



Medical Respite:

Insights from the Institute for Community Living (ICL) and Comunilife

September 2025

We would like to thank Sachs Policy Group, an Ankura Company, for their significant contributions in developing this report.

Executive Summary

For most patients after a hospital stay, being discharged means returning home to rest and recover. However, for the many New Yorkers experiencing homelessness or who have unstable or unsuitable housing, being discharged from the hospital means returning to crowded shelters or city streets, even while still healing. Often, they find it challenging to adhere to treatment plans and manage their medication regimens due to housing instability and without access to appropriate refrigeration.

Public agencies and health systems have struggled to respond to the needs of patients who no longer need an inpatient level of care but have no safe discharge destination. One promising solution is medical respite, a care model that helps guide individuals toward real recovery. Medical respite programs provide clients with a safe environment to heal, supported by staff who help manage medications and reconnect them with primary care instead of ricocheting between emergency departments and precarious living situations. Although this model of recuperative care has long been discussed, only a handful of early adopters --Comunilife, which opened the City's first medical respite bed in 2011 from a contract with Montefiore Hospital, and the Institute for Community Living (ICL)-- have taken the leap to build full-scale medical respite programs in New York City. These programs continue to grow through critical partnerships with health systems, including NYC Health + Hospitals (H+H), which has played a leading role in supporting their development.

Rather than keeping clients in extended stays in hospitals and then discharging them to unhealthy environments, medical respite programs address a simple question: does this person have a safe place to heal today, and can this setting be used to transition them into stable, community-based housing? Bluntly, can medical respite break the cycle of shelter to hospital to shelter?

"When you're going through something, [Comunilife] always has somebody. We need more places like this." – Former client of Comunilife's medical respite program

The model's pragmatism fills a critical gap in transitional care just as looming Medicaid cuts demand every avoidable hospital day be eliminated. By diverting recuperating patients from acute-care beds, medical respite care preserves inpatient capacity and prevents unsafe, premature discharges. Medical respite allows patients the dignity to heal and recover in the community, rather than in a hospital setting when they no longer need an inpatient-level of care. Equally as important, medical respite helps relieve hospital financial challenges of long-stay populations just as changes to Medicaid policy are likely to increase the number of uninsured individuals.

Yet even the best ideas and the strongest pilots cannot grow on goodwill alone. Scaling the model will require **deliberate investment** from the State, from hospitals eager to reduce avoidable days, and from insurance partners who see the return on health outcomes and financial savings that every dollar yields. It also demands **targeted regulatory reforms**, including more flexible certification standards and policies around braided funding, to ensure that the model can innovate to meet local needs. With strategic funding and flexible rules, medical respite can move from an emerging innovation to a statewide standard, ensuring no New Yorker is forced to recover on the sidewalk.

The Medical Respite Model

Model History

The health care system has long struggled with introducing high-risk patients back into the community after an inpatient stay. Across these populations, which includes individuals experiencing homelessness, individuals with behavioral health conditions and/or substance use disorders, individuals with intellectual/developmental disabilities, economically insecure individuals, and the frail elderly, hospitals and emergency departments have become the default housing option when no safe place for discharge can be found. And these patients, when discharged without a safe place to recover, often experience poor health outcomes and higher levels of readmissions.

To address this gap in transitional care, medical respite programs emerged as an alternative discharge destination. The first medical respite facilities were established in Boston and Washington, D.C. in the 1980s, and in 2000, the federal Health Resources and Services Administration funded a limited pilot program of ten respite sites across the country.¹

Since then, there has been growing evidence of the effectiveness of medical respite programs in improving health outcomes of respite recipients, while also reducing hospital utilization and costs.² As a result, adoption of the model has expanded across the country, with over 160 programs now operating across 40 states and territories.³ The vast majority are operated by nonprofit community providers, with a smaller number run by federally qualified health centers and hospitals. Today, only four medical respite programs operate in New York State, with two of them – those run by Comunilife and ICL—operating in New York City.

Model's Key Attributes

Despite differences in their organizational structures and day-to-day operations, medical respite programs share a common foundation: they are short-term residential programs that provide a person-centered service bundle designed to stabilize health. According to the National Institute for Medical Respite Care (NIMRC), medical respite care “allows people experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services.”⁴ Respite facilities may be dedicated units, converted hotel rooms, or semi-private dormitory spaces, and programs

¹ Zerger, S. (2006). An Evaluation of the Respite Pilot Initiative. National Health Care for the Homeless Council.

² Zerger, S., Doblin, B., & Thompson, L. (2009). Medical respite care for homeless people: a growing national phenomenon. *Journal of health care for the poor and underserved*, 20(1), 36–41.

³ National Institute for Medical Respite Care (NIMRC). Medical Respite Care Directory. <https://nhchc.org/medical-respite/directory/>

⁴ National Institute for Medical Respite Care (NIMRC). (2021, January.) *Standards for Medical Respite Care Programs*. <https://nhchc.org/resource/standards-for-medical-respite-care-programs/>

provide clients with daily meals, access to laundry facilities or services, and other basic amenities.

Medical respite programs use multidisciplinary care coordination teams to deliver services to clients, and all are staffed 24/7 for emergency needs. Other core components of the model are delivered flexibly, allowing programs to adapt eligibility criteria and service intensity to specific populations, ensuring that medically and socially complex clients do not fall through the cracks. Medical respite staff (such as on-site nurses) provide medical support, including daily wellness checks, managing medications, monitoring chronic conditions, and communicating changes in status to clients' primary or specialty providers. Staff develop person-centered care plans, schedule and accompany clients to follow-up appointments, and facilitate insurance or benefits enrollment. Case managers/counselors also provide robust case-management services such as arranging transportation, securing durable medical equipment, connecting clients to substance-use treatment or counseling, initiating permanent housing placements, and helping with supportive-housing applications.

“The social worker, case workers, and the nurse are willing to assist [you] in anything that they feel [you] need to move forward... I currently have my own apartment and am in the best of health... This program was a blessing from God.” – Former client of ICL’s medical respite program

Comunilife’s and ICL’s programs also demonstrate the importance of engaging with hospital partners, which serve as more than just referral partners and program funders. By actively collaborating with medical respite programs, hospitals help ensure that patients discharge safely into respite care and, following their recovery, support their transitions back into the community. NYC Health + Hospitals (H+H), which partners with both Comunilife and ICL, epitomizes a strong hospital partner. The H+H Housing for Health team has been instrumental in bringing the model to life through its support of the program on an executive level, dedicated financial support, and ensuring that staff members are engaged with Comunilife or ICL program staff from the moment a referral is made and throughout their respite stay and eventual discharge from medical respite. Further details on H+H’s engagement with its medical respite partners can be found in Appendix A for ICL and Appendix B for Comunilife. Also included in Appendix B is a summary of growth of Comunilife’s Respite program starting with its initial partnership with Montefiore Hospital, which was key to launching New York State’s first medical respite program.

A key strength of both agencies is their management of large housing portfolios, which allows them to transition clients from short-term post-acute medical respite care directly into long-term housing units. Unlike other medical respite programs that rely on

external partnerships for post-respite housing placements, Comunilife and ICL's programs are part of a broader continuum of housing options operated by the respective agencies, including transitional housing, family residential programs, and long-term supportive housing, and low-income affordable housing. This enables them to embed housing navigation and placements into their programs, allowing them to promote long-term stability and sustainable health outcomes for clients.

Medical Respite Outcomes

Internal data from ICL and Comunilife begin to validate medical respite's promise at improving housing stability and clinical outcomes while reducing overall system costs.

Program Outcomes:

Medical respite is premised on improving health outcomes by supporting housing stability. Programs typically evaluate their success in helping clients connect to permanent housing, an outcome that is often unattainable for this population without targeted support. Without access to permanent housing, individuals face ongoing stability that undermines long-term health and increases the likelihood of future hospitalizations.

Comunilife showed success in post-respite placements. In 2024, the majority of its respite clients who are primarily experiencing homelessness (65%, or 173 clients) were discharged to permanent supportive or independent housing. Included in the program design is post-discharge follow-up by the housing navigator. Of note, Comunilife differs from ICL in that it also admits individuals who are not experiencing homelessness but who lack an appropriate setting to recuperate in as well as hospital patients who are not eligible for city/state supportive housing programs.

ICL's data demonstrates its success at providing post-respite housing stability, which is particularly important given that its target population is individuals experiencing homelessness. In 2024, 31% (or 45) of its medical respite clients who had been experiencing housing instability prior to hospitalization were placed in permanent housing (generally supportive housing and private market housing). If not for medical respite interventions, these clients likely would have been discharged from hospitals back to shelters or the street and would have remained unhoused.

Client Perspectives:

The remarkable stories of two clients – one from ICL and one from Comunilife—illustrate the pivotal role that medical respite has played in their care journeys.

After spending 98 days at ICL's medical respite program, Mark described his stay as a turning point in his recovery. During this time, he gained valuable insight into both his mental health and medical conditions. With support from staff, Mark learned effective coping strategies and received hands-on education about managing his diabetes, including how to perform fingerstick tests, monitor his glucose levels, and administer insulin. Upon discharge, Mark successfully transitioned into a studio apartment at The Pearl, a senior housing development in Staten Island operated by Selfhelp Community Services. He continues to receive outpatient care at Kings County Hospital and to date has not been re-hospitalized.

At Comunilife, Elvis, 56, was a full-time contractor before the COVID-19 pandemic. After a work accident left him severely injured and unable to work, his life began to unravel. In 2022, he lost his mother to COVID, and shortly afterward, his brother died by suicide. With remaining family members returning to Puerto Rico, Elvis was left alone— living in his car, battling severe depression, and without access to medication for his schizophrenia. In 2024, Elvis was admitted to Comunilife's program, where he began adhering to his medication regimen and prepared for upcoming surgery with the hope of returning to work. With support from respite staff, he successfully enrolled in Social Security disability benefits and moved into an H+H permanent supportive housing apartment on the campus of Woodhull Hospital. When Comunilife's Senior Program Director handed him the keys to his new apartment, Elvis was overcome with emotion. "I don't even have words to express how much this building has helped me," he said.

System Savings:

Medical respite care offers a compelling value proposition for New York's health systems. Because hospitals are reimbursed through episodes of care, their financial sustainability generally depends on being able to discharge patients no longer require inpatient levels of care and using those beds for newly admitted patients. Without a stable housing option, patients remain in hospital beds even after they no longer require acute care. This disrupts patient flow, increases hospital inefficiencies, and limits the hospital's ability to generate additional revenue.

Medical respite programs offer an accessible discharge destination more appropriate for recovery than the inpatient setting. By reducing patients' inpatient length of stay and preventing readmissions, respite programs help hospitals to better manage capacity and effectively allocate inpatient resources.

Nationwide, various case studies have already demonstrated the system savings from a strong hospital and medical respite partnerships, including from hospitals in Los

Angeles⁵ and health systems in Richmond, Virginia and Cincinnati, Ohio⁶, which have demonstrated millions in cost avoidance annually.

Projections indicate that significant improvements could be accomplished across various hospital systems in the New York City metro area. As illustrated in the chart below, medical respite programs of varying sizes have the potential to free up hospital capacity and generate meaningful system savings. These estimates assume that that hospital partnerships with a respite program would reduce the inpatient length of stay of a patient experiencing homelessness by an average of 14 days, and these individuals would be discharged to a medical respite program where they would stay an average of 70 days. Additional details on the projection methodology can be found in the Appendix.

Medical Respite Programs and their impact on Hospital Partners

Number of Respite Beds	Potential Number of Respite Individuals Served Annually	Potential Additional Number of Patients that Hospitals can Serve	Estimated Hospital System Savings
25	130	395	\$5 million
50	260	790	\$10.02 million
75	390	1190	\$15.02 million

Medical Respite – Key Elements for Growth

The demand for medical respite in New York certainly exceeds the limited services currently available. In a 2017 analysis, the New York Legal Assistance Group found that of 3,800 hospital readmissions among patients experiencing homelessness in one year, 8%—or roughly 300 individuals—could have benefited from medical respite services. Another study from 2019 found that approximately 39% of first-time adult shelter users in NYC had visited an emergency department or were hospitalized in the year prior to entering shelter, and that 43% of users did so in the year after shelter entry, translating to over 41,000 episodes of ED care and over 16,000 hospitalizations over a seven-year

⁵ McCarthy, D., & Waugh, L. (2021). Medical respite care: Improving outcomes and lowering costs for individuals experiencing homelessness. National Health Foundation. https://nationalhealthfoundation.org/wp-content/uploads/2021/09/NHF_Commonwealth-2021_Final-1.pdf

⁶ National Health Care for the Homeless Council (NHCHC). (2011.) Medical Respite Care: Reducing Costs and Improving Care (April 2011). <https://nhchc.org/wp-content/uploads/2019/08/RespiteCostFinal.pdf>

period. The majority of these individuals were single adults, with older adults facing particularly high rates of inpatient hospitalization.⁷

Although not all these individuals may have needed medical respite care, the findings highlight the high rates of hospital utilization among people experiencing homelessness and their lack of adequate discharge options. The study's authors point to medical respite care as an evidence-based alternative to shelter discharges, offering a safer and more supportive environment for recovery than homeless shelters.

Furthermore, the need for medical respite extends beyond populations who are experiencing homelessness. For example, Comunilife serves individuals who do have access to stable housing but whose living situations may not be appropriate for recuperation (e.g. apartments with accessibility issues). These clients often require a safe space to heal and access to post-discharge medical care.

Yet for medical respite to grow, innovative providers like Comunilife and ICL will need the support of hospitals, payors, and government, with both investment and regulatory relief.

Financial Support:

Sustaining and scaling medical respite programs requires addressing both operational and capital funding gaps. The majority of medical respite programs are dependent on multiple funding sources and revenue streams—particularly from health systems. Both Comunilife and ICL contract directly with health systems to provide operational support for a pre-determined number of medical respite beds or on a per diem basis. ICL solely contracts with H+H, while Comunilife contracts with many New York City hospital systems and managed care organizations.

While partnerships with hospitals or managed care organizations may fund day-to-day operations, they rarely cover capital needs. Start-up costs for new programs, including facility acquisition or renovations to meet State physical plant requirements, can be substantial.

More recently, New York State's adoption of a Medicaid Section 1115 Demonstration waiver, has created new opportunities to support social care services, including medical respite. Through the waiver, the State has established nine Social Care Networks (SCNs), each of which has been allocated funding to support the expansion of services covered under the waiver. This marks the first time that the State has provided direct funding for

⁷ Treglia, D., Johns, E. L., Schretzman, M., Berman, J., Culhane, D. P., Lee, D. C., & Doran, K. M. (2019). When crises converge: Hospital Visits Before and After Shelter Use Among Homeless New Yorkers. *Health Affairs*, 38(9), 1458-1467. <https://doi.org/10.1377/hlthaff.2018.05308>

the medical respite care model. Unfortunately, these payments are only available in a limited set of circumstances: reimbursement is only available for services provided to individuals in Medicaid Managed Care and who are experiencing homelessness, and the medical respite provider must also first receive State certification, limiting the flexibility that this model otherwise demands.

Going forward, all stakeholders interested in the model must remain focused on finding opportunities to financially support the model's operating costs and the capital costs of new expansion. While the recently-enacted One Big Beautiful Bill Act (OBBBA) will reduce health care resources, medical respite should be seen as part of the solution to these reduced resources. Opportunities to support program costs include:

1. Hospital and Payer Investment: Hospital and payer direct investment in the model, with shared, ongoing measurement of the financial return on investment.
2. Regulatory Reform to Reduce Costs: Regulatory reform (also described in the next section of this paper) that would reduce the capital costs of starting a new program and their ongoing operating costs. This also would open the opportunity for medical respite providers to serve different populations and braid the associated funding streams.
3. SCN Investment: State direction to the SCNs to prioritize infrastructure support for medical respite programs.
4. Braided Funding: State guidance to ensure that medical respite programs are able to effectively braid funding streams in a way that does not threaten any one funding source (and discussed further in the next section of this paper)
5. Dedicated Medicaid Funding: Submitting a State Plan Amendment for coverage of medical respite as a Medicaid benefit post-waiver, or approving Medicaid Managed Care Organizations (MCOs) to voluntarily provide medical respite as an in-lieu services or as part of value-based arrangements. In addition, prior to any final rate-setting, DOH should engage with the current medical respite providers on reasonable/expected costs for the model.

Regulatory Reform:

Little regulatory oversight currently exists for medical respite programs. In January 2024, the DOH issued regulations for certifying medical respite programs. Subsequently, the 1115 Waiver guidance was released and clarified that only certified medical respite programs are eligible to provide waiver-reimbursed services.

To that end, the following regulatory reforms would ensure that the medical respite program remains flexible, able to be tailored to specific geographies or client needs.

1. Population Flexibility: DOH's certification framework requires that medical respite clients be homeless or at risk of becoming homeless and, unless otherwise approved by DOH, be limited to individuals aged 18+. With respect to the homeless criteria, DOH should ensure that this framework does not restrict a medical respite provider from providing care to other populations. While restrictions can be applied with respect to governmental funds (e.g. ensuring that certain reimbursement streams are limited to the homeless population), DOH should not restrict a provider from caring for non-homeless individuals, as there are populations who have permanent housing that may not be appropriate for post-hospitalization recovery due to accessibility issues.
2. Physical Plant Flexibility: The DOH regulations include certain specific requirements around a medical respite program's physical plant. While certainly best practices, there are many areas within New York City where such standards are not realistic – the providers do not have existing space, nor the capital support to purchase and build out new space – that can meet these requirements. In these instances, DOH should establish a waiver process if the provider can ensure that the program still meets the core needs of its patients.
3. Braided Funding: As noted above, medical respite providers currently fund their programs from a variety of governmental and private sources, and it is expected that this will be a need into the foreseeable future. State resources will only be further constrained under the OBBBA and there will be the rise in non-Medicaid and uninsured populations. State policymaking should ensure that neither the certification scheme nor any future guidance restricts providers from braiding funding for the program with maximal flexibility.

Best Practice Forum:

Given the newness of this model, the State should host (or collaborate in the development of) a forum to share medical respite best practices. This forum should be opened to both hospitals and interested medical respite providers to learn from those already developing best practices in the area, including Comunilife, ICL, and their key hospital partners.

Looking Ahead

Comunilife and ICL have both shown that medical respite care can serve as a bridge, not just from hospital to home, but from vulnerability to dignity, and from instability to sustained recovery. This report aims to illustrate how medical respite care, when rooted in strong, collaborative partnerships, delivers measurable benefits for clients, hospitals, and communities. What these early successes now require is broader support—flexible Medicaid funding; expanded hospital partnerships; capital funding; and updated

regulations to support the model's growth. By acting on the policy and financing recommendations outlined in this paper, New York can scale the model to a statewide resource, ensuring that recovery is not interrupted simply because a safe place to heal is out of reach.

Appendix A: Institute for Community Living (ICL) Program

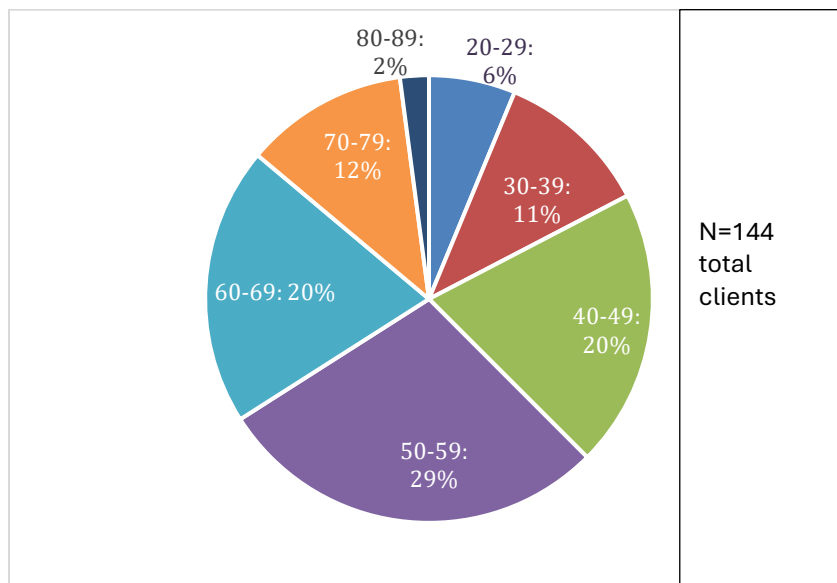
ICL's medical respite program was created through an exclusive partnership with NYC Health + Hospitals (H+H), whose executive commitment and funding have been instrumental in bringing the model to life. The success of the program depends on the close integration and care coordination between ICL and H+H, and is rooted in their shared commitment to serving underserved populations.

The program is comprised of 50 beds located at the Harlem YMCA. It is staffed by approximately twenty personnel, including case managers and a registered nurses who meet with clients every week, as well as counselors and peer specialists.

Client Characteristics

From October 2023 through January 2025, there were 144 clients discharged from ICL's medical respite program. The average length of stay in respite was just under 70 days. The vast majority (99%) of clients were male, representing a broad age range, with approximately a third of all clients aged 60 and older, as shown in Figure 1 below.

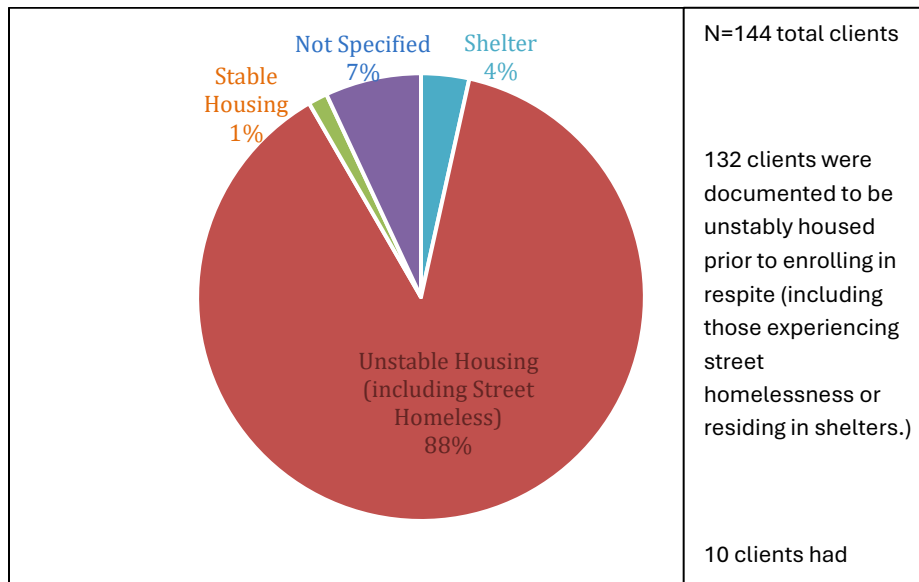
Figure 1. Breakdown of ICL Medical Respite Clients by Age Range



The vast majority (96%, through October 2023) of clients who were discharged from ICL's program had Medicaid coverage.

The vast majority of ICL's medical respite clients (over 90%) were unstably housed, street homeless, or residing in shelters prior to being hospitalized at H+H, as shown in Figure 2 below. The actual percentage may be even higher, as the housing status of the remaining clients was not documented.

Figure 2. Breakdown of Clients by their Pre-Medical Respite Location (i.e. Housing Status prior to hospitalization and respite enrollment).



Approximately 60% of ICL’s medical respite clients were eligible for housing assistance (as shown in Table 1 below).

Table 1. Breakdown of Clients by Eligibility for Housing Assistance

Location/Housing Status Prior to Medical Respite Enrollment	Clients Eligible for Housing Assistance	Total Clients by Pre-Respite Location	Percentage of Clients Eligible for Housing Assistance (based on Pre-respite location)
Shelter	2	5	40%
Unstable Housing/Street Homeless	84	127	66%
Stable Housing	0	2	0%
Not Specified	0	10	0%
Total	86	144	60%

Clients admitted to the medical respite program were in need of services such as medication management, occupational and physical therapy, nursing services, post-operative care, etc. The breakdown of these needs among the discharged population is listed in Table 2 below.

Table 2. Breakdown of ICL Clients Medical Respite Needs

Medical Respite Indicators	Count*
Medication Management	45
Occupational Therapy	9
Physical Therapy	24
Visiting Nurse	19
Postoperative Care	5
IV Infusion	2
Chemotherapy	3
Other	10
Not Specified	59

*Note: As individuals may have multiple respite needs, the total count of indications is greater than the number of clients served

Collaboration with New York City Health + Hospitals

The ICL team collaborates closely with dedicated staff from H+H to ensure seamless care transitions and ongoing care coordination for shared clients. The examples of coordination are numerous.:

1. Discharge Planning: ICL staff work directly with H+H's discharge team to manage all referrals transitioning into medical respite care. These clients are referred from a wide range of H+H settings. For referrals coming from inpatient settings, the H+H clinical team screens for respite eligibility. For certain clients, such as those requiring specialized services, such as wound care or physical/occupational therapy, ICL collaborates with H+H to determine an appropriate discharge schedule. In these cases, H+H liaisons and social workers facilitate connections to H+H home care providers before the client is discharged from the hospital, ensuring that the client will be able to access H+H specialty therapists and health aides on-site as soon as they are admitted to medical respite.

2. Care Coordination: ICL meets weekly with H+H social workers to review new admissions, discuss client progress, and coordinate discharge planning.
3. Technology Integration: Through EPIC integration, ICL and H+H can efficiently communicate updates on clients' medical conditions and treatment plans in real time.
4. Cross-Referrals: Follow-up medical appointments are scheduled with the client's original H+H hospital or another H+H hospital, based on their preferences and ongoing care needs. While most clients choose to receive their primary care through H+H's provider network, some maintain their own primary care providers. In such cases, H+H acts as a liaison between ICL and these community providers, helping to answer providers' questions on clients' medications, care plans, and housing status.

ICL's coordination with H+H continues through a client's discharge from medical respite. To prepare clients for this discharge, H+H staff participate in biweekly housing meetings with ICL, where H+H may flag housing opportunities that clients are eligible for, including affordable housing programs. ICL can also place clients into its own residential programs; due to ICL's extensive housing infrastructure, which includes more than 2,500 contracted supportive housing beds located across all five boroughs of New York City, the agency is well-positioned to support clients in securing permanent housing. This vast internal capacity allows ICL to streamline housing placements for eligible clients.

Once clients are discharged from respite, ideally to permanent housing, ICL provides 30-day follow-ups and when appropriate, connects them to care coordination services, including Medicaid health home services. Clients also continue to receive wrap-around services through H+H and its contracted partners.

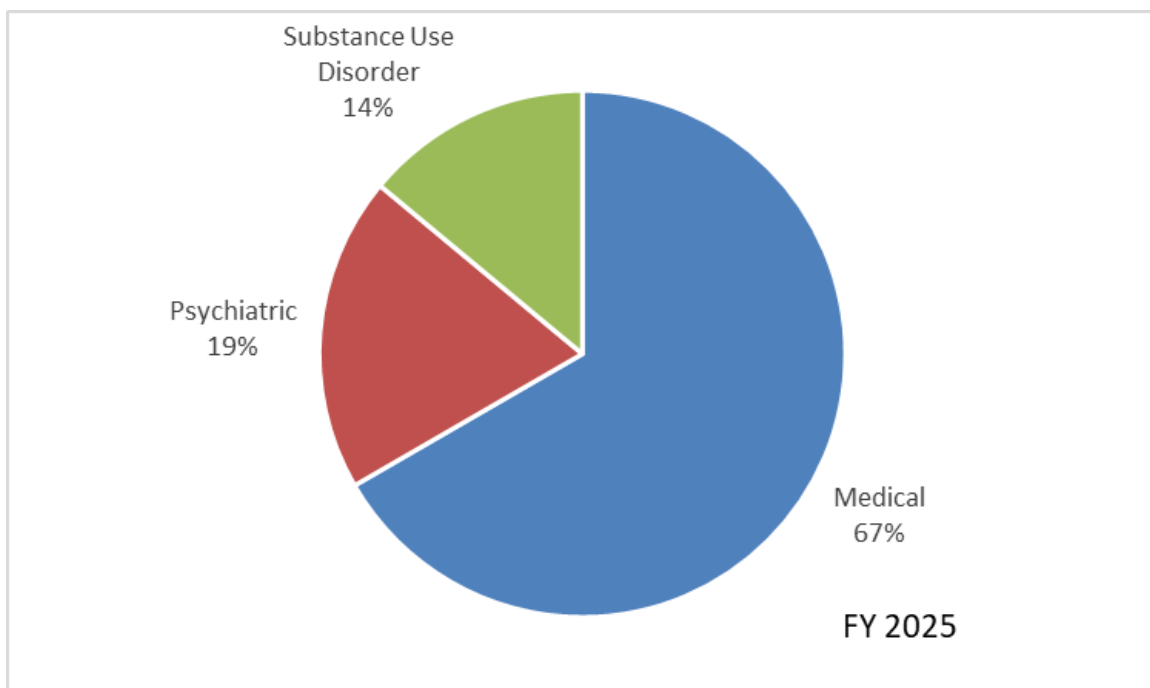
Additionally, for H+H patients who are referred to medical respite but are not eligible for permanent housing placements and thus must be discharged back to shelter after they have fully completed their recovery in respite, H+H has significantly invested in warm hand off processes, including completing reasonable accommodations for this population.

Appendix B: Comunilife Program

Comunilife opened New York City's first medical respite program, in 2011, in partnership with Montefiore Hospital. Its vision was to provide clients who do not have a suitable home with a safe environment in which to complete their recuperation with a short-term housing option. Since 2011, Comunilife's program has grown to 63 beds as the agency has partnered with multiple hospital systems and payors who reserve dedicated medical respite beds and offers placements on a per diem or an annual basis. In times of crisis (i.e. COVID, Monkeypox) Comunilife's Medical Respite Program has grown to meet emergency need.

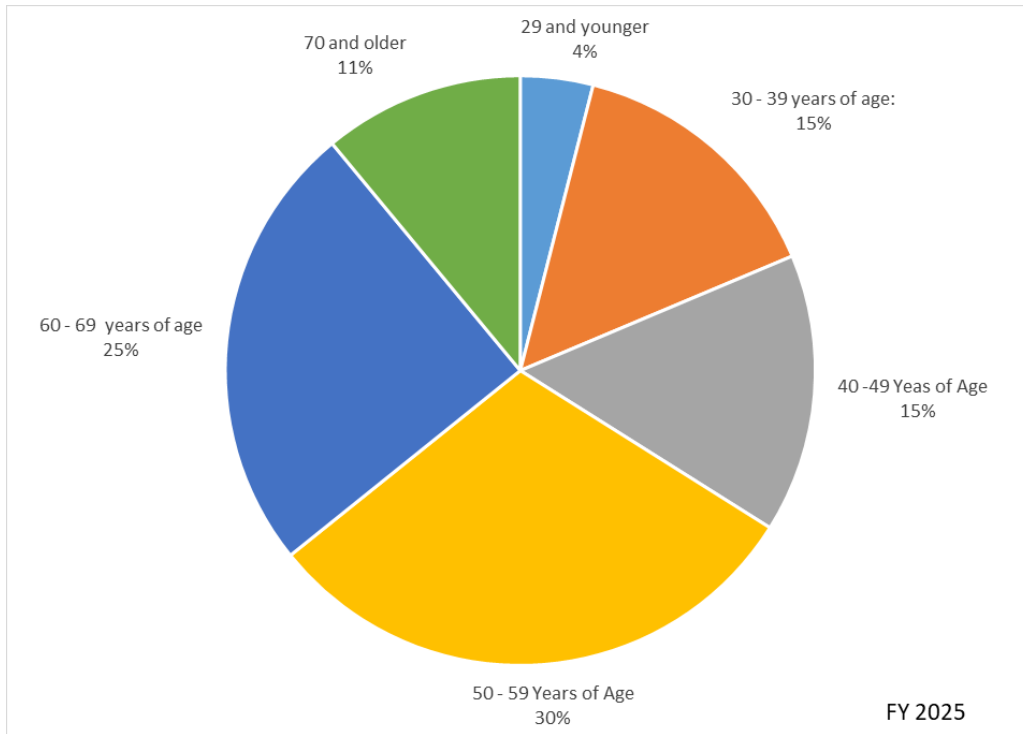
In Fiscal Year 2025 (July 2024 - June 2025), 273 new patients were admitted to Comunilife's Respite Program with a total of 328 patients receiving services.

Breakdown of Primary Diagnoses for Admission to the Medical Respite Program (N=273)

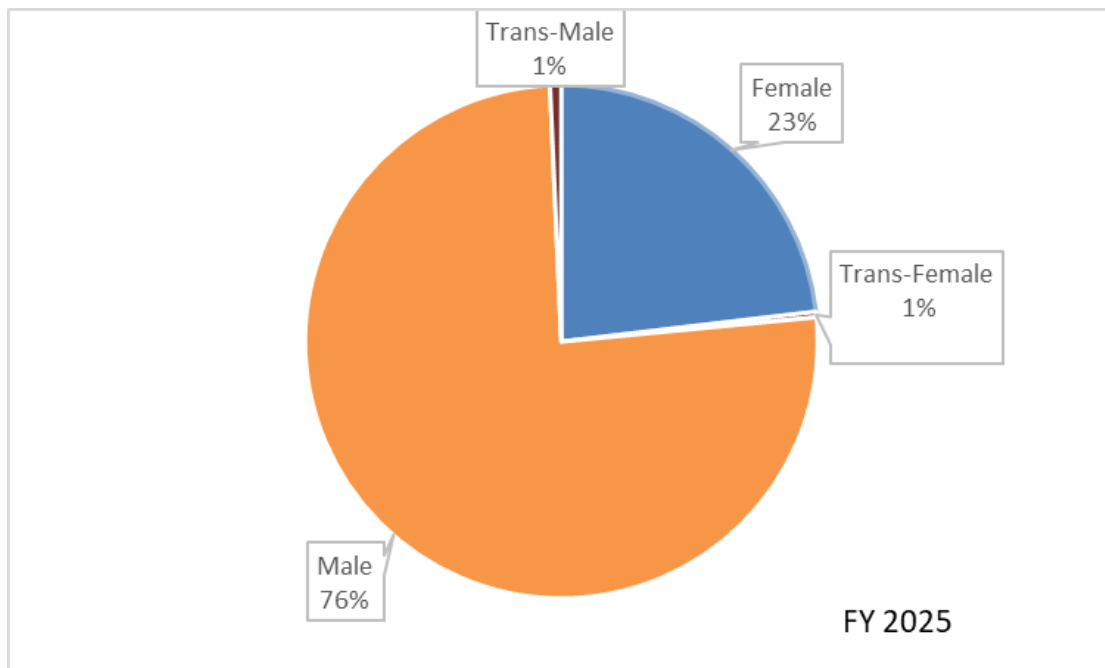


Since its inception, Comunilife's medical respite program has served over 2,500 clients across a variety of populations with complex health and social needs, including individuals with HIV/AIDS and/or serious mental illness. The vast majority of clients live below the federal poverty line, and approximately 90% identify as Latino and/or African American. Half of all clients are primarily or exclusively Spanish-speaking.

Breakdown of Medical Respite Patients by Age (N= 328)



Breakdown by Gender (N = 328)



What separates Comunilife's medical respite program from most programs is a housing navigation component that breaks the cycle of shelter to hospital to shelter. With a housing portfolio that includes more than 2,000 supportive housing units and over 1,000

scatter-site apartments, Comunilife is well-positioned to facilitate streamlined housing placements for its clients.

Comunilife's adaptable approach has made it a trusted partner across a diverse network of healthcare institutions and managed care organizations.

In all instances, Comunilife works with its partners' care teams to ensure smooth care transitions from hospital discharge to medical respite care. This includes aligning care plans, coordinating medication management, and facilitating follow-up appointments to support clients' medical stability.

Appendix C: Medical Respite Impact on Hospitals Projection Methodology

The average cost of an inpatient day in New York State was \$3,840 in 2023⁸. For patients who are not experiencing homelessness, the average length of stay is 4.6 days, which supports the conservative assumption that each new admission generates approximately \$17,664 in hospital revenue.

The estimated annual cost of a hospital contract for one medical respite bed is \$80,000. By partnering with a respite program, hospitals can discharge patients experiencing housing instability once they no longer require acute care, thereby reducing inpatient length of stay and enabling more frequent turnover of beds. This increase in capacity creates the opportunity for hospitals to admit additional patients and generate new revenue, while offsetting the cost of respite care.

⁸ Kaiser Family Foundation. Expenses per inpatient day by state. Kaiser Family Foundation. <https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day>