

Fact Sheet:

Medical Respite to Housing First: Cost Savings Analysis from other cities

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People experiencing homelessness typically access health care systems, especially expensive hospital care, more often and for longer periods than non-homeless patients. In addition, homeless patients largely have worse health outcomes than their housed counterparts.

Cost studies across the nation, however, suggest significant Return on Investments (ROI) through medical respite care programs. In addition, Housing First models show cost avoidance opportunities to communities.

This issue brief highlights a few of the many available cost studies and provides a starting point to examine the ROI potential for hospitals to work with recuperative care and Housing First programs to help break the cycle of homelessness.

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 in a hospital. 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. Medical respite care is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing.

- National Healthcare for the Homeless Council

Cost Savings through Respite Care

According to the National Health Care for the Homeless Council (NHCHC), homeless patients are less likely to be readmitted to a hospital within 90 days following their discharge if they enter a medical respite program. Readmission rates cited by the NHCHC fact sheet* were lowered by 50%. The report also listed the following cost savings by utilizing medical respite programs:

\$3 million annual savings for hospitals in Los Angeles, CA

\$3.5 million total savings over three years for one hospital in Portland, OR

\$6.2 million annual savings for three hospitals and the community in Cincinnati, OH

A study in Cook County, IL suggests that medical respite care not only improves health outcomes but also reduces health care costs. Authors cited \$706 as the average cost of respite care per hospital day avoided, which compared to \$1,500 per day in hospital costs.**

Cost Savings through Housing First

A study published in the New England Journal of Medicine in 1998 found that homeless individuals spent on average four days more in hospitals than housed patients. This accounted for an additional average cost of \$4,094 per discharge of a psychiatric patient, \$3,370 per discharge of a patient with AIDS and \$2,414 per discharge for all causes.***

More recently, a study completed in Seattle and published in 2009 examined the health care and public service use cost of chronically homeless individuals before and after Housing First. The authors found that during the year prior to the study, the median cost of services was \$4,066 per person per month. That median monthly cost decreased to \$1,492 per person after six months in Housing First and to \$958 per person after 12 months in Housing First. Total cost offsets for Housing First participants averaged \$2,449 per person per month.****

*National Health Care for the Homeless Council. February 2010. (<http://www.nhchc.org/Respite/respitesavings.pdf>)

** Buchanan D., Doblin B., Sai T., Garcia P. The Effects of Respite Care for Homeless Patients: A Cohort Study. American Journal of Public Health 2006. (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1483848/>)

***Salit S.A., Kuhn E.M., Hartz A.J., Vu J.M., Mosso A.L. Hospitalization costs associated with homelessness in New York City. New England Journal of Medicine 1998; 338: 1734-1740 (<http://content.nejm.org/cgi/content/short/338/24/1734>)

****Larimer M.E., Malone D.K., Garner M.D., Atkins D.C., Burlingham B., Lonczak H.S., Tanzer K., Ginzler J., Clifasefi S.L., Hobson W.G., Marlatt G.A. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. The Journal of the American Medical Association 2009. Vol. 301, No. 13, 1349-1357 (<http://jama.ama-assn.org/content/301/13/1349.full.pdf+html>)

One of the most cited cost analyses of permanent supportive housing stems from Greater Portland, Maine.* This study shows the following reductions after chronically homeless individuals were placed in Housing First:

- Ambulance transports decreased 60%
- Emergency room costs decreased 62%
- Physical health care costs decreased 59%
- Mental health care costs decreased 41% while utilization of treatment increased 35%

Even more cautious authors describe not only outcome benefits but also cost effectiveness of Housing First. As such, Culhane and Byrne report:

Permanent supported housing programs require investment. A housing subsidy can cost as much as \$8,000 per year, and support service costs for chronically homeless persons with mental illness are generally in the range of \$6,000 to \$12,000 average annually (with variations in client costs from year to year). It has been essential to demonstrate the effectiveness of these high cost programs. Both academic and non-academic studies have demonstrated reductions in inpatient hospitalizations, emergency room visits and utilization of other expensive acute services subsequent to placement in permanent supported housing. *The primary implication of these studies is that the costs of supported housing for chronically homeless persons can be offset, either partially or totally, by acute care service reductions in this targeted population.***

Conclusion

While cost avoidance/savings widely vary among studies and cost analysis reports, it is generally agreed that health outcomes improve when homeless individuals are enrolled in Housing First programs. The same observation upholds for Hospital to Respite Care programs.

In addition, cost offsets for emergency response and hospital stays are registered in many communities that support Hospital to Respite Care and Housing First programs. Another common denominator of these programs is partnerships. Collaboration among communities is the key to success.

*Mondello M., Gass A.B, McLaughlin T., Shore N. September 2007. Cost of Homelessness: Cost Analysis of Permanent Supportive Housing. State of Maine- Greater Portland (<http://www.nlhc.org/doc/repository/ME-Cost-Of-Homelessness.pdf>)

**Culhane D.P., Byrne T. March 2010. Cost-Effective Opportunities for Interagency Collaboration: A White Paper Commissioned by the New York State Office for Mental Health and the New York City Department of Homeless Services (http://funderstogether.org/files/documents/Culhane_whitepaper_interagency_collaboration.pdf)

Additional Resources:

National models of medical respite care programs include the Barbara McInnis House in Boston, MA (<http://www.bhchp.org/pdf/BMHBrochure-JYP.pdf>) and the Recuperative Care Program of Central City Concern in Portland, OR (<http://www.centralcityconcern.org/rcp.htm>).

On its Website, Central City Concern lists the following impact of the program:

More than 600 people served since its founding in 2005

Successful discharge rate (full recovery and completion of care): 74%

Percentage discharged to stable housing: 61%

CareOregon recently assessed costs for one complex patient and found that the patient's referral to RCP saved the health plan \$79,000 in the following year.

The National Health Care for the Homeless Council created an online resource page devoted to medical respite care resources (<http://www.nhchc.org/Respite>), with access to a tool kit, news, grant opportunities, and national best practice models.