Delivering the Right Care, at the Right Time, in the Right Place, From the Right Pocket

How the Wrong Pocket Problem Stymies Medical Respite Care for the Homeless and What Can Be Done About It

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"Money is like a sixth sense without which you cannot make a complete use of the other five."

— W. Somerset Maugham, in *Of Human Bondage*

Health care authorities in the US are searching for ways to make institutional changes that are sensitive to the vexatious role of poverty and social marginalization in care delivery. Driven by an understanding of the social determinants of health, this approach to reforming health care places a greater emphasis on the communities where patients live and how those communities shape population health.[1]

Housing is often cited as one of the most prominent social determinants of health.[2] By extension, homelessness presents one of the most salient examples of the challenge that poverty poses to health care providers. In the United States, where the health care ecosystems are fragmented and siloed, hospitals bear an especially prominent responsibility as a backstop in the care of patients experiencing homelessness.[3,4] One study of data from 474 US hospitals observed that 1 out of every 26 hospital admissions involved a patient experiencing homelessness.[5] When patients are without a safe and stable place to live, they tend to present for care with more complicated illness and fewer resources to adhere to treatment plans (especially in cases involving chronic homelessness).[3–5] Challenges from homelessness can lead to longer hospital stays,[6] more medical complications,[7] and greater odds of 30-day readmission when compared to patients with stable housing.[4,5]

Discharges in these cases are especially complicated. A patient's ties to the hospital medical team can be quickly severed by the vagaries of homelessness. In the absence of suitable accommodations, it is not unusual for these patients to convalesce after a hospital stay in areas such as tents or public parks.[8] Dispatching a home health nurse to care for a patient is an altogether different experience when "home" for them is not the kind of place with a roof and a mailing address.

MEDICAL RESPITE CARE UNITS FOR PATIENTS EXPERIENCING HOMELESSNESS

Patients can find themselves in situations where they do not require the level of care provided at an acute hospital, yet need more than what can be provided by postacute options. Their cases expose a diffusion of responsibility problem, where their

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health needs are too great for a homeless shelter to manage, and their housing needs are too severe for a health care provider to resolve. Medical respite care (MRC) units have emerged as a solution to this problem. According to the National Institute for Medical Respite Care (NIMRC):

"Medical respite care is acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from an illness or injury on the streets or in a shelter, but who do not require hospital-level care. Unlike 'respite' for caregivers, 'medical respite' is short-term residential care that allows individuals experiencing homelessness the opportunity to rest, recover, and heal 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, motels, and transitional housing."[9]

Within the broader context of American health care, these programs are relatively cheap and simple to administer. They do not require expensive diagnostic equipment; nor do they rely on large nursing staffs or on-site pharmacies in the way hospitals must. In essence, they are stepping into the void left when a patient has no kith and kin network able to take them in and care for them as they recover. Table 1 displays the stark differences between a typical expense for a day in the hospital versus a day of MRC across the United States.

While MRC units are no panacea for getting to the root causes of homelessness, they do present a practical strategy for managing one of the most perilous stages in the American health care ecosystem: the transition from a hospital to a postacute setting. A broad scope of research has been conducted to test the impact of MRC units on health and economic outcomes for patients experiencing homelessness. This includes a systematic review,[10] randomized controlled trials[11,12] policy evaluations[13] and pilot studies of a variety of program models.[10,14] One cost-benefit analysis estimated that each dollar invested in MRC yields a benefit of $1.81 in avoided hospital costs.[13] This body of evidence broadly concludes that MRC is a safe, cost-effective means of improving health care outcomes for patients in a manner that is tailored to their specific needs.

If MRC units are indeed safe, effective, and economically efficient (and homelessness is also prevalent) it would stand to reason that an abundance of such programs would be operating. Yet this is not the case. Across the entire nation, only roughly 150 MRC programs appear on the NIMRC registry; and these programs can be as small as 5 beds. Nine states have no MRC programs at all. Figure 1 illustrates the geographic distribution of programs in the United States.

MEDICAL RESPITE AND THE WRONG POCKET PROBLEM

What explains this dearth of programs? We argue that the prime culprit is the wrong pocket problem. As defined by McCollough, the wrong pocket problem occurs "when one entity makes an investment in or bears costs for an initiative that, if successful, will generate benefits for a different entity."[15] The unique amalgamation of stakeholders and economic incentives that emerges when a patient has no safe discharge disposition creates a prototypical wrong pocket problem. Consider a hypothetical scenario where a homeless shelter receives a $500,000 federal grant to operate a 10-bed MRC unit for 1 year. Assuming the cost/benefit ratio of 1.81 estimated by Shetler and Shepard,[13] the respite unit should generate ~$900,000 in savings to local hospitals. In this example, the hospitals spent nothing to save a respectable sum. On the other hand, the homeless shelter spent half of one million dollars and is left empty-handed once the grant is gone. Because the costs and benefits were spread across different "pockets," this economic model of providing MRC is unsustainable.

In the language of economics, the wrong pocket problem is a case of market failure, and the savings accrued by the hospitals in the previous example is an example of a positive externality.[16] Because those externality benefits are often diffuse (eg, more than one hospital benefits), and the patients themselves lack the ability

TABLE 1. Comparison of Daily Hospital and Medical Respite Expenditures in 6 States

State	Hospital adjusted expenses per inpatient day*	City	Medical respite daily expense		Expenditures avoided per day in medical respite	
			2011 Dollars†	2021 Dollars‡	In Dollars	As a percentage of hospital expense (%)
California	$4181	Costa Mesa	$200	$241	$3940	94
		Los Angeles	$200	$241	$3940	94
		San Francisco	$180	$217	$3964	95
Florida	$2629	Fort Lauderdale	$125	$151	$2478	94
Illinois	$2997	Chicago	$90	$108	$2889	96
Texas	$2913	Houston	$125	$151	$2762	95
Utah	$3179	Salt Lake City	$135	$163	$3016	95
Virginia	$2518	Richmond	$68	$82	$2436	97

Table is inspired by the information that appears within Figure 3 of a policy brief published by the National Healthcare for the Homeless Council. Medical Respite Care: Reducing Costs and Improving Care (April 2011).

*Source of data: Kaiser Family Foundation (KFF). Hospital Adjusted Expenses per Inpatient Day | KFF. Dollar values are in 2021 dollars.

†Source of data: National Healthcare for the Homeless Council. Medical Respite Care: Reducing Costs and Improving Care. Figure 3 RespiteCostFinal.pdf (nhchc.org).

‡Simple inflation adjustment of the 2011 dollar values reported in the National Healthcare for the Homeless brief.

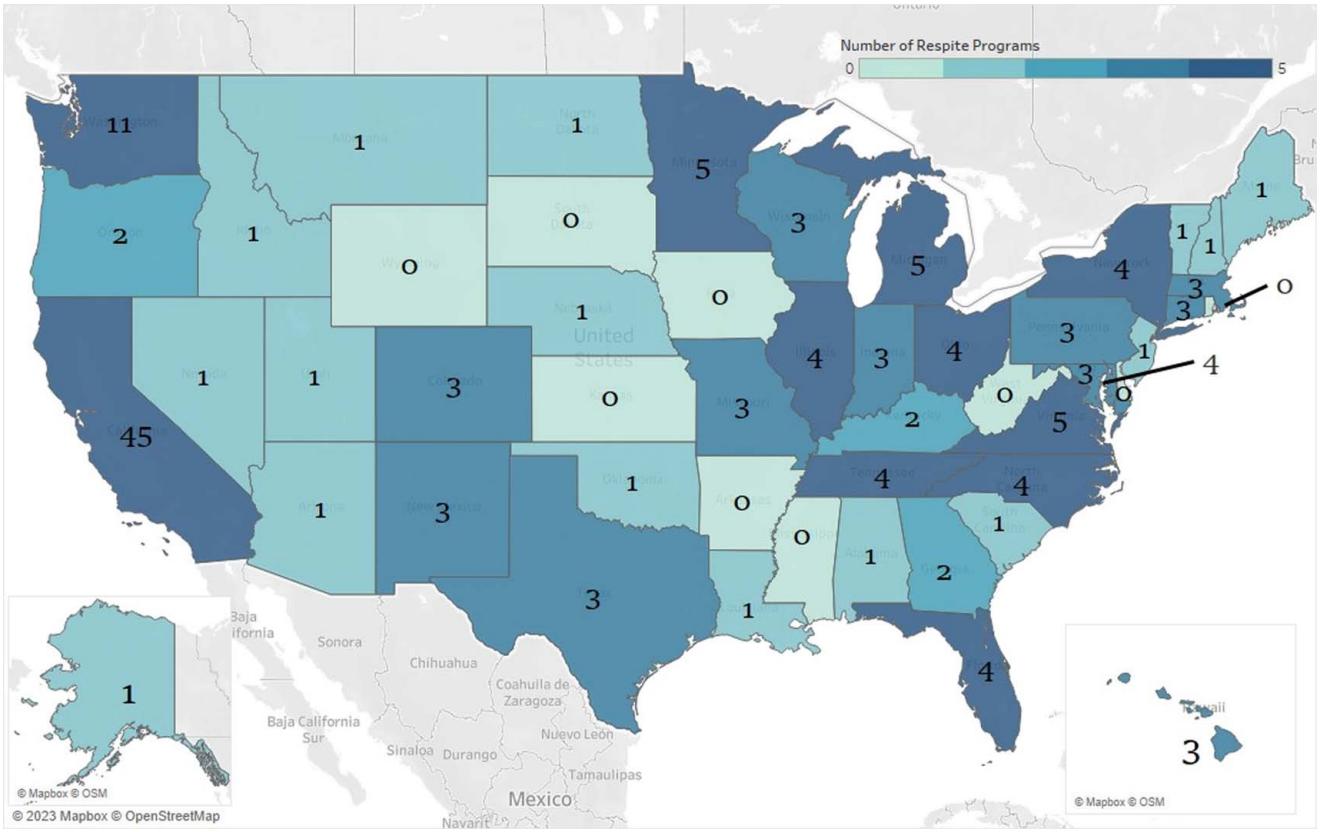

FIGURE 1. Count and geographic distribution of medical respite units in the United States. Source: Graphic uses data from the National Institute for Medical Respite Care (NIMRC). NIMRC Medical Respite Directory - https://nimrc.org/medical-respite-directory/; current as of November 2023. Permission was obtained by the NIMRC to present in this manner. full color online

to pay for them, it is challenging for MRC providers to capture the economic returns they produce. Therefore, to sustain operations, some mechanism must be in place that allows them to internalize or capture some of that value they are creating for society. These can take a variety of forms, including contracts with hospitals, adding MRC as a Medicaid-billable service,[17] receiving funds from commercial health insurance organizations, and appropriations from municipal governments (Fig. 2).[18]

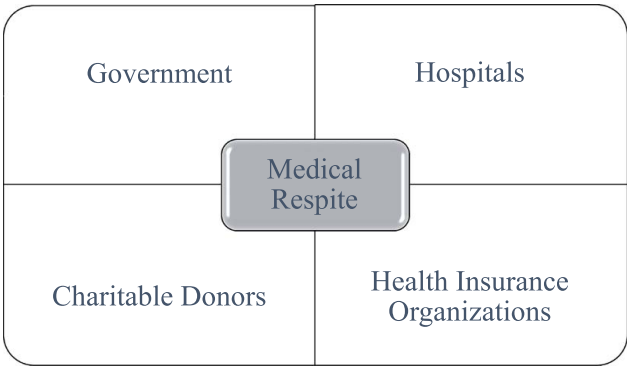

FIGURE 2. Sectors of society that can pay for and benefit from medical respite care. full color online

A CASE FROM KENTUCKY

Kentucky's hospitals have firsthand experience of the unique challenges of treating patients without stable housing. To improve conditions for patients, representatives from the Homeless and Housing Coalition of Kentucky (HHCK) and University of Louisville School of Public Health and Information Sciences (ULSPHIS) approached the Office of Data Analytics (ODA) within the Cabinet for Health and Family Services. This effort involved 2 initiatives. First was the creation of a method for using administrative data to estimate the volume of hospital discharges where the patient was identified as experiencing homelessness.[19] Second was an advocacy process where HHCK and ULSPHIS used that data to appeal to health care leaders and to the Kentucky state legislature for a policy solution to sustain MRC.

The advocacy initiative spawned 2 newly operational MRC units, one in Louisville at a site called Hotel Louisville and the other in Covington at a homeless shelter called Welcome House of Northern Kentucky. Moreover, it catalyzed new funding mechanisms to resolve the inevitable wrong-pocket problems that these units will contend with. In the short term, these units used an assortment of federal American Rescue Plan funds and contracts with local hospitals to support their operations. For the longer term, Senate Joint Resolution 72 in 2022 resulted from advocacy

efforts and led to a legislative directive for Kentucky's Medicaid program to apply for a waiver to include MRC services in its covered benefits.[20] McCollough[15] argues that "building the evidence-base and political will"(p2) are two necessary conditions for solving wrong pocket problems in public health. Both conditions were met in the Kentucky example: ODA supplied evidence, and the advocates from HHCK and ULSPHIS used it to build political will.

CONCLUSIONS

Hospitals have rightly committed to efforts to reduce risks to patient safety and improve quality of care. The phrase "right care, in the right place, at the right time" is commonly used to animate quality improvement initiatives. By including penalties for 30-day readmissions, the Affordable Care Act effectively tied together the fortunes of hospitals and their most vulnerable patients. Therefore, these quality initiatives now have an incentive to extend their vision beyond the walls of the hospital and into the communities where their patients return to. We argue that solving the wrong pocket problem for MRC units is one meaningful way to do this. In so doing, hospitals (alongside their community partners) can achieve new efficiencies and more closely align their practices with their ethical mission to honor their patients' dignity and alleviate human suffering.

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