NATIONAL HEALTH CARE for the HOMELESS COUNCIL

BUILDING A SUSTAINABLE PROGRAM:

Financing Approaches to Start & Grow Medical Respite Care

October 2, 2018

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

PRESENTERS & GOALS

Brandon Clark, CEO, Circle the City, Phoenix, AZ

Rhonda Hauff, Deputy CEO & COO, Neighborhood Health, Yakima, WA

Barbara DiPietro, Sr. Director of Policy, National HCH Council

Goals:

1. Identify major funding sources for medical respite
2. Learn strategies for engaging potential funders
3. Learn about two successful programs currently in operation

DISCUSSION AGENDA

- Overview of medical respite programs & available resources
- Neighborhood Health/Yakima program overview
- Circle the City/Phoenix program overview
- Vocabulary lesson (learn the lingo!)
- **Focus on finances:** Neighborhood Health & Circle the City
- Moderated discussion
- Audience Q&A

OVERVIEW OF RESPITE PROGRAMS

- 80 known programs
- 1,574 beds
- Size: 21 beds (ave)
- LOS: 30 days (median)
- Venue: variable
- Staff: highly variable
- Criteria: extremely variable

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MEDICAL RESPITE RESOURCES

- Fact sheets, research, development workbook, planning guides, & FAQs
- MOUs & sample contracts
- Program standards
- Program directory

https://www.nhchc.org/resources/clinical/medical-respite/

RESOURCE: FINANCING BRIEF

- Seek $ from wide range of partners
- Start small & build up
- Get involved in the CHNA & hospital community benefit funds
- Talk with Medicaid director and MCOs
- Talk with local philanthropy & grant-makers

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Medical Respite Care:
Financing Approaches
June 2017

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.

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

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]

- **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.

National Health Care for the Homeless Council | PO Box 60427, Nashville, TN 37206 | (615) 226-2292 | www.nhchc.org

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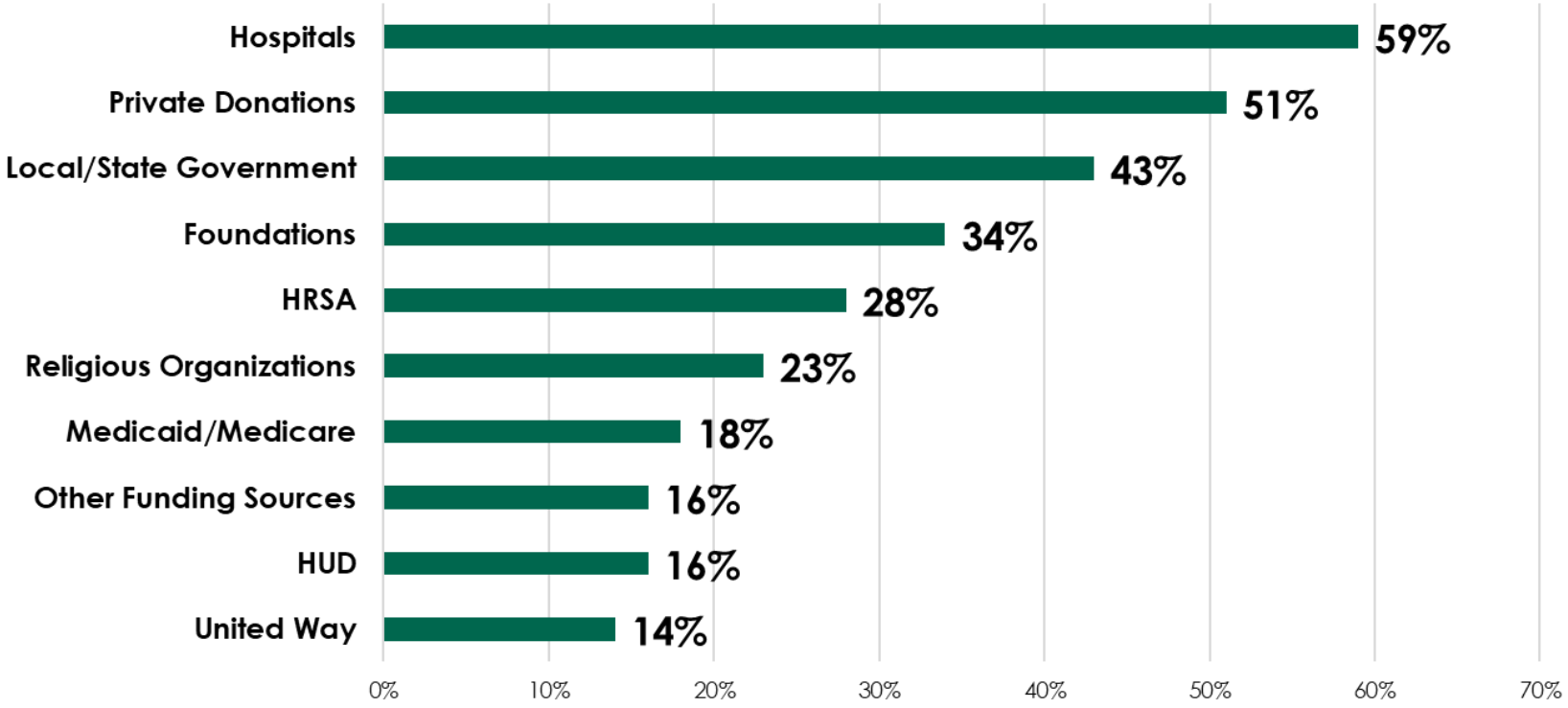
Check out the webinar too!

COMMON MEDICAL RESPITE CARE FUNDING SOURCES

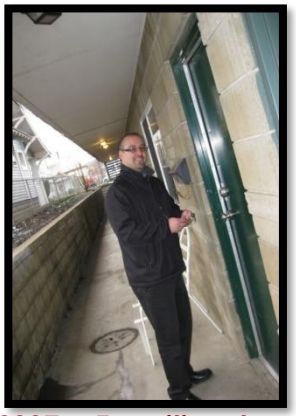


Percentage of programs with this type of funding

Yakima Neighborhood Health Services – 43 Years in the Yakima Valley

2018- Community Services Resource Center opens (Transitional Housing for Chronically Homeless)

2016 – "The Space" LGBTQ Youth Resource Center



2013 – Homeless Resource Center opens

2010 – Medical respite program opens

2007 – Transitional and Permanent Supportive Housing

2005 – First Federal Award – BPHC Health Care for the Homeless

1975-YNHS founded

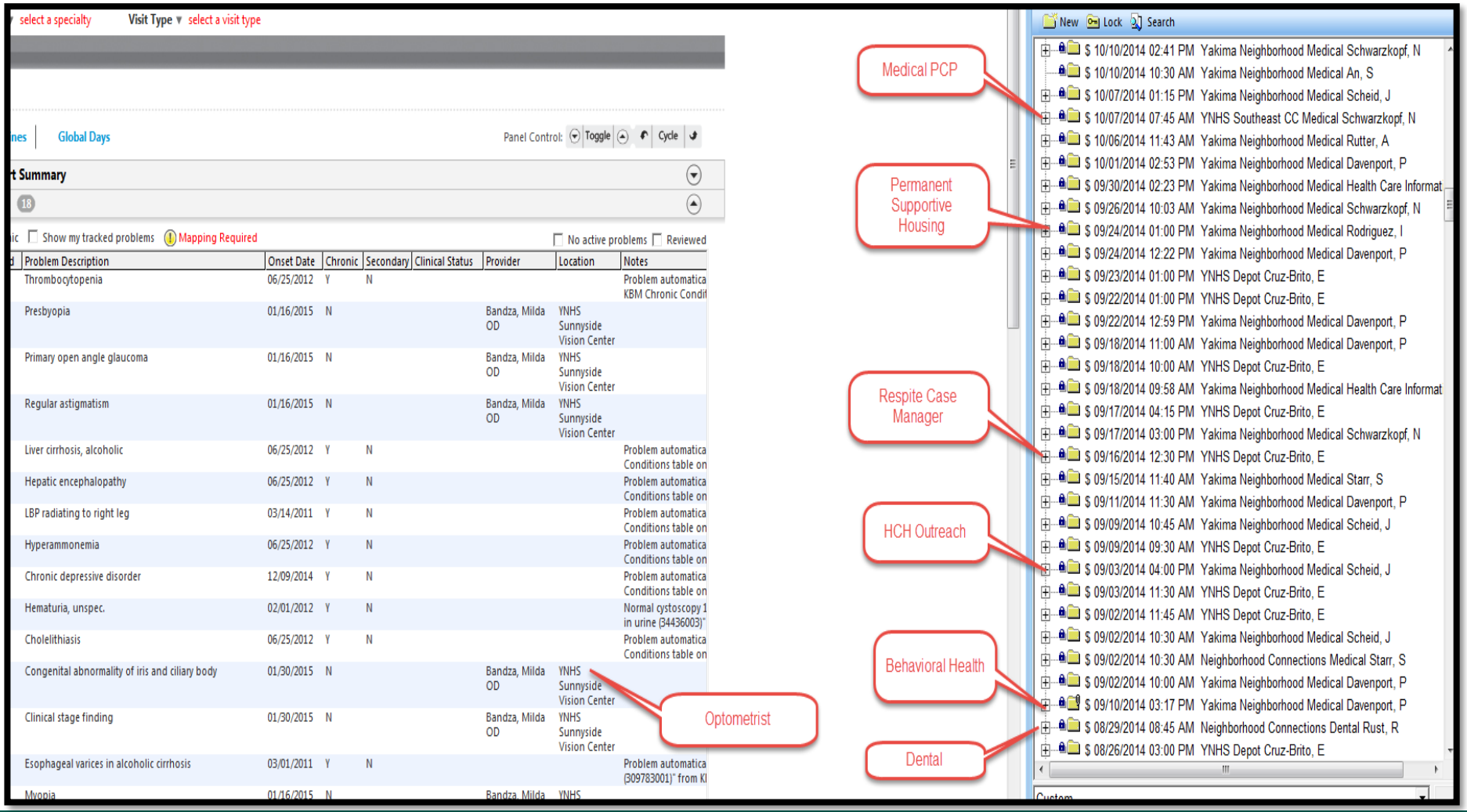
1992- Major Expansion of CHC to ready for Managed Care

Homeless Services =
10% of our Business
90% of our Time !

YAKIMA NEIGHBORHOOD HEALTH SERVICES

- Organization has very low hierarchy
  - → Integration, Cross-training, and Cross Collaboration is our STANDARD
    - (can't afford to do it any other way)
  - → When serving homeless individuals, this is our "Secret Sauce"
- "New" concept ☺ - Social Determinants of Health
  - → Basic needs – food, security, hygiene, safe place to recuperate, basic health.
  - → Our program is a solution for the community
    - Hospitals, shelters, encampments who don't have the capacity / skills
    - Our "Niche" in the community is serving the chronically homeless.

Multi-Disciplines – One Record



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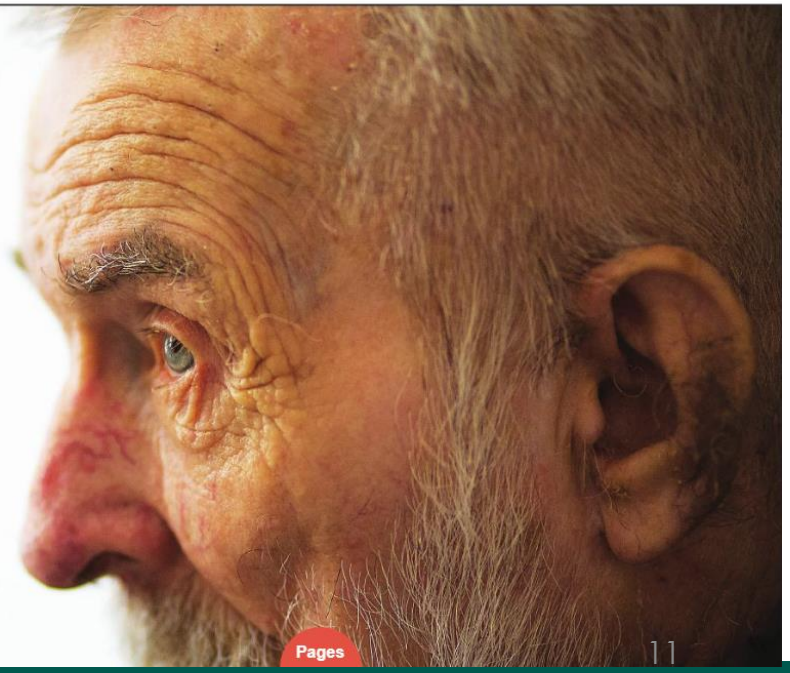
YAKIMA HERALD-REPUBLIC

HOMELESSNESS › AGING, ILL AND NOWHERE TO GO

In need of care

Respite program can be a lifesaver, but there are only six beds in Yakima; what will happen as aging homeless population



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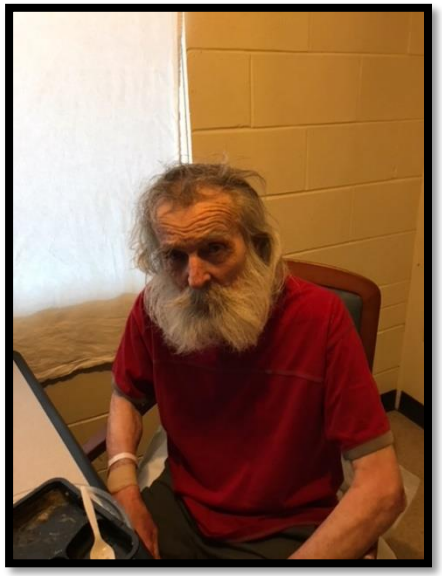
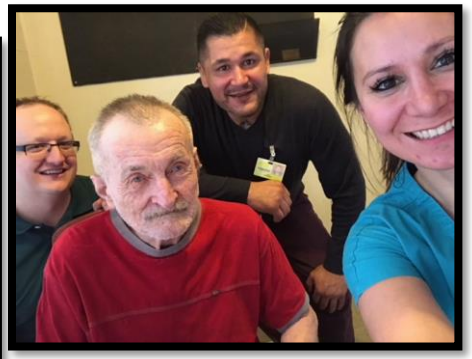
Bob's Story (with permission from Bob)

- ✓ 78 year old homeless man
- ✓ Hip surgery Summer 2017
  - ✓ Rehab didn't complete (sanctioned out)
- ✓ Discharged to shelter (sanctioned out)
- ✓ Frequented E.R.s for hip pain(8 times / 3 months)
- ✓ "Non-compliant and aggressive"
- ✓ Dropped off at Depot at 2am (twice)
- ✓ Admitted to respite
  - ✓ RN, BH, CM, PCP care team
- ✓ Successful nursing home placement August 2018





Since January 2018		
30 days Inpatient (rehab)	**=**	**$37,230**
8 visits to E.R.(avg $500e)	**=**	**$ 4,000**
45 days in respite	**=**	**$ 5,220**

Circle the City's Mission…

To create and deliver innovative healthcare solutions that compassionately address the needs of men, women and children facing homelessness.

Circle the City Continuum of Care

Homeless Primary and Preventative Care

Homeless Medical Respite Care

Low-Barrier Experience

Access to Care

Data Sharing and Integration

Integrative Care

Case Management

Care Coordination

Community-Based Homeless Health Outreach

Permanent Housing Partnerships


Circle the City
Glendale
Scottsdale
Mesa
Chandler
Gilbert
Guadalupe
Tempe
Phoenix
Medical Respite Site
Primary Care Site
Administrative Site
Mobile Clinic Partner Site
Street/Backpack Medicine Site

Circle the City

Our vision is a healthy community without homelessness.

HEALTH CARE FINANCING: TERMS TO KNOW

- Accountable Care Organizations
- Accountable Communities of Health
- Fee for service
- Hospital Community Benefit funds
- Managed care
- Managed Care Organization
- Medicaid waiver
- Per diem
- Value-based contracting

YNHS FINANCING
2010 – 2015

- Continuum of Care Ten Year Plan **50%**
  - → State and Local Filing Fee $1million/year
    - Strategic Plan
      - – Leasing Costs and Meals
- YNHS HCH Grant **35%**
  - → Professional staff (RN, Case Manager)
- Private Foundations / Donations **15%**

MEDICAL RESPITE CARE SAVES $$

HOSPITAL STAFF REPORT A SAVING OF 67 INPATIENT DAYS IN 2017 ($135,269 FOR DEPRESSION OR $392,400 FOR REHAB)

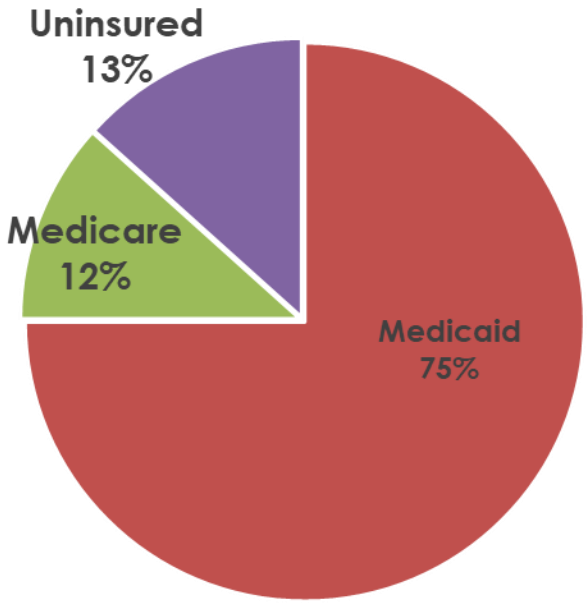
Respite care reduces public costs associated with frequent hospital utilization.

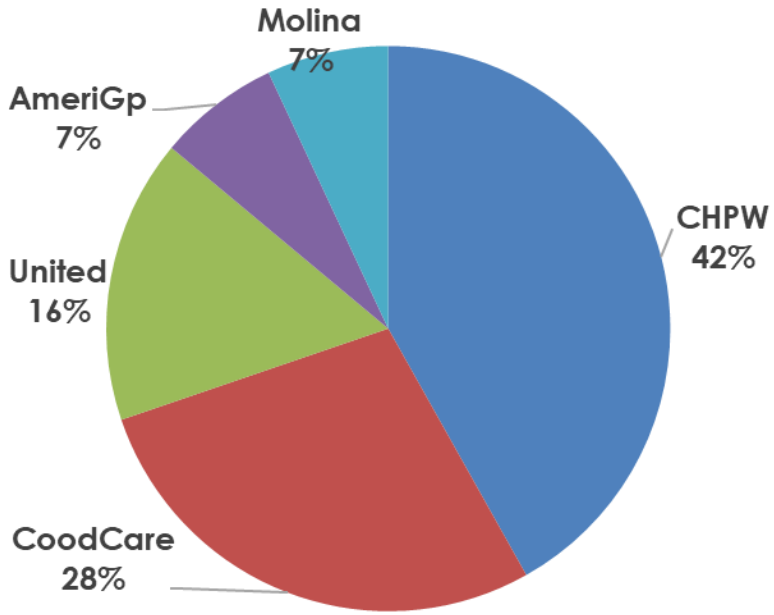
	Average Hospital Charge for Depression*	Average Hospital Charge for Rehab*	Average Respite Program
Average Length of Stay	13 days	8.1 days	21.5 days
Average Charge Per Patient **(Case Rate)**	$16,133	$29,166	$2,533
Average Charge / Cost per Day **(Per Diem)**	$1,241	$3,600	$116

*WA State Hospital Association - Hospital Pricing –www.wahospitalpricing.org

PRIOR TO THE ACA

65% OF OUR RESPITE PATIENTS WERE UNINSURED





2017 Health Coverage

2017 Medicaid MCOs

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YNHS FINANCING
2016 - PRESENT

- Patient Fees (Medicaid) **50%**
- YNHS HCH Grant **35%**
- Private Foundations / Donations **15%**

PER DIEM OR CASE RATE – WHICH IS BETTER ?
60 PATIENTS STAYED 1,311 DAYS

Length of Stay	People	Reason for Respite Needed
One Week or Less	17%	Pneumonia, cellulitis, MAT induction
1 to 2 weeks	21%	Abscess, COPD, mental health, gangrene, cellulitis
2 – 4 weeks	27%	Fractures, surgery recovery, cellulitis
4 weeks or longer	21%	Gunshot wound, endocarditis, surgical recovery, fractures, MAT stabilization

OPPORTUNITIES

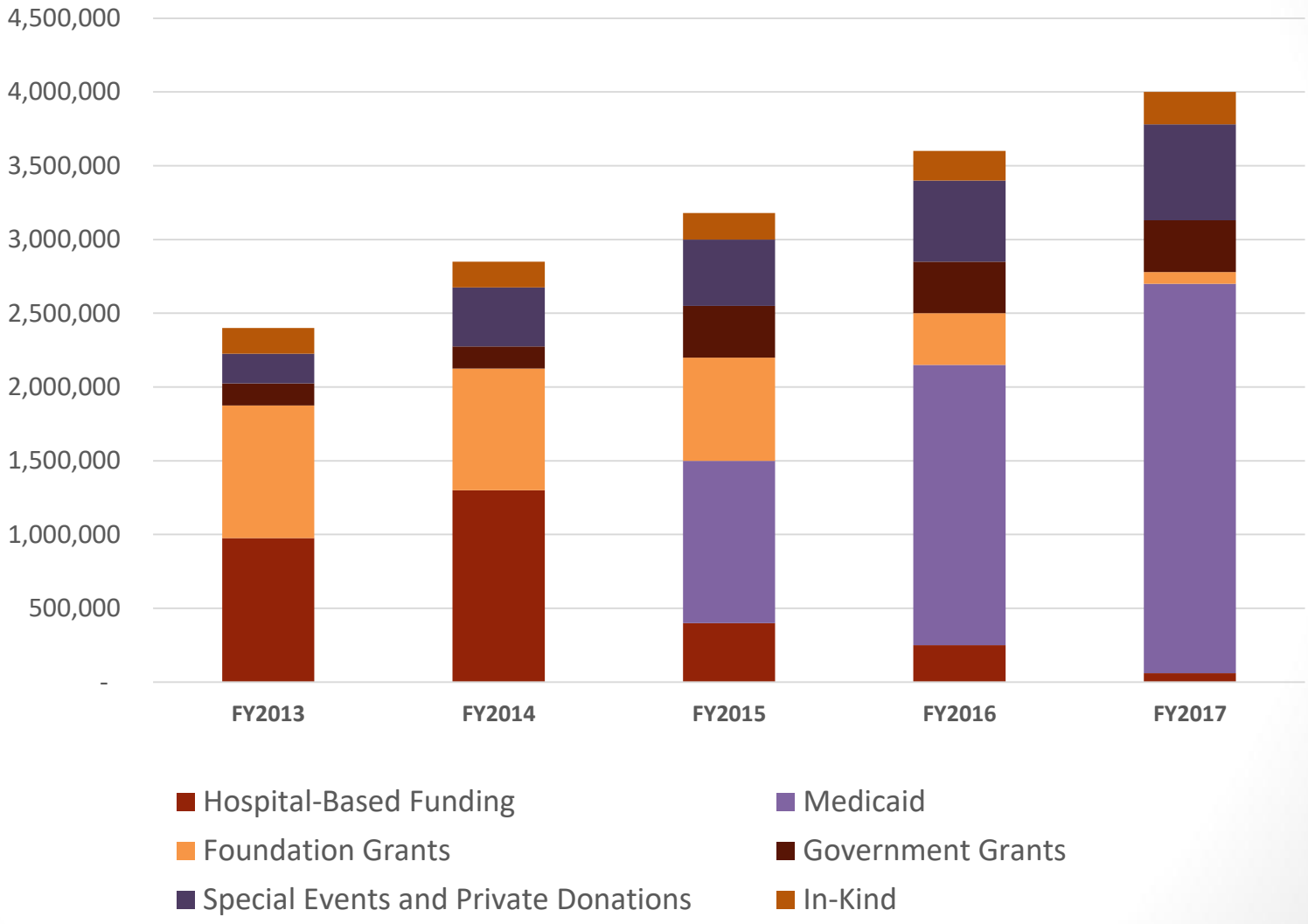
- Medicare – our population is aging
  - → What about Bob?
- Medicaid – state options
  - → Expansion to single adults
  - → Payment for services in respite (Procedure Code G9006)
  - → Not dependent on relationships with Managed Care
- Medicaid Waiver
  - → Accountable Communities of Health
    - Collective Impact / Social Determinants

Medical Respite Program

- Overview
  - 50 bed, free-standing medical respite center in Central Phoenix, AZ;
  - Staffed 24/7 by nurses (RN's/LPN's), respite assistants, and security;
  - 2 providers on-site 7 days/wk.
  - Serves ~500 patients/yr.

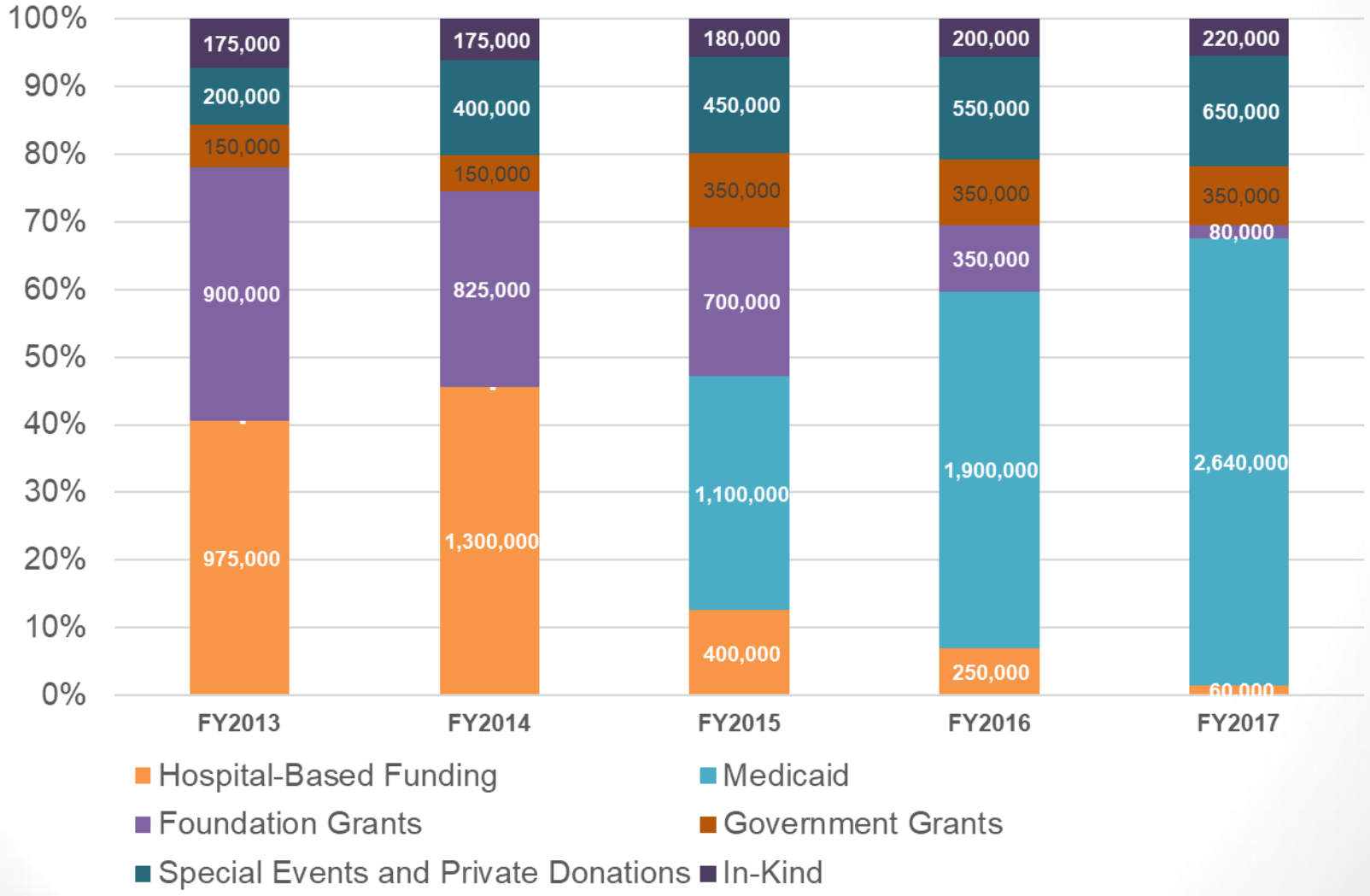
Medical Respite Program Funding

FY2013-FY2017



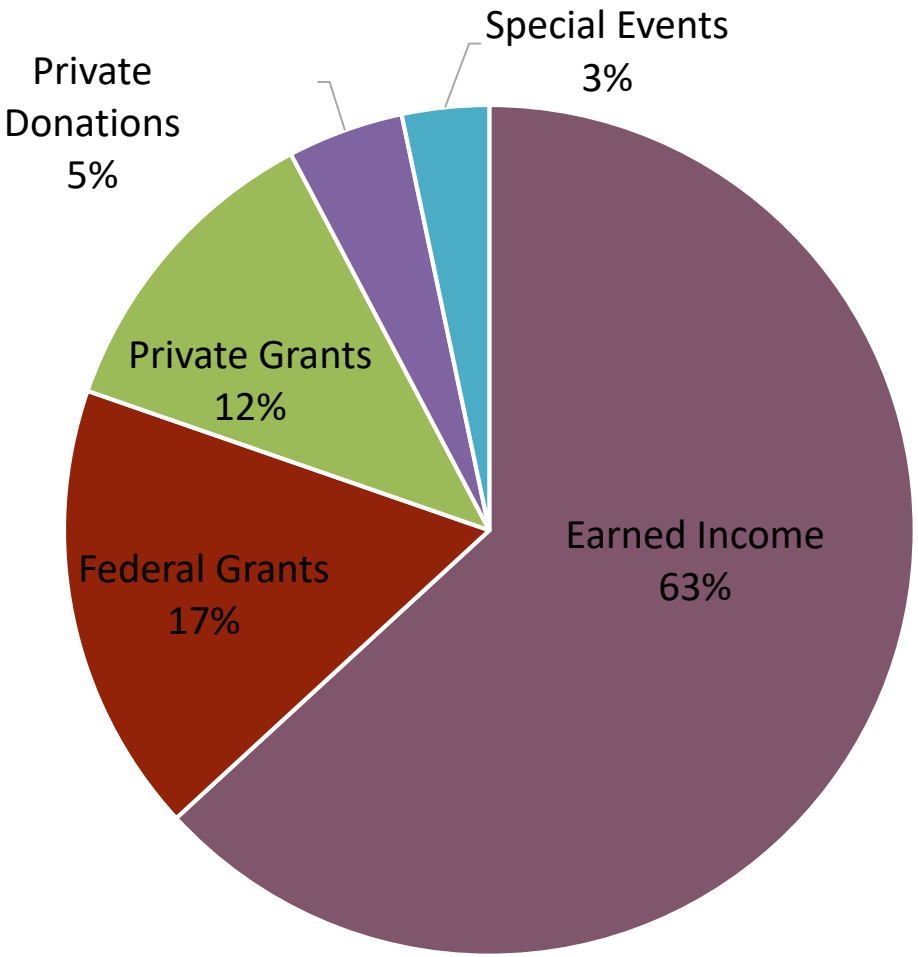
Medical Respite Program Funding

Normalized to Growth; FY2013-FY2017



Circle the City Revenue Model

FY2018, $12.5M Operating Budget



What We've Tried So Far…

- Bed Block Fees
  - Hospitals pay flat rate to 'reserve' beds in respite. Example: CTC initially charged $70k per bed, per year.
- Per Diem Fee-for-Service
  - Pay as you go based on bed occupancy. Can be invoiced to hospitals or claimed to payers.
- Tiered Per-Diem Fee-for-Service
  - Same as above but rates are tiered based on patient complexity and/or services rendered on a daily basis. CTC experimented with three tiers of acuity.
- Encounter Fee-for-Service
  - Professional fees (rather than facility fees) billed for services rendered by respite practitioners and paid to the employing respite organization.
- Quality Incentives / Pay for Performance
  - Incentives or bonuses paid for achieving pre-determined quality targets.
- Value-Based Payments / Shared Savings Incentives
  - Funding tied to a pre-determined methodology that calculates the impact of the total cost of care reduction following a respite stay and shares a portion of those savings back with the respite provider.

What We've Tried So Far…

Funding Mechanism	Source	Pro's	Con's
Bed Block Fees	Hospitals	- Immediate cash flow - Committed partnerships - Guaranteed utilization	- Complex accounting - Lack of clarity about rules - Challenging expectations
Per Diem Fee-for-Service	Hospitals and MCO's	- Easy, census-based billing - Smooth predictable revenue	- Concerns about utilization - Not encounterable to CMS
Tiered Per Diem Fee-for-Service	Hospitals and MCO's	- Paid for complex patients - Take pressure off utilization	- Complex accounting - Tiers not always well defined - More to negotiate with payer
Encounter Fee-for-Service	MCO's	- Encounterable for payers - Turnkey business model - Smooth predictable revenue	- Provider-heavy model - Requires steady throughput - Utilization questions
Quality Incentive / Pay for Performance	MCO's	- Paid for value, not volume - Resonates with providers - Leverages benefits of respite	- Patient attribution issues - Which quality metrics? - Need sophisticated reporting - Benchmark homeless data?
Value-Based Payment / Shared Savings	MCO's	- Paid for value, not volume - Big upside opportunity - Takes pressure off utilization	- Patient attribution issues - Difficult to track and report - Unpredictable and leveraged

FREQUENTLY ASKED QUESTIONS

1. Early challenges, current challenges & lessons learned
2. Two biggest factors influencing respite financing locally
3. Medicaid non-expansion states
4. Predicting the future

QUESTIONS & DISCUSSION

Brandon Clark, CEO, Circle the City, Phoenix, AZ

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