of several elements of these programs, including the typical number of beds per program (5-35); various sites (apartments/motels, homeless shelters, transitional housing programs, assisted living/nursing homes, substance abuse treatment programs, stand-alone facilities); average lengths of stay (ranging between five days and 60 days); staffing (clinical and non-clinical); and durational needs.

That policy brief also provided financing approaches that reflect a diversity of funding sources. More than half of the national programs had three or more funding sources, the largest of which were hospitals (57%); private donations (51%), and local/state government (43%). The remaining programs have two funding sources (20%) or only a single source of funding (23%).[7] The policy brief addressed the interest of hospitals in reducing lengths of stay, preventing readmissions, and ensuring a safe patient discharge. It was suggested that philanthropic funding could be used to help support and fill the gaps left by other sources including one-time costs, renovations, specific program needs, and support for the undocumented. State and local government could provide indirect funding through agencies that look to improve the health of chronically ill people who are homeless. More directly, while there is no discrete billing code for medical respite in Medicaid or Medicare, there is some thinking by the Homeless Council that it could be billed through a waiver, or Medicaid managed care organizations could enter into an agreement that provides for flat monthly payments or for a set number of referrals. For medical respite programs affiliated with a health center, HRSA health center grants could fund staff or services.

The Homeless Council also described the rationale for medical respite by citing results of studies that show significantly higher admission and readmission rates to the emergency room for the homeless population compared to their housed counterparts, and stays in the hospital 4.1 days longer than other low income patients.

A more in-depth review of programs in a dozen cities around the country as well as in-person presentations by three medical respite programs at our December 1st convening, illustrated a range of approaches to program size, staffing, services provided, funding sources accessed, legal/regulatory frameworks, and pathways into and out of respite. Despite the differences among the programs, we found that there were several common threads that ran through these models.

The medical respite programs uniformly serve only single homeless adults who can perform their ADLs. They don't provide bedside care but rather have an on-site health clinic or are close in proximity to medical clinics. Most require patients to have a medical condition that can be addressed within a relatively short period of time. The sites are either freestanding or co-located with a shelter or with other programs serving the homeless or with a medical facility like an FQHC. Services and staffing are dependent upon the site of the medical respite program and the facility with which it might be co-located. Social services staff includes social workers, case managers, housing specialists, and administrative staff including security, food service, and maintenance. Medical staff generally includes nurses, nurse practitioners, and physicians, both full-time and part-time. Referrals for the most part are from hospitals and in some cases, from outpatient clinics and shelters. Sources of revenue include Medicaid (predominantly) and Medicare for billable services, funding from hospitals and MCOs, as well as some private funding (A review of how medical respite is funded in cities throughout the country reflects a goal of diversity of funding sources, with some focused on clinical care and others on associated costs such as room and board.). Critically, most programs do not operate under a specific license. Some are described as "transitional housing," others fall within a health agency designation; (one says it's an "unclassified health facility"). Still others describe themselves as licensed under assisted living or regulated as housing with health care services delivered by those licensed to provide them. The medical respite program is often governed by the regulations of the site to which it is connected.

THE NEW YORK LANDSCAPE: WHAT IS NEEDED TO PILOT MEDICAL RESPITE CARE IN NYC

Understanding these models of medical respite around the country enabled us to explore the unique needs and interests of the stakeholders in New York City. Having brought diverse perspectives together in our Planning Group, Work Groups and in the convenings, our challenge was to build upon the experiences of other models to develop one or more models in New York that presented a viable starting point.

NEEDS ASSESSMENT

In order to determine the initial number of beds needed to be created for medical respite in New York City, we reviewed several studies conducted during the last few years assessing both need for medical respite and the extent of the population, as well as data from both the hospital and shelter systems.

Two organizations conducted limited hospital-focused needs assessments. The Bronx Health & Housing Consortium, with support from other groups, conducted two one-day point in time needs assessments of six acute Bronx hospital in-patient wards[8] in 2017 and 2018 and identified 21 individuals deemed suitable for respite and eight additional people who might be eligible.[9] Unable to be discharged due to lack of housing, these 21 individuals spent a collective 955 days in the hospital beyond when they were medically cleared for discharge at a cost of $1.9 million, an average of 45 unnecessary days/person. Hospitals were then asked specifically to estimate the number of homeless patients they would propose for a respite program monthly. Extrapolating from the data received, each hospital would require six respite patient beds per month.

Unable to be discharged due to lack of housing, 21 individuals spent a collective 955 days in the hospital beyond when they were medically cleared for discharge at a cost of $1.9 million, an average of 45 unnecessary days/person.

NYLAG conducted an assessment of the need for medical respite in September, 2017 with its partner hospitals. Twelve hospitals across four boroughs participated in the survey. On the day of the survey, nine hospitals had a total of 22 homeless inpatients ready for discharge. Responding to the question whether lack of insurance and access to home care barred this person from returning to a place they lived prior to hospitalization, 18 answered yes.

In an assessment conducted by Immigrant Health, data from Montefiore suggested that for a facility with 87,012 annual discharges, 1524 active beds and 33% of patients who receive Medicaid, four respite beds would be needed initially per year. Using three variables (discharges, beds, payer mix) and data from Montefiore, an estimate was made of the number of beds needed per borough.

Additional data that was reviewed included: yearly discharge data from acute care hospitals across all NYC boroughs, the SPARCS[10] 2016 acute care hospital data set, data on referrals from acute care hospitals for shelter stay at two women's assessment shelters, and data on annual EMS calls for medical and psychiatric

conditions evaluation from one women's shelter. All data sets were limited and imperfect.

SPARCS data from 2016 suggested that, using a coding of homeless (ICD10 Z-59), 3800 unique patients were coded as homeless. Their rates of return through inpatient and ER visits were 6,500 within one month and 7,600 within three months. The data does not contain information on clinical condition.

The women's shelter data was taken from both Susan's Place (200 medically and behaviorally complex women +110 additional women) and Franklin Avenue shelter. The data for Susan's Place reflect 13 unique residents who had five or more ER visits in the preceding 12-month period. At Franklin, of 386 hospital discharges to the shelter referred over one month, 16% were inappropriate since they needed more intensive medical services than the shelter could provide.[11]

While additional investigation and analysis need to take place, it's clear that there is a homeless population in the hospitals, in the shelters, and in the streets, who need a place to recuperate. And, as will be clear from the cost-benefit discussion below, there is a great benefit in both cost and services to the hospitals and shelters to provide medical respite.

PATHWAYS INTO AND OUT OF RESPITE

In order to understand the pathways for a homeless individual to access respite or longer term care, we needed to look at current systems including issues of housing vouchers, chronicity, and priority eligibility for permanent housing when in non-DHS settings.

While there is recognition of the need for long-term institutional care for some of the homeless population, the immediate focus has been on short-term care or respite with ideally a transition into permanent housing. Depending on the payer, the pathways into and out of medical respite could include:

INTO RESPITE	OUT OF RESPITE
Directly from the hospital or from the shelter into respite	To shelter and to permanent housing
Indirectly from the shelter to the hospital, to respite or to the hospital and then nursing home into respite	To permanent housing or to shelter and then to permanent housing
From shelter/street to respite for pre-hospitalization for surgery, to hospital, to either respite or permanent housing	

These variations represent the initial focus of pathways into and out of respite. It should, however, be noted that in the future, other pathways need to be addressed including enrollment in the respite program by those who are unstably housed or recently incarcerated and those coming from an adult home.

There is no question that our ultimate goal should be identifying permanent housing for this population. However, remaining challenges to be addressed include the shortage of housing resources and the immediacy of the medical situation for this population. It was generally agreed that time in respite would not be considered housing and therefore a person's stay in respite should be counted among their "homeless days" to determine homeless chronicity for many housing programs.

SITES FOR PROGRAMS

Even in a city like New York where space is at a premium, we've learned that there are a number of potential sites for a small medical respite program. Co-locating it in a building shared with a shelter but not on shelter grounds, is something that DHS is willing to consider so long as there's a separate entrance and separate staffing for the medical respite program. In many ways this would make the most sense. A clinical provider could then serve those in medical respite or the site could be in close proximity to a medical facility. DHS and the Coalition for the Homeless have taken the position that even if co-located inside a shelter, medical respite will not exist under shelter regulation, and would need a different regulatory structure.

The program could theoretically be sited at an FQHC where clinical services could be provided and financially supported through that facility. Similarly, there has been some interest shown in siting the program within an unused section of a hospital and in exploring the use of transitional care beds in hospitals, although this would require a change in legal requirements.

Representatives from supportive housing providers such as CAMBA and ACMH, Inc. have shown interest in providing beds for respite within their housing stock but have been reluctant to commit until a respite model has been regulated and funding has been determined. Moreover, there is some concern that any use of transitional emergency housing for medical respite beds would reduce the number of beds available for the homeless population in general.

An additional option is to site respite at a stand-alone location with easy accessibility to nearby clinical services. This would be the most expensive option since the program would have full financial responsibility for all building costs and services.

BUDGET

Based on the information gathered about the range of services that could be provided, we developed several budget options for a respite program. We split the budget into two sections: one for varying levels of social services/operating costs and another for varying levels of medical services which can be combined into different configurations. The current configurations represent the highest and lowest possible costs for 15 beds. Costs for items like security 24/7 could be lowered if this were a shared cost rather than paid for singularly in a free standing location. Costs like rent, maintenance, and salaries are based on averages from various providers.

The budget items for social services begin at the lower end with only social services staff with increased options to add 24/7 security and a PT cook. The most expensive option includes all of these services in a

free-standing location rather than co-located which increases building costs. Included in this budget are personnel services as well as OTPS and rent/overhead; it also includes a separate line for start-up costs. The social services themselves could include program and case management, security, medications monitoring, appropriate meals, entitlement assistance, housing assistance, and linkage to legal services.

We also developed a medical services budget, again with several options that take into account billable revenue at a conservative 30%. Costs for medical staff were derived from the Institute for Family Health and Care for the Homeless as well as from consultation with a number of FQHCs that provide health care services for the homeless. The options range from full-or part-time nurses, medical doctors, nurse practitioners, LPNs, and medical assistants. For purposes of developing this budget, all clinical staffing assumes relationships with an FQHC or similar organization that would have additional staffing paid for by the respite program. Some of the visits would be eligible for Medicaid reimbursement, others not.

The site of the medical respite program will determine the extent of services. Depending on whether and how the respite program is co-located within another program, some costs can be shared. Critical to the cost is whether the clinical services are provided on site, for example by Care for the Homeless, or are off-site but in close proximity to the medical respite program.

FINANCING APPROACHES

Based on the literature and advice from leadership in respite programs around the country as well as from the Homeless Council, diversity of funding sources and their sustainability are critical to the financial health and durability of the program.

Funding sources could include hospitals, managed care organizations, foundations, and government. The latter could include innovations like "in lieu of services" to fund services not currently included in the State Medicaid plan, (similar to telemedicine in the home). Funding could also come from projects focused on social determinants of health through the new Bureau of Social Determinants of Health in the NYS Department of Health.

Several managed care plans and hospitals have already agreed to fund some respite beds. BronxCare Health System, Montefiore Medical Center, and United Health Care are currently funding beds in Comunilife. Empire Blue Cross Blue Shield and New York Presbyterian are exploring purchasing beds as well.

The sale of Fidelis by the Catholic Church to a for-profit entity has resulted in the preservation of $2 billion to address social determinants of health including housing. Distribution of the funds is at the discretion of the Governor in conjunction with the Attorney General, DOH and DSS.

An additional source of funding is through DSRIP, which currently is funding an upstate medical respite program. However, DSRIP is approaching its end (2020) and it's unclear how these programs will be funded in the future.

There is consensus in programs around the country and agreement by the participants in this project, that funding for respite programs needs to include support for the undocumented. Foundation support can play a key role in implementing services for this vulnerable population.

LEGAL & REGULATORY ISSUES

While many of the programs around the country that we reviewed have no separate legal or regulatory structure, New York City's combination of "right to shelter" and strong tenancy laws,[12] underscore the importance of having a regulatory structure in place.

To have a medical respite program for the homeless located in a shelter or as a stand-alone, the most relevant legal structure is 18NYCRR Part 491, which authorizes the certification and operation of shelters for adults serving 20 or more individuals. One medical respite program outside NYC has been certified by OTDA under Part 491,[13] however, it has been the practice in New York City that any shelter opening under Part 491 must be approved by both the NYC Department of Homeless Services and by the Coalition for the Homeless. Both have taken the position that they do not intend to approve medical respite programs in City shelters. They did allow that a program could be co-located as a separate facility in a building that also includes a certified shelter. Another option might be regulation under a Part 491 framework while leaving open which agency would administer the program.

Article 28 of the Public Health Law authorizes the operation of hospitals and sub-acute Transitional Care Units on the grounds of hospitals. There currently is no specific authorization for medical respite under this Article. Moreover, Transitional Care Units are limited by where they can be sited (on hospital grounds) and by funding (only Medicare) as well as by the limited length of stay (average 21 days).

A unique piece of legislation could be developed, similar to the NYS Domestic Violence Protection Act, which created domestic violence shelters overseen and regulated through the NYS Office of Children & Family Services.

Including respite beds in permanent supportive housing is an additional option. Doing so in existing housing is of concern since the physical design may not be amenable to adding a respite program and we do not want to reduce the number of permanent housing units available for the general homeless population to accommodate a more temporary living situation. Additionally, supportive housing is not set up to meet medical needs. New construction and allocation of additional beds, as well as a regulatory structure to provide for medical care, could resolve those concerns but would not address the immediate needs.

There are a few examples of respite programs currently in operation in New York State. One is in Rochester and is funded through DSRIP. It has 14 beds in two sites including in an old group home and is not licensed nor regulated by OTDA. Another in the greater Albany area, located at St. Mary's Hospital, is funded through DSRIP and certified by OTDA, regulating it as a shelter for adults. In NYC, the only medical respite program is run by Comunilife, with many of its beds purchased by hospitals and MCOs. There is no legal or regulatory structure in place for this respite program. It is co-located with a DHS Safe Haven program and currently has 14 beds for respite: four funded by Montefiore, six funded by BronxCare, and two funded by United Health Care. The other two are used as per diem.

Additionally, Mount Sinai is moving forward with a small, three-bed medical respite program for people under its PPS in collaboration with the Institute for Community Living. Clinical care will be provided by Mount Sinai and the maximum stay for this population will be 25 days. Funding for the PPS will end in 2020 and it's not clear how this program will be funded beyond 2020.

COST-BENEFIT ANALYSIS

Almost without exception, all the literature and data we've reviewed make clear that the benefit of medical respite programs to the patients, the hospitals, the managed care companies, and the government payers exceed the costs incurred.

Length of hospitalization is a critical metric. NYC homeless people are documented to have had hospitalizations 4.1 days longer (+36%) than other low-income populations served in NYC public and private hospitals as early as 1992-1993.[14] Local data spanning 2017-2018 from the Bronx Health & Housing Consortium, described earlier, establishes a much longer length of hospitalization beyond the date when homeless patients, who may be eligible for medical respite placement, were ready for discharge. It determined that homeless individuals spent an average of 45 days longer in the hospital beyond their dates of medical clearance. These data suggest a broad range of reduced hospitalization days.

Homeless individuals spent an average of 45 days longer in the hospital beyond their dates of medical clearance.

The increased costs of extended hospital stays are similarly reflected on a wide scale. Using NYS data from 2015,[15] an inpatient stay costs at least $2,475 per day (In 2018 and in NYC, this may be significantly higher although the Bronx Respite Needs Assessment used the very conservative estimate of $2000/day.). Translating the 4.1 extra days in a hospital described above, the total cost would be a minimum of $10,147.50 per person above the costs for other low-income populations. Using the figures from the Bronx Assessment of 45 inpatient days beyond medical clearance, that figure would be closer to $90,000.

To calculate the number of people who would be eligible for respite and the commensurate number of beds needed to accommodate this population, we turned to the Shetler study cited earlier.[16] The subject study found that 8% of inpatient readmissions of homeless individuals were eligible for medical respite. Based on SPARCS data from 2016, there were 3800 inpatient readmissions within one month of discharge. Multiplying this by .08 (those who are potentially eligible for respite) results in 304 individual respite placements. The needs assessment workgroup estimated the need for 63 medical respite beds citywide based on all cost benefit analyses. With a typical medical respite average length of stay of 45 days, this capacity could accommodate approximately 500 homeless individuals per year (which also takes into account those who are undocumented and those who "may be" eligible).[17]

In calculating medical respite costs based on this average 45 days in respite and a 15 bed unit (in four of the five boroughs and three in Staten Island), one site could serve about 120 individuals per year.[18] The budget for medical respite for an average stay of 45 days is between $6,930 and $11,925. This cost would be offset by a reduced inpatient stay for each patient. Even if we were to reduce that number by 15 days (a conservative estimate), the cost of an inpatient stay could be reduced by $30,000 per patient, (also based on a conservative estimate). The net savings would be at least $18,075 per person, a savings to hospitals and health plans for a 15 bed program serving only Medicaid recipients would exceed $2 million a year ($18,075 x 120 patients per 15 bed program).

Finally, participants in medical respite programs reduce their emergency room visits in the year following placement by 1.8 visits and have reduced inpatient readmissions as well (lower by .6 admissions per patient per year), an equivalent of nearly 6 days in NYC.[19] Using an example in the Shetler study,[20] the financial impact of enrolling individuals in a medical respite program was $1,575 in savings to the provider and $1,274 in savings for the payer. We applied this to the Daily Report from the NYC Department of Homeless Services of total single adults in shelter for a single day, June 21, 2018.[21] There were 15,367 homeless individuals on that date in the single adult shelter system X 8% (potential medical respite eligible in a year[22]) equals 1,229 eligible individuals for medical respite. When we multiply that by $1,274 (potential payer savings), it equals $1,565,746 annual payer savings. Similarly, when we multiply 1,229 eligible individuals X $1,575 (potential provider savings), it equals $1,935,675 annual provider savings.[23]

Based on information obtained from Medicaid expansion states with medical respite programs, a state like New York may be able to save $2,829 per respite stay (provider saves $1,575, payers save $1,254). These savings are achieved through a decreased duration of stay (two days shorter on average); lower likelihood of participants becoming inpatients within the subsequent year (35% lower) and decreased use of emergency rooms within the subsequent year (45% lower).

While the data is wide-ranging, it's clear that medical respite programs are a win-win for all parties involved, from the patient to the hospital, managed care, government funders, and to private funders as a win on their investment. The savings from the respite program will be most significant and longest lasting, if patients are able to be placed into housing.

RECOMMENDATIONS

RECOMMENDED MODEL

During the year-long process of developing a model of respite for the medically homeless in New York City, we had the opportunity to not only engage in discussions with local stakeholders but also with those on the national level and in one case, Canada, on the international level. In addition to learning about the particulars of their programs, we received what sounded like sage advice. Start small and grow; maintain flexibility in programming as patients with different needs emerge; hire staff with experience working with a homeless population and are culturally competent; financing and budgetary choices, as well as the location of the respite program, drive the extent of the services provided; and most critically, obtain clear long-term funding from multiple sources. Our recommended model described below, includes the population, the programs, the initial pathways to enter respite, the budgetary requirements and more specific funding and regulatory options to be explored.

Our model for medical respite in New York City will serve a population of homeless single women and men, transgender and non-binary individuals, whatever their immigration or insurance status. They have acute medical needs, are able to perform their ADLs but need extra support to become healthy enough to move to shelter or a permanent home that doesn't provide this extra support. Exceptions may be made for

someone unstably housed if they could return to housing post medical respite. An exception may also be made for someone with temporary ADL dependence who can have limited outside assistance in a respite site, for example, help with showering. These are individuals who do not require hospital level care or bedside care, neither of which will be provided.

We recommend that our initial focus should be on the smaller population of those who require short-term medical respite care (up to 90 days).[24] While this is the recommended range of stay, exceptions could be made on a case-by-case basis for those requiring slightly more than 90 days. Services feasible to be provided within that time could include: two weeks of IV antibiotics, intensive medications management, severe wound care, post mastectomy, or pre and post kidney transplant. This approach reflects the models of respite care across the country as well as the recommendation of the NYS Interagency Council on Homelessness' Health Facility Discharge Group.

We recommend that the initial paths to access respite as we develop the program in New York City include hospital discharge and pre-hospitalization.

We recommend a minimum of one respite program per borough with approximately 15 beds in four of the five boroughs and three beds in Staten Island.[25] Wherever it is located (co-located in a shelter or with a health facility or with other programs such as supportive housing or freestanding), it should be in close proximity to health services such as a hospital, FQHC, or similar site to support access to care.[26] Two sites have been identified in the Bronx: the Pyramid which is also part DHS Safe Haven at this time and Jerome Avenue Men's Shelter. The recommended space requirements should be ADA compliant, include a mix of shared rooms and bathrooms, dining space, administrative space, and consulting rooms for private conversations or care.

Recommended on site services include: program and case management, including connecting people to medical services/appointments; arranging accessible transportation; medications monitoring; appropriate meals; entitlement assistance; housing assistance and linkage to legal services. Staffing would include administration and case managers as well as security, food services and maintenance (either direct or through contract). Recommended medical services would be either on or off site and would include nursing, physicians, psychiatrists, behavioral therapists, aides, and others.

Procedures would be established detailing admission criteria and process, discharge plans, ongoing case conferencing and establishing outcome measures including health care resource utilization, health care status, financial impact, housing stability, and consequent shelter use.

Our recommended annual budget costs for social services range from $764,190 to $1,118,550 depending upon whether the program is co-located or free standing. The per diem would range from $154 to $226. Annual budgeting costs for services described above include personnel as well as OTPS and billable revenue at a conservative 30%, and range from $104,489 for one full-time RN to $194,134 for both full- and part-time medical staff. The medical services per diem would range from $21 to $39. Budgeting costs for start-up furniture would be an additional $77, 253.

Based on the above, the cost for a 45 day stay in medical respite would be between $6,930 and $11,925.

This would be offset by a reduced inpatient stay for each patient beyond the date of readiness for discharge. Assuming the latter could be reduced by 15 days on average, the cost of an inpatient stay would be reduced by $30,000 per patient.[27] The net savings could be at least $18,075 per person resulting in a saving to hospitals and health plans for a 15 bed program serving only Medicaid recipients to exceed $2 million per year.

RECOMMENDED ANNUAL BUDGET

SOCIAL SERVICES
$764,190 TO
$1,118,550

PER DIEM
FOR PATIENT:
$154 TO
$226

STAY IN MEDICAL
RESPITE BETWEEN
$6,930 TO
$11,925

NET SAVINGS
COULD BE AT LEAST
$18,075
PER PERSON*

* ASSUMING A REDUCED IN PATIENT STAY OF 15 DAYS ON AVERAGE.

The Medical Respite Legal and Financial Workgroup Chair issued a final report on August 10, 2018 that focused on the regulatory and funding options that exist as well as a cost-benefit analysis. The latter results have been described in an earlier section. What follows are some of its recommendations regarding funding and regulatory options.

FUNDING OPTIONS

While there is no specific Medicaid or Medicare billing code for medical respite services, for the remaining months of DSRIP, Performing Provider Systems could pay for medical respite services through innovation funds. Clinical services could be provided as an "in lieu of service" or possibly through other Medicaid payment reform options including Value Based, Value Added, or Quality Incentive Payments; Alternate Payment Models; or Enhanced Care Coordination. Hospitals engaging in Value Based Payment (VBP) arrangements, or interested in vacating beds, could also consider direct funding of medical respite services.

Hospital per diem payments can be used to reimburse operators for medical respite services and may cover the room and board expenses and operating costs. For example, Montefiore and Bronx Lebanon are paying via annual contracts. Per diem payments are used in some programs but a contract for X number of beds is also an option.

Hospital Transitional Care Units, which are currently financed by Medicare for onsite acute care, could be modified for delivering care outside the hospital setting and with Medicaid funds

NYS Department of Health Medicaid Redesign Options could include: Rapid Transition Housing, Medical Respite as Social Determinants of Health, new waivers under Medicaid, Home and Community-Based Services, long term services and supports. We've submitted a recommendation to Liz Misa with the NYS Department of Health for funding medical respite and for additional funds for subsequent supportive housing in the amount of $6 million.

Other sources of funding could include:
FQHC, HUD, other housing, charitable contributions, and foundations.

LEGAL/REGULATORY OPTIONS

Certification and licensing options could include certification by OTDA as a shelter (Social Services Law NYCRR Title 18 Sect. 491[28]) licensing within the health system (Public Health Law Article 28), or a new respite certification through state authority.

While Article 28 of the Public Health Law, does not currently authorize medical respite programs, it might be possible to use some elements of that law that covers the operation of hospitals, sub-acute transitional care units and outpatient clinics, to authorize medical respite programs.

Another option could be to use the provisions of Transitional Care Units to create a new authorization to operate medical respite programs on or off hospital grounds and the creation of a payment mechanism consistent with this approach that expands to Medicaid as well as Medicare. Other possible options could be to design medical respite programs within skilled nursing facilities. Additionally, the State Department of Health could create a new Article 28 medical respite license that would apply to the program in any setting. In the last few months, we have met with members of the Governor's staff to discuss solutions to the legal/regulatory challenges that exist to establishing medical respite in New York City. There appears to be political will to make this a reality. This challenge has not yet been resolved.

Identifying and implementing a regulatory scheme remains the final barrier and challenge to meeting the needs of this vulnerable population. It is urgent that this is addressed immediately and before the surge that we anticipate in an aging medically homeless population.

RECOMMENDED NEXT STEPS

The medical needs of homeless adults is on a continuum, with those at one end who need short-term recuperative care and those at the other end needing long-term, more extensive care. We have focused on the short-term needs in part because there are fewer individuals involved, their needs are urgent, and the likelihood of success in creating this program is greater. However, the long-term needs of this population must be addressed as well and a needs assessment should be conducted to determine the extent of this population. As a further result of the work we've accomplished over the last 18 months, the following actions need to be implemented:

BETTER DATA COLLECTION IS NEEDED FROM ALL STAKEHOLDERS, INCLUDING HOSPITALS AND THE CITY.

A better system for hospital coding for homelessness and its implementation needs to be created and we need to develop further data on the number of homeless discharges from hospitals; a specific zip code analysis has been created but the numbers need to be confirmed. We need to directly assess the incremental respite bed needs in each borough. More granular data needs to be collected to help further shape respite policy.

The determination of need has been based on limited assessments done in several hospitals over a period of time. There can be a further refinement of need when DHS provides additional data from those with medical needs within the shelters and those who have been denied admission due to medical needs, as well as data from H+H. It would be valuable if hospitals assessed for homelessness at every admission or stage of hospitalization as well as at discharge. And we need to assess the numbers of people leaving Rikers Island jail who could meet the criteria for accessing medical respite.

ALL STAKEHOLDERS MUST COME TOGETHER TO COORDINATE ALL ASPECTS OF THE PROGRAM.

Once a medical respite program has been established, we, the stakeholders and interested parties, need to function as an integrated team to identify sites for medical respite, build the program within those sites, and communicate to the relevant parties that these respite programs exist and the criteria for admission. Moreover, there is a need to establish coordination between and among the hospitals, shelters and housing specialists/case managers to support identifying permanent housing for the homeless. And we need to develop an evaluation process to better understand the costs and benefits of medical respite in NYC.

WE NEED TO WORK WITH THE GOVERNOR'S OFFICE TO CREATE A LEGAL AND REGULATORY STRUCTURE.

This includes better understanding of the extent to which the Butler decision[29] impacts on the eligibility for shelter of homeless people with medical issues. According to DHS, the Butler decision is not expanding the population who receive services in the shelter system, but

expanding the services available to people already in the purview of the system. And, as described earlier, we need to continue to address the issue of political will and work with the Governor's office to create a legal/ regulatory structure for medical respite whether within or outside of the shelter system.

A MODEL NEEDS TO BE DEVELOPED TO ADDRESS HOMELESS PATIENTS WITH LONG-TERM ADL DEPENDENCIES.

Addressing the needs of homeless ADL (Activities of daily living) dependent patients who end up staying in the hospital, or in other inappropriate settings, without access to ADL support and long-term care, is an important next step.

CONCLUSION

Being homeless has a profound impact on a person's health and wellbeing. There is a massive aging cohort of homeless people that will create significant challenges in the future. Medical respite programs are an affordable and sustainable step in the continuum of needed health and housing services and could make a significant contribution to those who are homeless as well as to the institutions and agencies that serve them.

There is a broad spectrum of responsibility for homeless persons who need medical care including the shelter systems, hospitals, and supportive housing providers. In order for medical respite programs to be effective, all must take responsibility and work together to serve this vulnerable population. We are hopeful that within this year, New York will join other cities around the country in providing a respite program for the medically homeless.

CITATIONS

1	National Health Care for the Homeless Council. (June 2017.) Medical Respite Care: Financing Approaches. (Author: Barbara DiPietro, Senior Director of Policy.) Available at: https://www.nhchc.org/policy-advocacy/reform/nhchc-health-reform-materials/.
2	An issue was raised by DHS about whether this population should be included as eligible for respite if there is cognitive capacity and ability to perform their ADLs. Concern with including this population focused more on the difficulty that already exists with limited capacity and other barriers for placement, suggesting respite would not be a good alternative.
3	Report of the Chair, Shelly Nortz, Medical Respite Legal and Financial Challenges/Opportunities Workgroup, Final Report August 10,2018
4	Shetler, Dan, Shepard, Donald S. "Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage." Journal of Health Care for the Poor and Underserved, Volume 29. Number 2, May 2018 pp. 801-813. Project Muse, DOI: https//doi.org/10.1353/hpu.2018.0059.
5	More recently, in April, 2018, a program opened in Philadelphia.
6	DiPietro, op cit
7	The Models Work Group identified other funding sources accessed by the medical respite programs throughout the country including managed care organizations, HUD, medical/clinical through Medicaid and/or HRSA grants.
8	Montefiore Medical Center, Bronx-Lebanon Hospital Center, St. Barnabas Health System, and New York City H+H: North Central Bronx, Lincoln Hospital, Jacobi Hospital
9	The Bronx Health & Housing Consortium "Bronx Medical Respite Needs Assessment, Summary of Findings" Updated: May, 2018 http://www.bxconsortium.org/uploads/2/5/2/4/25243019/bronx_needs_assessment_final_report_.pdf
10	The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive data reporting system which collects patient level detail regarding discharge.
11	The NYC Department of Homeless Services says they didn't provide the data and that the percentage here is much higher than what they see for men discharged to shelter where 2-3% are medically inappropriate for shelter. (It is noted by the authors that to our knowledge, this was not raised by DHS during the course of the project).
12	The Unlawful Eviction Act provides that if you live in a place for 30 days, other than in a hospital or shelter for our purposes, you acquire an entitlement to due process through landlord tenant court.
13	Albany (Troy) program described below
14	Salit, M.A., Evelyn M. Kuhn, Ph.D, et al "Hospitalization Costs Associated with Homelessness in New York City. "New England Journal of Medicine, June 11, 1998; 338: 1734-1740
15	Henry J. Kaiser Family Foundation "Hospital Adjusted Expenses per Inpatient Day." https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day
16	Shetler, op. cit.
17	One of the programs who presented at our December 15th convening,, Columbus House, Inc., a shelter and medical respite program, was created based on research conducted at a hospital in Connecticut published in the journal Medical Care in 2013 that showed that the 30 day hospital inpatient readmission rate for patients who were homeless was 50.8% and the rate of 30 day revisits including emergency department stays and observation stays was 70.3%
18	360 days in a year divided by 45 days = 8 bed placements X 15 beds = 120
19	Shetler, op. cit.
20	Shetler, op. cit.
21	The most recent Daily Report from the Department of Homeless Services is available at https//www1.nyc.gov/site/dhs/about/stats-and-reports.page, however archived information is available here: https//data.cityofnewyork.us/Social-Services/DHS-Daily-Report/k46n-sa2m/data.
22	Shelter, op. cit.
23	DHS was critical of this calculation saying it was not sound since the majority of DHS clients have no hospital stays and those that do are not readmitted. Moreover they say that this reflects only one night and there are many more homeless individuals in shelter annually.
24	There was consensus, however, on the need to address long-term care and a recommendation that a workgroup be created to begin to explore the extent of this population in NYC and their needs.
25	This recommendation does not take into account the need based on shelter to respite since we have no results from any needs assessment that may have taken place by DHS. We note that this is a conservative estimate and using this number of beds would mean that all beds would be full at all times.
26	If co-located with an FQHC serving as the medical provider, the facility could pay for prescriptions and get discounts for purchasing medications for the uninsured.
27	Using the conservative estimate of $2000 per hospital day described in the cost-benefit analyses earlier.
28	Although DHS and the Coalition for the Homeless have made clear this would in no way be overseen by DHS
29	Butler v. City of New York is a federal class action lawsuit to make the DHS shelter system accessible for people with disabilities and provide reasonable accommodations for those in the class. A settlement was reached in the matter.

ABOUT LEGALHEALTH

LegalHealth, a division of the New York Legal Assistance Group, provides free legal assistance to low-income New Yorkers with serious health problems within hospitals across New York City. LegalHealth complements health care with legal care, bringing together legal and medical professionals to improve the lives of these clients and their families where and when they need it most. In addition to onsite free legal clinics, LegalHealth trains health care professionals to recognize legal issues that may negatively affect medical outcomes.

ABOUT NYLAG

The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services, financial counseling, and engages in policy advocacy efforts to help people experiencing poverty.

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