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

APPENDIX A

Standards for Medical Respite Programs

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

Data: National Institute for Medical Respite Care.

APPENDIX B

National Health Foundation Housing Path Scale

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

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

Data: National Health Foundation, Impact Report 2021.

APPENDIX C

Select Evidence for Medical Respite Care Outcomes

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

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

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

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

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

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

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

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

NOTES

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

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

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

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

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

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

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