

# Medical Respite Services for Homeless People

Practical Planning

Revised by  
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First edition written by  
Marsha McMurray-Avila

June 2009

Health Care for the Homeless  
**RCPN**  
Respite Care Providers' Network

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*Imagine a person who is homeless with a fractured leg and who also suffers from a chronic disease such as diabetes. This person leaves the emergency shelter early in the morning and wanders the streets all day with no place to rest, take medication or bathe. He struggles to find a meal, a bathroom and a place to sit. Exhausted, weak and believing he has no other option, he seeks the nearest emergency room for support. Once discharged from the emergency room or after an inpatient stay at the hospital, he is back on the streets where his health is again put at risk. Medical respite care offers him a safe, nurturing alternative environment from the rigors of the street in which to recover and receive medical and nursing care while keeping him out of the emergency room and safe from harm.*

## **PREFACE**

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The detrimental impact of homelessness on the health of individuals and families has been widely documented. Either physical or mental health problems may be the impetus for an individual's or family's loss of income and housing, and the state of being homeless further jeopardizes health status. The following excerpt from "Balancing Act: Clinical Practices that Respond to the Needs of Homeless People"<sup>1</sup> summarizes the effects of homelessness on health.

*As a consequence of the poor nutrition, lack of adequate hygiene, exposure to violence and to the elements, increased contact with communicable diseases, and fatigue that accompany the conditions of homelessness, people without homes suffer from ill health at much higher rates than people living in stable housing. Several studies have found that one-third to one-half of homeless adults have some form of physical illness.<sup>2,3,4,5,6</sup> At least half of homeless children have a physical illness<sup>7</sup> and they are twice as likely as housed children to have such illnesses.<sup>8</sup> This lack of health takes its toll by preventing many homeless people from exiting homelessness. For example, one-quarter of homeless adults reported that their poor health prevented them from working or going to school.<sup>9</sup> Even more seriously, rates of mortality are three to four times higher in the homeless population than they are in the general population.<sup>10,11,12,13,14,15</sup>*

This increased vulnerability to illness and trauma, and resulting higher prevalence of health problems, is further complicated by current trends in medical care. In today's cost-conscious world of health care, an increasing number of services and procedures are being provided on an outpatient basis. Hospital stays are becoming progressively shorter, relying on the ability of the patient to return home for recuperation where family members can provide support and basic care. But what happens when there is no home to which the patient can return and no one to provide the needed support? Without a home and family or friends to help out, an early discharge is much more problematic. Homeless people are often discharged with prescriptions for medication they cannot afford to get filled and instructions for self-care—such as resting and drinking fluids—that cannot be followed.<sup>16</sup> Providers of health care to people without homes have become increasingly aware of the need for alternatives to discharging patients to the streets or shelters where safety cannot be guaranteed and the basic facilities needed for successful recuperation are rarely available.

What can be done with people who are not sick enough to be hospitalized, but who are too sick to be in an emergency shelter or out on the streets? For a variety of reasons, many emergency shelters do not allow their guests to remain on the premises during the day. Some expect their clients to be out looking for employment. Others do not have the resources to staff their program during the day, or use the daytime hours to perform

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maintenance of the facility. There are also homeless individuals who do not use the shelter system and regularly stay outside. For whatever reason, homeless people who are sick or injured must often resort to wandering the streets during the day or sitting in crowded day shelters where they are exposed to more illnesses or may expose others to communicable diseases.<sup>17</sup>

Three of the most common physical illnesses among homeless persons are upper respiratory tract infections, trauma and women's health problems.<sup>18</sup> Clearly, homeless people with these health conditions—ranging from pneumonia to knife wounds to risky pregnancies—need extended access to a safe bed in which they can rest, adequate restroom facilities, nutritious food and clean water, secure storage and/or refrigeration for medications, assistance with dressing changes and general nursing care. All of these elements are necessary for successful outcomes.

This monograph offers an introduction to medical respite care, a cost effective and humane approach to caring for people experiencing homelessness who are too sick to be on the streets but not sick enough to be in a hospital. The information that follows is intended to encourage and assist hospital and health center administrators as well as other homeless service providers in developing a medical respite program in their community.

## **INTRODUCTION**

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The current financing and delivery of medical care is characterized by shorter hospital lengths of stay with the expectation that recuperation will take place in the home. Hospitals caring for patients who do not have a home are faced with a difficult dilemma. With limited discharge options, hospitals must make the decision to discharge these patients to the street or shelter where opportunities for recuperation are bleak or allow them to stay in the hospital for an extended amount of time until they are fully stabilized. Because homeless people are sicker than people who are housed and often have co-occurring mental health and/or substance use issues, the latter option is extremely costly and hospitals often lack the staffing and expertise to assist such patients.

Many hospital discharge planners naturally seek the assistance of emergency shelters. However, emergency shelters generally provide night shelter only. Typically, guests arrive late in the afternoon, get a hot meal and shower, and are released to the street early in the morning on the following day. Even for a homeless person who is not ill, there is considerable exhaustion associated with making it through a day without easy access to a bathroom, food, or a place to rest. When a homeless person is sick and diagnosed with a combination of illnesses, an overnight emergency shelter bed is inadequate for recovery.

Some hospital discharge planners might also seek nursing home care for homeless patients. While many homeless patients might qualify for temporary care and recovery in a nursing home, skilled nursing facilities frequently refuse to accept a patient because of the same discharge issues faced by hospitals. Not wanting to discharge a patient to the street and lacking adequate staffing to manage housing placement or behavioral health care needs, most nursing homes simply refuse to accept homeless patients. With reluctant nursing homes and limited options for day shelter, many homeless patients need to remain in a hospital bed until their health is stabilized.

Many communities have designed medical respite programs as a humane and dignified approach to recuperative care for people who are homeless. Traditionally, the term “respite” is used to refer to a break or time off for a caregiver of a disabled child or elderly adult. However, the term has taken on a new meaning over the last two decades for providers of health care services to homeless people. The term “medical respite care” has emerged to describe recuperative or convalescent services needed by homeless people with medical problems. The Respite Care Providers’ Network (RCPN) defines medical respite care as “acute and post-acute medical care for patients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in shelter or on the streets, but who are not sick enough to be in a hospital”. Medical respite care fills a service

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gap between hospital and shelter, and provides home-like care to those without a home. Medical respite services are provided in a variety of settings including homeless shelters, motel/hotels, apartments, board and care facilities and stand alone facilities. Medical respite programs provide a safe place to recover with medical monitoring and support services such as food, laundry, transportation to medical appointments, medication management, security, case management and referral to specialty appointments.

In addition to providing a safe and dignified place for recuperation, studies of medical respite programs have linked program participation with improved health and housing outcomes. In a national evaluation of ten pilot medical respite programs receiving support from the Health Resources and Services Administration (HRSA), the following outcomes were reported:

- Severity of primary diagnoses dropped a full point on the [severity index] scale. And while just one-third had a regular source of primary care when admitted, half did by the time of discharge.
- Access to financial resources improved, including an increase from 23% to 33% of medical respite service recipients who obtained Food Stamps.
- Housing status improved: the percentage of respite patients listing the hospital as their source of housing fell from 34% at admission to 8% at discharge, and the percentage of hospital patients discharged to the street dropped from 13% to just 4%.
- Clinicians working with respite clients perceived that two-thirds had benefited from the respite environment during their stay; about half said the social interaction was beneficial and/or that the client had learned to manage his/ her health condition. Nearly one out of ten decided to enter a treatment program after receiving medical respite care.

Medical respite care also reduces hospital utilization. A growing body of literature demonstrates that participants in medical respite programs require fewer hospital days than homeless individuals who do not participate in a medical respite program. One major study in Chicago looked at the impact of medical respite care on 225 hospitalized adults consecutively referred from an urban public hospital. The study found that individuals who participated in a medical respite program required fewer hospitalizations during 12 months of follow up. The group receiving medical respite care spent 4.6 fewer days in the hospital than individuals who did not receive medical respite care<sup>19</sup>. Another study of the hospital readmission rates of patients discharged from Boston Health Care for the Homeless Program's medical respite program found that even for patients with higher medical needs, receiving medical respite care was associated with a reduced chance of hospital readmission<sup>20</sup>.

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Thus, medical respite care provides a safe alternative for hospitals and for individuals in need of post-discharge medical care. But it also assists hospitals in providing continuous care to individuals who might otherwise return to their emergency department. The benefits for the health and well being of a homeless person as well as the cost savings for communities are significant incentives for planning and implementing a medical respite program. The following sections provide detailed descriptions of the steps involved in developing a medical respite program.

### HOMELESSNESS AND HOSPITAL UTILIZATION

While many homeless sick adults are connected to Health Care for the Homeless (HCH) clinics, the use of the emergency department by patients experiencing homelessness is typically very high. A snapshot of emergency department (ED) use in Boston by three of the major tertiary care hospitals in 2007 found that the majority of the high users of the ED were homeless. At Boston Medical Center, approximately 15 of the highest 25 users of the ED were homeless in a given month. At another hospital, 16 of the highest users of the ED were homeless and generated 400 ED encounters annually. And at a third teaching hospital, 13 homeless patients of the top 27 users of the hospital ED generated a minimum number of 16 ED encounters per patient per year. Another study of the Boston HCH Program<sup>21</sup> resulted in similar findings with 2.7 emergency or urgent care visits per year for homeless people utilizing Boston's HCH primary care clinics. A San Francisco study<sup>22</sup> in 1993 found that homeless persons averaged 2.5 visits to the emergency department each year, while the general population only averaged 1.6 visits.

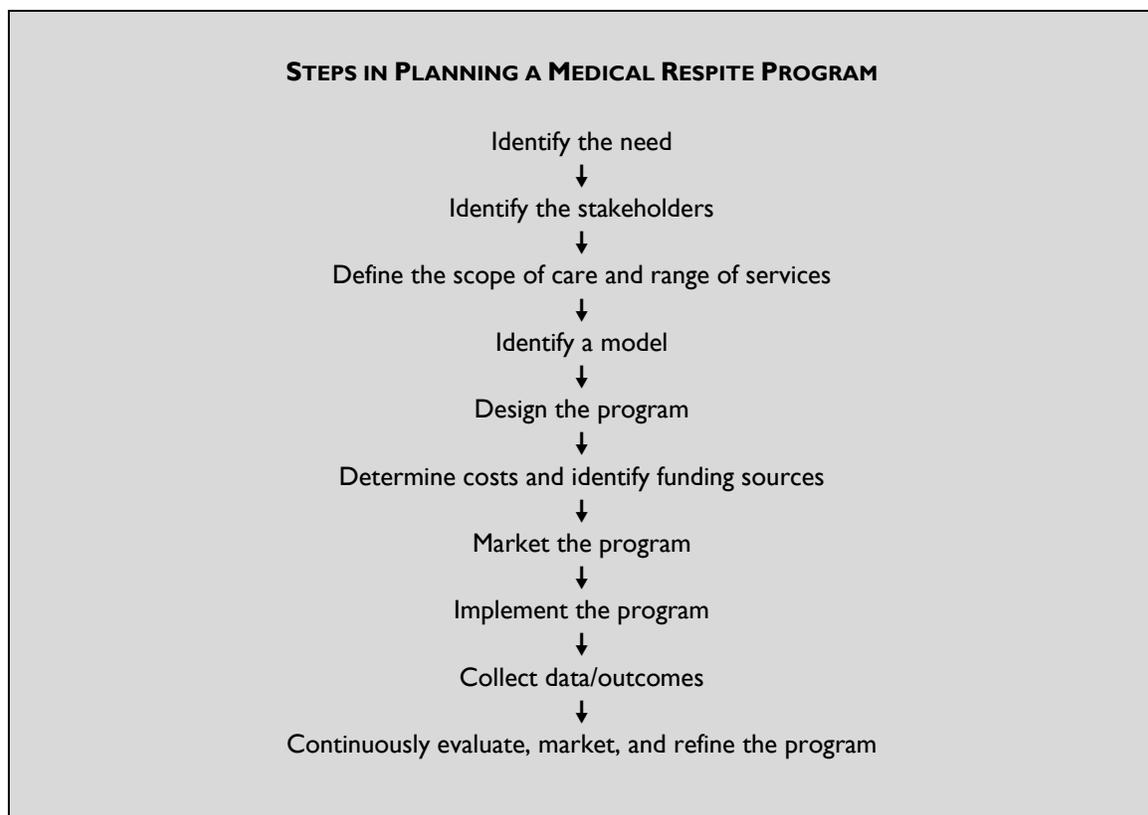
In addition to frequent ED use, other studies have found that homeless people have higher rates of hospitalization than comparable low-income populations with housing. A Hawaii study found that the average length of stay for acute care hospitalization was 10.1 days compared to the statewide average at that time of 7.9 days. The authors of that study estimate that the cost of the "excess" hospitalization was approximately \$3.5 million. A study of discharge data from New York Health and Hospitals compared homeless adults and other low-income adults admitted to all general hospitals in New York City during 1992 and 1993. Adjusting for demographic characteristics and other clinical issues (including mental illness and substance abuse), the authors determined that the lengths of stay for homeless individuals averaged 4.1 days more than for other low-income adults—a difference of 36%. The cost of the additional days per discharge averaged \$4,094 for psychiatric patients, \$3,370 for patients with AIDS, and \$2,414 for all patients.

In a survey of homeless adults across the United States, investigators found that 62.8% of participants had one or more ambulatory visits during the preceding year, 32.3% visited an emergency department, and 23.3% had been hospitalized. In addition, of the participants who had been prescribed medication, 32.1% reported difficulty with treatment adherence<sup>23</sup>.

## PLANNING A MEDICAL RESPITE PROGRAM

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Each community is unique in its needs and resources and may adopt a different approach to program planning. Numerous factors—ranging from cost to timing to community support or lack of it—play a role in designing a program. The information that follows is intended to be used by administrators and other homeless service providers who are interested in designing a medical respite program and describes basic steps involved in program planning. The steps should be used as a general guidance with the understanding that each community has unique needs that will influence the planning process.



## **Identifying the Need**

Often the impetus for a program is the identification of a need or a problem. In the case of medical respite care, the need is often presented by the frequency with which homeless patients utilize hospital in-patient services and by the dilemmas faced by discharge planners responsible for finding a safe environment for a homeless patient. Though a need might seem evident, planners will still benefit from a formal needs assessment. Often, data will reveal needs that are much more complex than anticipated. The magnitude and complexity of a community's need will be important in planning program services and operations and in identifying all of the stakeholders.

Hospital data are extremely helpful in determining the recuperative care needs within a community's homeless population. In addition to the incidence of hospital inpatient stays for recuperation, data might include the average length of stay for homeless patients, primary admitting diagnoses, prevalence of co-occurring illnesses, gender and more. When conducting a needs assessment, planners might also consider the data that compares the need for a medical respite program in the target community to that of other communities.

A needs assessment might also include information regarding the consequences of not having a particular intervention. Some consequences of not having appropriate recuperative options for people without homes include:

- Continuity of care suffers when providers lose their patients to the streets, with no ability to follow up on their efforts or ascertain outcomes.
- Without a secure location in which to recuperate, patients have difficulty adhering to the medical advice of their providers.
- The patient's inability to adhere to the recommended treatment may then result in complications and emergencies, which in turn result in higher use of the hospital emergency room and increased costs to the medical system.
- Patients and providers are both frustrated and dissatisfied when medical treatment seems ineffective due to incomplete recuperation.

Data collected from other medical respite programs can also be useful in a needs assessment. The chart below provides information regarding the primary admitting diagnoses in order of frequency for ten medical respite programs located across the country. Using the chart, planners can get an idea of the kind of health issues they might encounter in a medical respite setting. Information from other medical respite programs should be used cautiously since data will be affected by a program's intake criteria as well as the community's unique characteristics and needs.

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<b>ADMITTING DIAGNOSES REPORTED BY TEN MEDICAL RESPITE PROGRAMS IN THE U.S.</b>				
(Numbers of diagnoses listed by ICD-9 code categories)	<b>Primary Diagnosis (N=1507)</b>		<b>Additional Admitting Diagnoses (N=2403)</b>	
	<b>Number</b>	<b>Percent</b>	<b>Number</b>	<b>Percent</b>
Injury and Poisoning	316	21%	90	4%
Diseases of the Skin and Subcutaneous Tissue	276	18%	58	2%
Diseases of the Respiratory System	164	11%	133	6%
Diseases of the Circulatory System	132	9%	257	11%
Diseases of the Digestive System	103	7%	187	8%
Diseases of the Musculoskeletal System and Connective Tissue	90	6%	82	3%
Persons Encountering Health Services in Other Circumstances	80	5%	26	1%
Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders	62	4%	167	7%
Infectious and Parasitic Diseases	57	4%	101	4%
Symptoms, Signs, and Ill-Defined Conditions	44	3%	101	4%
Mental Disorders	39	3%	1051	44%
Diseases of the Nervous System and Sense Organs	37	2%	33	1%
Diseases of the Genitourinary System	34	2%	28	1%
Neoplasms	30	2%	21	1%
Persons with a Condition Influencing Their Health Status	11	<1%	5	<1%
Persons Encountering Health Services for Specific Procedures and Aftercare	10	<1%	5	<1%
Diseases of the Blood and Blood-forming Organs	6	<1%	35	1%
Congenital Anomalies	6	<1%	5	<1%
Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations	5	<1%	0	0%
Persons with Need for Isolation, Other Potential Health Hazards and Prophylactic Measures	2	<1%	4	<1%
Persons with Potential Health Hazards Related to Personal and Family History	2	<1%	2	<1%
Accidental Falls	1	<1%	0	0%
Complications of Pregnancy, Childbirth, and the Puerperium	0	0%	3	<1%
Persons with Potential Health Hazards Related to Communicable Diseases	0	0%	9	<1%

Source: Zerger, S. (March 2006). An evaluation of the respite pilot initiative: Final report. Available online at: [www.nhchc.org/Respite/](http://www.nhchc.org/Respite/)

## **Identifying the Stakeholders**

Although it is tempting to begin the planning process as an energetic individual or small group, it is important to involve representatives of all stakeholders from the earliest planning stages. Having a planning group made up of key stakeholders is extremely advantageous. For example, members of the planning group will likely include hospital administrators who can access data for a needs assessment. Another advantage of involving other community members—whether from hospitals or local government—is the opportunity to encourage support for the project, which could conceivably result in additional resources and/or funding for the project. A planning group for respite services would be wise to include:

- Top-level decision makers in the organization (executive director, board members)
- Front-line providers and practitioners who will be involved in program implementation
- Homeless or formerly homeless people who have experienced the need for respite services
- Representatives of hospitals or other entities that may be involved in referring clients for care
- Representatives of local government who have responsibility for health planning such as the public health department
- Other community members such as staff from shelters, meal sites or other homeless programs
- People with expertise in behavioral health care and substance abuse treatment

The kinds of initial questions that must be considered by this planning group include:

- What is the approximate size of the homeless population and how many people usually need respite services during a given period of time?
- What are the medical problems that necessitate respite care?
- What are the characteristics of the population needing respite care—gender, age, ethnicity, family status, length of time homeless, types of homelessness (episodic, temporary or chronic)?
- Where do most referrals for respite care originate—hospital discharges, homeless clinics, shelters?
- What other resources are available in the community—e.g., agencies serving people with HIV/AIDS, public health offices, cooperative shelters, etc.?

Many of the answers to these questions will have been identified during the needs assessment. The information will help the group determine the most appropriate model to meet the community's needs and will guide the group in planning program elements such as the scope of medical care, range of services, staffing, and facility.

When multiple stakeholders are involved in planning and implementing the program, clear expectations should be established regarding the nature of the collaborations. The roles of each stakeholder are important and must be dealt with during the planning phase so that later conflicts or issues of control can be avoided. Such discussions will also help determine the type of respite model that will be used and who has administrative authority. The fewer hidden agendas there are and the more up-front discussion of issues during the planning phase, the better.

### **Defining the Scope of Care and Range of Services**

Homeless people—like the general population—experience the full range of health problems, from mild, self-resolving conditions to extremely serious and life-threatening illnesses. In an ideal planning scenario, the scope of medical care would be dependent on the health problems identified in the homeless population of your community. In reality, the scope of medical care is based on the availability of monetary and in-kind resources. Basically, a program's resources will determine the range of patient conditions that can be safely and successfully treated. At a minimum, basic nursing care should be made available so that a program can safely provide care for injuries or non-infectious illnesses. With more medical coverage, a program can provide care for individuals with serious diseases such as tuberculosis or AIDS. Programs with sufficient medical and nursing staff may be able to provide palliative care at the end of life to people with minimal family support systems or who have nowhere else to go for care.

In addition to nursing and other medical care, what other services will be necessary in order to promote recovery in a safe environment? Understanding the population you plan to serve will help you answer this question. Homeless people who have a mental illness and/or addiction disorder will need access to behavioral health and substance abuse services. The majority of homeless people need access to social services or case management support either on site or through appropriate referrals.

In many communities, medical respite care has evolved into more than a safe place for recovery. Today, a number of medical respite programs are able to take patients in need of post-surgery recuperation, preventative care (e.g., colonoscopy), intravenous antibiotics and monitoring, and support during chemotherapy and radiation treatments. Long-standing medical respite programs such as those in Boston, Chicago, Los Angeles, and Washington, DC, have become an essential and integrated component of the continuum of health care for people who are homeless and a much relied upon service for hospitals and health centers.

**CLASSIC MEDICAL RESPITE SERVICES**

- Acute medical care (by a nurse, physician, physician assistant, and/or nurse practitioner)
- Medication (storage, dispensing, sometimes pharmacy)
- Case Management (benefits acquisition, housing placement, health education, etc.)
- Onsite or referral for mental health/substance use treatment
- Transportation
- Food
- Security
- In-kind (pastoral care, activities, haircuts, clothing)

## Identifying a Model

What kind of facility will allow you to effectively implement the program you've planned? Is there an alternative approach that will allow you to work towards your ideal setting if you are not able to implement it initially? In determining the type of facility needed, special consideration should be given to physical accessibility, safety/security, and whether or not people with communicable diseases will be admitted. Communities with a high prevalence of tuberculosis will have to consider a program that addresses the risks of infectious disease, with an emphasis on a facility that has appropriate ventilation systems and limits exposure of others.

Special attention also needs to be given to how acceptable the facility and location are to those who will receive the services. Programs that will be serving women and families should consider how to arrange for families to stay together. Location and easy access to other services and resources is also an important consideration, especially for those in the final stages of recuperation who are ready to be discharged.

Organizations planning to set up a freestanding medical respite unit will want to investigate a number of different options for facility location. For example, there may be possibilities of leasing a vacant nursing home that is appropriately designed for a medical program. Smaller programs may more easily be started in a residential-type setting. Consideration of all facility options will be affected by the size of the program envisioned and costs of leasing, purchasing and/or renovating.

Local and state regulations must also be considered in choosing program options. There may be licensing or zoning regulations that prohibit particular approaches. Although few states have gone so far as to develop licensing specifically for respite units of this type, there are related licensing issues ranging from operation of nursing homes to serving food to providing medical care that must be investigated. For example, the state of Georgia has

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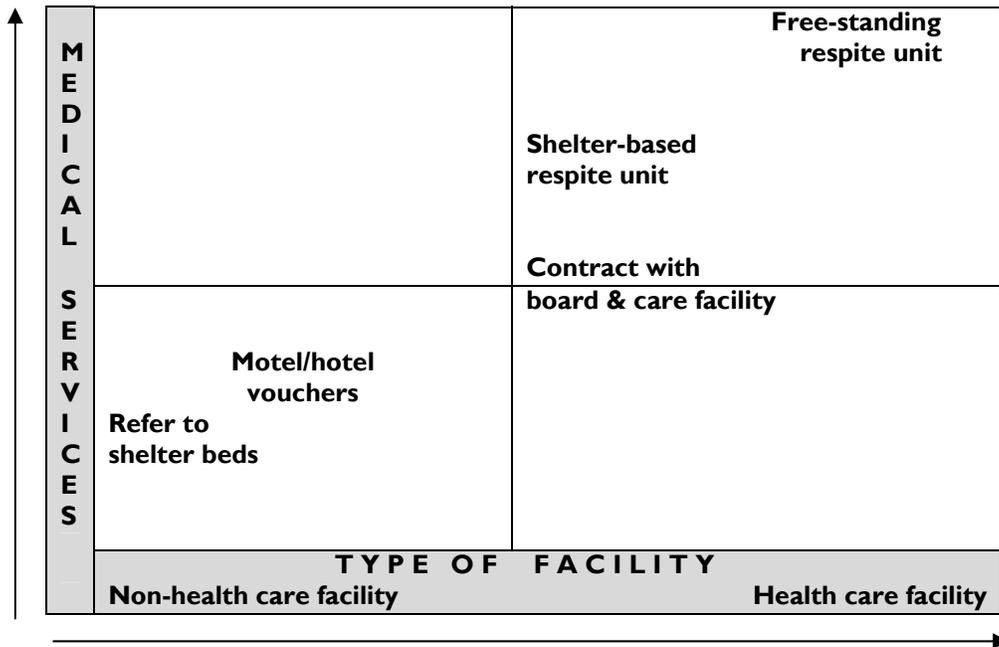
rules and regulations for “personal care homes,” which appear to be quite similar to what we have described as respite services.<sup>24</sup> Every community has different zoning regulations for types of facilities and activities that can be sited in particular locations. It is absolutely essential that all of these state and local regulations be thoroughly researched during the planning process.

The final consideration in determining which model to pursue is, of course, cost. Although it is clearly a driving force in the decision-making process, hopefully it can be balanced with the client needs.

Two basic models are presented here with the understanding that there are numerous variations, combining 1) range of intensity and type of services with 2) different facility options. These two primary models are:

- Freestanding respite units
- Shelter-based models

Models for medical respite services can be placed along a rough continuum, with level of medical care on one axis and type of facility on the other axis. The models placed in each of the four matrix zones below are only examples and do not indicate absolutes. Within each of the four areas there are additional gradients of cost, control over admissions, and other characteristics such as location and control over the environmental health and safety issues. For example, a shelter-based model may be designed in such a way that health care provider staff control admissions, rather than shelter staff. Shelter-based models can also vary greatly in cost, based on the extent of staffing and services offered. The chart below is offered only as a tool to begin thinking about the trade-offs and balance that must be found among various factors. It should be noted here that more than one approach may be used simultaneously, depending on client characteristics, type of health condition and resources available.



**Freestanding medical respite unit**

The ideal medical respite care model is the freestanding respite unit. In this model, generally one organization owns and operates the program in a separate leased or purchased facility, designed specifically for medical respite services. While clearly more costly than the other approaches, this model does provide the most appropriate environment for delivering medical services to homeless people in need of recuperative care. The ability to control policies and procedures—including admissions, length of stay, the delivery of care, discharge planning, and health and safety guidelines—creates an opportunity to design a program best-suited to the needs of the homeless patients served in that community. The immediate medical need also serves as an incentive to bring homeless people into a stable environment in which they can be linked with other services that ultimately may be the key to positive change in their lives. Effective integration of behavioral health, nursing care, medical care, substance abuse treatment, case management, dental and other specialty services can enhance the potential for full physical and emotional recovery and a possible return to housing.

In 2009, 12 medical respite programs listed in the Respite Care Providers’ Network’s 2009-2010 *Respite Care Program Directory* operated a free-standing medical respite unit. Many of these programs have been able to expand the scope of services to include diagnostic testing, medical evaluation, and access to dental care and specialty medical services. Freestanding medical respite programs often require more administrative support, with policies and procedures clearly spelled out in multiple service areas.

<b>ADVANTAGES</b>	<ul style="list-style-type: none"><li>• Ability to provide more comprehensive services—medical and non-medical</li><li>• Respite program controls policies and procedures, and defines scope of care</li><li>• Respite program controls environment (health and safety issues)</li></ul>
<b>CHALLENGES</b>	<ul style="list-style-type: none"><li>• Identifying adequate funding to support needed services and operations</li><li>• Finding an appropriate facility</li><li>• Possible licensing and zoning issues</li><li>• Possible conflict from neighborhoods (if a new facility)</li></ul>

### **Shelter-based models**

Most stand-alone respite programs began their respite programs in a shelter. Starting a respite program in this way allows the program to demonstrate the need for services and establish ongoing relationships with hospitals and other stakeholders while allowing time to develop outcomes and credibility.

There are numerous configurations within the shelter-based model, varying primarily in the intensity and comprehensiveness of medical and other services offered, as well as differences in who employs the staff. Shelter-based respite care has developed out of the specific needs of the shelter’s homeless guests who are too sick to go to the street but who have no other place to go to recover. Like other models, it is responsive to hospitals and health centers looking for ways in which to support their patients who have no place to go to recover.

Some shelters have set aside areas within their facilities for medical respite units where guests have access to nursing care and other supports. These respite programs are sometimes developed as collaborations using shelters to provide the facility, while another agency—such as a homeless health care project—provides the management of admissions, respite and clinical services. This model is similar to a freestanding respite unit, with the exception that the facility and beds are still provided by an existing shelter and there are other shelter guests and activities taking place in the vicinity.

The next level of shelter-based care involves a slightly less formal arrangement within the shelter, perhaps with a particular area set aside and shelter personnel responsible for the basic care of respite clients. This arrangement is most suitable for clients who do not need 24-hour nursing care and who are not too sick. However, shelter staff need easy access to

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on-call medical personnel in the event of emergencies or medical complications, and it is also desirable that health care workers visit the shelter regularly to provide medical services and provide guidance to the shelter staff.

The most basic response to the need for respite services is a referral to a shelter that is willing to set aside a bed for people needing 24-hour rest and time for recuperation. This arrangement will usually require clients to be quite medically stable, ambulatory and capable of self-care. Because of the possibilities of exposure to other shelter guests, admission of some clients with contagious diseases is not appropriate. Without the presence of at least nursing services, this arrangement is barely more than a guaranteed shelter bed which allows for added rest and time to further recover. This type of arrangement does not meet the definition of medical respite care. A term that is sometimes used for this level of care is “Stay In Beds,” which allow the sick homeless person to continue to rest and be monitored in the shelter setting.

<b>ADVANTAGES</b>	<ul style="list-style-type: none"><li>• Uses expertise of existing programs (shelters for beds, health program for services)</li><li>• Reduces facility costs by utilizing existing facility</li><li>• May eliminate need for special licensing (depending on state law)</li><li>• Encourages coordination and collaboration between agencies</li><li>• Helps to demonstrate the argument for the need for respite care</li><li>• Hospitals and other stakeholders benefit from having a safe place to discharge a patient to, may come to the table for the development of stand alone facility or expanded program</li><li>• Demonstrates outcomes in making the argument for respite programs</li></ul>
<b>CHALLENGES</b>	<ul style="list-style-type: none"><li>• Shelters and health programs may have differing philosophies- ongoing tension</li><li>• Possible conflict over admissions policies and control of the beds</li><li>• Health program has little control over health and safety issues in shelter environment</li><li>• Services are more limited and patients have to be quite stable and so some patients are too sick to be in this model</li><li>• Sobriety is challenged in a shelter where others are misusing substances</li></ul>

## Combined model

For many established programs, there are never enough beds to continually meet the needs of clients who are referred and need respite care. For this reason, some medical respite programs have learned to complement the respite beds available in their stand alone respite facility with respite beds in a shelter. Boston, for example, has Medical Stay-In beds in two large area shelters where patients can be referred either to wait for a medical respite bed to become available in the stand alone facility or to continue recovery and rest after their more acute needs have been met.

<b>ADVANTAGES</b>	<ul style="list-style-type: none"> <li>• Provide safe discharge from stand alone Respite Care</li> <li>• Provides time for additional recovery for those no longer meeting medical necessity of more acute medical respite bed or hospital</li> <li>• If patient declines, can be referred back to stand alone medical respite care for further treatment without being lost to care</li> <li>• Opportunity to continue step down level of care</li> <li>• Safe place to transition for newly homeless clients from respite to the shelter setting</li> <li>• Assists with safe discharge and increases access for sicker patients to more acute medical respite beds in stand alone</li> </ul>
<b>CHALLENGES</b>	<ul style="list-style-type: none"> <li>• Shelters and health programs may have differing philosophies- ongoing tension</li> <li>• Possible conflict over admissions policies and control of the beds</li> <li>• Health program has little control over health and safety issues in shelter environment</li> <li>• Services are more limited and patients have to be quite stable and so some patients are too sick to be in this model</li> <li>• Sobriety is challenged in a shelter where others are misusing substances</li> </ul>

Not all communities have adequate resources to develop a formal medical respite program. This should not imply that nothing can be done to assist homeless people who are in need of recuperative care. Many organizations have employed creative strategies to make up for the lack of a medical respite program in their community. Programs that are just starting out may want to consider an approach that is fairly easy to implement and less costly than a

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full medical respite model which also allows for generating valuable data and experience that can be used to expand the program later.

The following approaches may serve either as initial steps toward the development of a more comprehensive program, or can be used in conjunction with a medical respite program as an interim solution for homeless people who are waiting for a medical respite bed to become available.

### Motel/hotel vouchers

Some communities utilize motel or hotel rooms for respite care, either directly renting rooms as needed or collaborating with other organizations in operating voucher programs. In this approach, the health and social services staff make “home” visits to the motels/hotels, with transportation arranged for clients needing to go to a clinic or hospital. Arrangements must also be made for providing meals and/or assuring that there are cooking facilities available. This can sometimes be accomplished through collaborative agreements with local meal programs such as Meals-on-Wheels.

Respite clients placed in motels or hotels need to be ambulatory and able to care for themselves, including taking their medications appropriately. This approach works relatively well for families, when one family member needs rest and recuperation and another is present to assist and provide support. It also prevents families from being separated during times of stress caused by health problems.

ADVANTAGES	<ul style="list-style-type: none"><li>• Relatively low cost (depending on community)</li><li>• Easy to start up</li><li>• No licensing or other regulations needed</li><li>• Families can stay together</li><li>• Effective way to isolate a contagious disease</li></ul>
CHALLENGES	<ul style="list-style-type: none"><li>• Relatively expensive for what is gained (depending on community)</li><li>• 24-hour nursing care not available in motels/hotels</li><li>• Proximity to other services may be limited</li><li>• Have to arrange for meals</li><li>• Hard to guarantee safe environment in motel/hotel</li><li>• Clients are isolated – limited human contact to support healing</li><li>• Relationship with motel/hotel owners often needs nurturing</li></ul>

## **Nursing home/board and care home contracts**

Nursing homes offer a wide range of personal care and health services for people who can't be cared for at home or in the community. Some nursing homes may provide skilled care after an injury or hospital stay. While medical respite care is not the same as care provided in a nursing home, some hospitals and health centers have partnered with nursing homes to provide medical respite care. This kind of collaboration with nursing homes is a creative way for patients to be served when funding for a stand-alone facility or the capacity to bill for medical respite care cannot be achieved. This arrangement can work well for patients with more complex medical needs, depending on the quality of the facility, which contractors may need to monitor.

Board and care homes provide help with activities of daily living such as eating, bathing, and using the bathroom for people who cannot live on their own but do not need nursing home services. It is sometimes called a "group home". Contracting with board and care homes addresses the issues of meals and supportive human contact. However, there is still no guarantee of a safe, healthy environment and appropriate care, unless there are good state regulations governing such agencies.

<b>ADVANTAGES</b>	<ul style="list-style-type: none"><li>• 24-hour nursing care (for nursing homes)</li><li>• Meals provided</li><li>• Supportive human contact</li></ul>
<b>CHALLENGES</b>	<ul style="list-style-type: none"><li>• Little control over appropriateness and quality of care</li><li>• Little control over health and safety issues</li><li>• Difficult to assure appropriate care for person with co-occurring disorders such as mental illness or substance abuse</li><li>• Limited opportunity for connection to other needed services</li></ul>

## **New and emerging models**

Since the first edition of this publication in 1999, a number of communities have employed innovative approaches to meeting the recuperative needs of people who are homeless while also addressing the need for housing. One approach is the Transitional Housing Medical Respite Program. These programs are generally located within a transitional housing facility or residential treatment center, or the program allows patients to stay for prolonged lengths of time until permanent housing becomes available. The housing needs of patients are given as much priority as their medical needs. Needless to say, the primary challenge in this type of program is the limited availability of beds. However, because the program is considered transitional housing, the program is eligible for housing and supportive services grants that might not be available to other traditional medical respite programs.

A much newer model of care is the provision of medical respite care in a permanent supportive housing setting. This type of program is very similar to an onsite medical clinic except that patients can receive recuperative care at their bedside. The program staff are available to provide ongoing health care education and support in an effort to assist the client in remaining stably housed. The challenge with this type of program is that eligible patients are limited to those who will live permanently in the housing unit. However, like the programs that are in a transitional housing setting, additional grant opportunities may be available for this kind of program.

### **Evolution of programs**

The first approach that an organization chooses to provide respite care may actually be a stepping-stone to a more extensive model. Some of the information necessary for planning an actual freestanding respite care unit may not be available immediately, but can be gathered during the implementation of an intermediate approach, such as use of motel/hotel vouchers or collaboration with a shelter. Concerned communities across the country have been developing a variety of innovative respite care programs, ranging from collaborative models that share space and services to freestanding full-service medical respite units. There is no one model that works best for every community, given the differences in client needs as well as available resources. The one thing that all communities have in common is that people who are sick or injured—and homeless—need a safe place to recuperate with appropriate staff to care for them. Creativity and compassion are key to creating such resources.

### **Designing the Program**

Once the scope of medical care and the program model have been determined, other details of the program such as staffing, regulatory compliance, and policies and procedures should be worked out.

### **Staffing**

Staffing decisions that must be made include: type of staff to be hired, whether or not staff will be located on site, and whether volunteers will be used. Programs based in existing shelters will not have the same staffing needs as stand-alone programs. For example, many shelters will already have security, case managers, human resource administrators, and environmental services. In a shelter-based program, additional staffing might include a respite care coordinator and one or more medical providers such as a nurse, nurse practitioner, physician, and/or physician assistant.

Staffing arrangements vary across the range of medical respite models. In some communities with limited resources, an employee of the hospital acts as the respite care coordinator. In other communities, the respite care coordinator is employed by the respite program but is based at the hospital so that assessments can be made before transition to the medical respite program. In the same respect, medical providers for a medical respite program might be employed by a Federally Qualified Health Center, a hospital, or a non-profit organization responsible for the program. Depending on the level of care offered to program participants, medical providers might work on site or visit patients intermittently during their stay. Patients with higher medical needs will need more supervision and assistance than patients who are ambulatory and able to provide self care.

### **Regulations/licensing**

In addition to staffing, programs must make sure that the scope of services and program model comply with various laws governing regulations and licensing. Medical respite programs are a relatively new phenomenon and are not currently regulated in the same way that nursing home care is regulated. This may change with time, particularly if targeted funding at the federal or state level becomes a reality. Any regulation of existing medical respite programs will vary from state to state and depends on local politics, local regulations and funding. Boston's program, for example, is regulated by the State Department of Public Health that oversees licensure of the clinics in the medical respite program but does not exert authority over the actual beds in the program. For this reason, patients in Boston's medical respite program are clinically assessed and treated at onsite clinics rather than at their bedside. Programs that are able to bill for services to Medicaid must comply with Medicaid guidelines and regulations, and those programs that store or dispense medications will need to consider what compliance is required by the Federal Drug Enforcement Agency. Respite programs operated by HCH projects or other Federally Qualified Health Centers (FQHC) should be included in the grantee's Scope of Project to assure Federal Torts Claims Act (FTCA) protection and FQHC reimbursement rates for health care services provided to patients with Medicaid.

### **Policies and procedures**

Once the scope of services, program model, and staffing are determined, there are still a multitude of other decisions that need to be made, including the development of policies and procedures. Policies and procedures will evolve as the respite program develops and grows. The table below specifies only some of the policies that a program might consider and is by no means an exhaustive list. Most of the operational policies will evolve as the program identifies a particular challenge, and some will be determined by regulatory and licensing bodies such as government agencies (federal, state, city and county) and even funders.

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<b>Clinical policies and procedures</b>
Clinical protocols Safety Infection control Medical or psychiatric emergencies Medications
<b>Administrative policies and Procedures</b>
Admission criteria and referrals Waiting lists Discharge criteria Administrative discharge with guidelines for readmission Patient complaint and abuse reports Supervision Fire/evacuation plans Billing

To discuss each policy in detail is beyond the scope of this monograph; however, the authors feel that a discussion of admission and discharge policies is warranted. Admission policies define the consumers of the program and correspond with the need in the community. Discharge policies are discussed due to the challenges that programs face in releasing a patient when affordable and supportive housing options are limited.

*Admissions policies* These policies clarify whom the program is intended to serve. The admissions process can be the most satisfying as well as the most challenging aspect of operating a medical respite program. While it is necessary for the admission criteria to be clear, exceptions will need to be made for those who might not exactly fit eligibility criteria but for whom respite care, while not the ideal, is the only place to receive care. The admissions criteria will constantly be challenged by the unique and variable needs of people experiencing homelessness. Respite care is constantly evolving, and exists for homeless individuals whose medical and other needs cannot be met elsewhere. This may mean that newly housed patients need to return to medical respite programs for short-term stabilization or support in sobriety as responsibility for their care becomes too burdensome for home care teams or visiting nurses, who under ordinary circumstances might take care of these individuals in their homes.

Admissions staff are also challenged to manage inappropriate referrals from hospitals that are under increased pressure to discharge patients quickly. In this case, admission staff may consult with the hospital in trying to find an alternative when a respite bed is not available, while continually working to improve and maintain effective relationships with hospitals.

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While all of the above are true, medical respite care programs do need fundamental admission criteria to form a framework within which to operate. Essential admission criteria for medical respite programs require that the patient:

- Lack suitable housing
- Have an acute or post-acute medical illness which requires short term resolution and care or
- Need an environment in which to prepare for or recover from medical procedures such as surgery, chemotherapy, radiation, endoscopy
- Be independent in Activities of Daily Living (ADL) with the ability to dress, bathe, transfer and ambulate independently or with mechanical assistance such as wheelchair, crutches or cane
- Be psychiatrically stable enough to accept and receive care and not interrupt the care of others
- Be sick enough to need more than an emergency shelter bed for the night
- Not be sick enough to require hospital level of care or other medical care (nursing home, psychiatric in-patient admission, rehabilitation hospital).

The patient may or may not have other chronic illnesses which further complicate the situation (hypertension, diabetes, HIV/AIDS, mental illness, substance abuse) and which make it difficult for the patient to do well in other settings. For instance, a patient who needs treatment for an infection such as cellulitis but who also needs to detoxify from alcohol and other drugs might not be accepted by a detox facility, as the associated medical illnesses are too challenging to care for in that setting. This patient can be cared for in a medical respite facility that has the experience, policies, and procedures to assist patients in medical detoxification.

*Challenges and exceptions to admission criteria* Medical respite programs are frequently challenged to accept patients who do not fit their admission criteria. Since medical respite care exists as a service for homeless patients that have nowhere else to go for care, flexibility and creativity are necessary in trying to meet patients' needs. Programs may be asked to take chronically ill, undocumented individuals who have no options for admission elsewhere; patients who are oxygen dependent; those in need of end-of-life care who are not eligible for hospice; and others who might not meet the program's admission criteria.

Because of facility and staffing limitations, some programs limit services to single adult males. Women who are homeless and in need of respite care are usually more vulnerable than their male counterparts. Life on the streets is particularly brutal for women. Respite care provides not only an opportunity for healing but for preventative (women's health) care. Programs that limit admission to males will undoubtedly be faced with the dilemma of dealing with females in need of care.

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*Admission criteria for shelter based programs* Admission criteria for medical respite programs vary depending on the scope of services provided, the relative intensity of staffing, and the space. For this reason, admission criteria for a shelter based medical respite program might differ from criteria in a stand-alone facility.

A shelter-based program's admission criteria may require the patient to be:

- Medically stable
- Independent with ADLs (activities of daily living)
- Able to manage own medications
- Adherent to shelter rules and regulations

*Readmission criteria* As a respite program grows, it will develop a history with patients who are readmitted for subsequent illnesses. Admissions staff should keep records of problematic admissions with the goal of creating specific plans of care for patients who return and need more support. Some patients benefit from a treatment agreement or contract to help the patient stay focused on his or her clinical plan of care and the structure of the environment (see appendix for a sample treatment agreement). Readmission criteria are written for patients who might have had a difficult prior admission. The other purposes of readmission criteria are to underscore accountability and safety for all, to remind the patient of expectations for his or her stay, and to encourage a stay that is structured and focused on success, safety and compliance.

*Discharge planning policies* One of the most difficult processes faced by clinicians and administrators alike is that of discharge planning. Ideally, just as in any tertiary medical facility, discharge planning should begin on the day the patient is admitted to the medical respite program. During the initial assessment, the clinician and others involved in the client's care identify the client's medical needs and vulnerabilities. Once stabilized, clinicians are challenged with finding a safe environment that will not undermine the health gains made during medical respite care. Discharge to the streets might expose the client to an array of addictive substances, inadequate mental health support, compromised nutrition, lack of rest, and other dangers. In an effort to sustain the health gains made while in the program, discharge decisions might be made by a team of providers who weigh the risks and benefits of the discharge. While the decision to discharge some patients is fraught with potential problems, many patients are able to come in for medical respite care, receive treatment for the resolution of the acute medical illness, and be safely discharged to a shelter or transitional program, or ideally, permanent housing.

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Essential questions to answer in the development of discharge planning policies include:

- Who is responsible for deciding when a patient is ready for discharge?
- Who refers the patient to the next step?
- Who arranges transportation, medications, and medical appointments?
- What steps have been made to ensure future medical follow up and care?

A number of situations can create challenges in discharge planning. Some issues that are likely to be faced by a medical respite program include: limited availability of affordable and supportive housing, patients who are too sick to stay in emergency shelters, patients who have an addiction, patients with cognitive impairment, undocumented patients, and patients who are terminally ill. Each of these issues is briefly described below.

*Limited availability of affordable and subsidized housing* Housing placement after discharge is largely dependent on a community's supply of affordable and subsidized housing. Some programs with a healthy supply of affordable housing will have access to housing vouchers, allowing them to expedite the patient's transition into housing. Unfortunately, most communities face a shortage of affordable housing. With limited housing opportunities, some programs extend the patient's length of stay, while others have no choice but to discharge the patient to the street or shelter. When housing is obtained, the case manager or another staff member should work with local agencies to help the patient set up utilities, obtain furniture, a telephone, television, and to help the patient move into their new home.

*Patients who are too sick for shelter (oxygen dependent, blind, disabled)* Most emergency shelters are not able to accommodate people with disabilities who require special assistance. Respite programs providing care to patients with a disability frequently have to find other housing alternatives or wait for housing to become available. As soon as a patient with a disability is admitted to a medical respite program, a case manager should determine the patient's eligibility for programs such as Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI)<sup>25</sup> or HUD housing programs designated for people with disabilities.<sup>26</sup>

*Patients who abuse substances and/or have addictions* Many respite programs will care for patients who are not only very sick but who also have a severe addiction to one or more substances. On occasion, patients who repeatedly use addictive substances need to be discharged to a detox facility or be given a short break from the program before being readmitted to continue care. Treatment agreements or contracts are sometimes helpful in facilitating short and successful stays for patients challenged by addiction.

*Patients who have a cognitive impairment.* Most medical respite programs provide acute and post acute medical care for patients who have signs and symptoms of cognitive decline, frequently related to substance misuse or head injury. However, medical respite care is not ideal for patients who have cognitive impairment or dementia without an acute medical illness. Referral to a residential treatment facility that can evaluate the person over time is a better alternative.

*Patients who are undocumented.* The challenges of caring for homeless clients who are also illegal immigrants are many. Patients who are undocumented may not be eligible for health insurance, housing, or other inpatient care such as a nursing home. With limited discharge options, the medical respite program is encouraged to create a network of support for such patients by partnering with various community programs and public hospitals that serve all people regardless of immigration status.

*Patients who are terminally ill* Although respite programs may not be designed to care for terminally ill patients, it is not unusual to provide this level of care, especially when such clients have had previous relationships and successful stays in the respite program and feel safer in the program than in a hospital or hospice program. The diagnosis and level of care required are often factors that determine whether a patient can be given such care in a respite program. Some factors will preclude caring for the dying patient, such as inability to control pain or the program's inability to provide the intensity of services needed by the patient.

*Policies addressing the management of behavior, drugs and alcohol* Upon admission to a medical respite program, policies governing patient rules and expectations should be reviewed with each patient. Safety for all of the staff and patients in the respite program is not negotiable. All patients and staff must feel safe and supported in an environment that is designed to be accommodating and nurturing for patients who need to recover from an illness. Safety is a real concern when some of the patients are struggling with addiction, have long histories of mental illness and difficulties adapting to the structure of the respite environment. Managing substances is particularly challenging for those respite programs that operate in wet shelters (shelter that do not require sobriety). Respite programs need to develop policies on the possession and use of substances and these policies must be clearly communicated to the patients. If needed, staff can work with patients to develop a plan to help patients avoid situations that would violate program policies.

To support patients in their understanding of safety and program expectations, it is important to give every patient a **complete orientation** to the respite program upon admission. An orientation prepares patients for the day to day activities of the program and offers an opportunity for patients to ask questions regarding program policies. Patients

need to be aware of program expectations, the daily schedule of events, and should understand the boundaries and operations of the facility. Most patients thrive in the respite environment. However, for some patients, especially those with a mental illness, adapting to program policies and respecting boundaries can be difficult. Other patients might experience continual pressure to misuse substances and might violate drug and alcohol policies while out on appointments. Some respite programs have trained security staff who are familiar with the patients and who can support the goals of the program and the safety of others by screening patients who return from appointments in a way that is supportive. Respite programs should have clear expectations as to how illicit substances will be handled. An example of patient policies from the Boston McInnis House Program can be found in the appendix.

*Administrative discharge* Most respite programs will be challenged to adapt and be flexible to the ever-changing and unique needs of their clients. This often involves developing new ways to take care of patients outside of the usual operational guidelines or policies. For example, substance use might be prohibited in the respite program; however, discharge from the respite program due to a violation of substance use policies might not be feasible if the client is very ill, is in the middle of extensive treatment and when there is no safe discharge plan. Perhaps the only time that an administrative discharge (discharge by program administration rather than clinical staff) is mandated is when the viability of the program or the safety of other clients and staff is put at risk by the patient's behavior. As a first step, it is optimal for the patient to be clinically assessed by the team caring for the patient and the risks of discharge evaluated by a team in balance with the overall safety of the program. Even when administrative discharge is required, it is best if an alternative program can be found for the client where his recovery and care may continue.

### Determining Costs

Program planners will need to identify adequate funding to cover the costs of the program. The actual budget for a medical respite care program will depend primarily on the model chosen and the local rates for staffing, supplies, etc. Some of the program elements that will affect the size of the budget include facility, staffing, medications and supplies.

As described earlier, the cost of providing medical respite services is greatly influenced by the type of facility chosen for the program. A freestanding facility is the most expensive, unless the facility is donated or provided rent-free by another organization. Programs that are part of a collaborative effort with a shelter may be able to obtain free use of shelter space. Costs for contracting shelter beds or board and care beds will vary depending on the community, as will motel/hotel voucher costs, depending on the motels or hotels that are chosen for the program.

Staffing costs will vary dramatically based on the model chosen for your respite program. A freestanding program with on-site medical and support staff will obviously be the most expensive. The costs of providing other services on site, such as mental health care, substance abuse treatment services, social work/case management or dental services, need to be considered in the budget as well. Programs based in shelters or motels/hotels that use visiting medical staff will need to determine the costs for those providers' time out of the existing budget, or additional hours may need to be added for those providers. Volunteer services or any donated time of shelter staff should be included in the budget for purposes of tracking actual costs.

A Health Care for the Homeless project that is expanding its facility and/or services to include medical respite care is likely to have an idea of the costs of medications and supplies from experience working in the clinical outpatient setting. For programs serving Medicaid beneficiaries, medications are usually paid for by insurance. Alternative arrangements will need to be made when insurance does not cover the costs of medication. Medication management in health care facilities is strictly regulated, and medical respite programs must comply with state and federal regulations including requirements of the Drug Enforcement Agency. As pain management is a continual challenge for homeless patients who are struggling with addiction, policies that define the prescribing and dispensing of controlled substances must be given particular attention, and internal and external auditing of processes should be in place.

### **Funding Sources**

The funding streams from which medical respite programs draw their support vary from program to program. Many programs have been very innovative in their approach to financing services, allowing them to implement novel approaches to care such as mental health respite beds and permanent supportive housing medical respite. Many other medical respite programs have limited staff who cannot spend time on such grant proposals. Programs with limited staff should, at a minimum, explore the common sources of funding for medical respite programs, described below.

#### **Hospitals**

Increasingly, hospitals are investing in medical respite programs in order to avoid discharging sick patients to the streets and to decrease future hospital utilization by costly frequent users. In fact, many respite programs receive ongoing, long-term support from hospitals as a cost reduction measure. A growing number of medical respite programs are funded solely by one or more hospitals and do not accept referrals from any other institution. This type of arrangement is often designed to meet an immediate need of a

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hospital and is not ideal for the long term since it excludes a number of people who need medical respite services. Programs are encouraged to diversify funding in order to offer their services to a broader population of homeless people.

Most hospital contributions come in the form of annual grants. However, some hospitals contract with medical respite programs on a *per referral*, *per day*, or *per bed* basis. For example, in Portland, Oregon, a medical respite program receives an average of \$4,000 per referral with no stipulation on the length of stay. This arrangement allows for more flexibility, so that the medical respite program can determine the length of stay based on the patient's need. Hospitals benefit from this arrangement in that they are not asked to pay an additional amount for patients who stay for a prolonged period. Each community should evaluate the pros and cons of each kind of contract. For example, a *per bed* contract risks situations in which the hospital needs more beds than are provided in their contract or the bed is needed for a patient who is not referred from that hospital.

In addition to financial contributions, hospital support can include in-kind contributions such as:

- Medications
- Patient information
- Supplies/Equipment
- On-going physician care
- Nursing care
- Physical therapy
- Laboratory services
- Access to labs and radiology
- Volunteer consultative specialty care such as dermatology, optometry, and podiatry

### Federal government

Despite the tremendous benefits and cost savings of medical respite programs, no targeted federal funding stream exists for medical respite care as of the writing of this monograph. That is not to say that federal funding is not available for specific services offered by medical respite programs. In fact, a variety of federal funding has been used by medical respite programs to support specific services such as medical care, outreach, case management, transportation, etc. The following sections describe these federal funding opportunities.

***Health Center funding*** Programs operated by community health centers should consider using health center funds to support medical respite care services. The U.S. Department of Health and Human Services through its Health Resources and Services Administration (HRSA) oversees over 1,000 community health centers across the United States. Over 200

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of these health centers are Health Care for the Homeless (HCH) projects, which provide primary care services to homeless families and individuals. In a 1999 Program Assistance Letter titled, *Principles of Practice: A Clinical Resource Guide for Health Care for the Homeless Programs*, HRSA strongly encouraged HCH programs to provide, or make arrangements for clients to access, respite/convalescent services (among other services).

In 2002, “recuperative care services” was added to Section 330 of the Public Health Service Act (42 USCS § 254b), the authorizing statute for the HRSA Health Center Program. The service was added to the statute as an “additional health service” that health centers are permitted to offer using their Health Center grants.

Despite HRSA’s encouragement and the demand for medical respite services, only 10% of HCH projects operate medical respite programs. One reason that more HCH projects do not operate medical respite programs is that HRSA health center funds only cover the cost of the health services as well as other enabling services which will be described shortly. HRSA funding does not cover costs associated with providing and maintaining the medical respite facility. Therefore, HCH programs that wish to operate a medical respite program often work collaboratively with a shelter, assisted living facility, transitional housing facility, or a permanent housing facility or raise enough funds to develop its own housing component. A number of barriers are encountered in such collaborations including staffing issues and stringent shelter/housing policies that sometimes conflict with the health center’s philosophy of wellness.

Depending on the availability of funds appropriated by Congress for the Health Center program, HRSA from time to time makes additional funds available to its grantees, on a competitive basis, for the expansion of existing operations or for the addition of new services. Grant opportunities vary from cycle to cycle, but can include funding for new sites, or for the increase of services at existing sites. In a particular grant opportunity, eligible activities may include one or more services authorized in Section 330, such as substance abuse treatment, dentistry, or enabling services. Enabling services are non-clinical services that enable individuals to access primary health care services and improve health outcomes. Enabling services may include but are not limited to: case management, services to assist health center patients in applying for entitlements to obtain financial support for health and social services, outreach, transportation and interpretive services, and education of patients and the community regarding the availability and appropriate use of health services. Medical respite programs are a primary source of enabling services as described throughout this publication.

**EXPANDED MEDICAL CAPACITY GRANT**

**Case example: County of Santa Clara Medical Respite Program**

In 2008, more than 7,000 people were homeless each night in Santa Clara County, California. Fifty-five people died on the streets that same year. To meet the recuperative care needs of patients being discharged from hospitals and to increase access to health care services, the Valley Homeless Healthcare Program (VHHP), in collaboration with seven area hospitals and local shelter provider EHC LifeBuilders, opened the County of Santa Clara Medical Respite Program. This 15-bed medical respite program is located in the EHC LifeBuilders shelter and includes an onsite clinic staffed by HCH clinicians. To help support the program, VHHP (Santa Clara County's HCH program) applied for and was awarded a HRSA Expanded Medical Capacity grant. The grant will help the HCH program serve 400 additional patients in a medical respite setting. The grant allowed the program to expand its on-site clinic hours from 24 to 36 hours per week and supports .75 FTE Physician and 1.0 FTE Clinical Nurse positions.

Administrators of medical respite programs that are operated by a health center or seeking a collaborative relationship with a health center should frequently check for HRSA grant announcements. HRSA Grant announcements can be found online at [www.hrsa.gov/grants](http://www.hrsa.gov/grants).

*U.S. Department of Housing and Urban Development grants* The Department of Housing and Urban Development (HUD) is a funding source for the housing component of many homeless programs. In addition to funding short-term and long-term housing, HUD is responsible for the distribution and oversight of funds used for supportive services in housing. In 2009, 12 medical respite programs listed in the *2009–2010 Respite Care Program Directory* received HUD support under the Emergency Shelter Grant (ESG) Program or the Supportive Housing Program (SHP). The May 2009 reauthorization of the HUD McKinney Vento Homeless Assistance program made significant changes to these programs. The reauthorization slightly expanded the definition of homelessness, increased the amount of funding for HUD homeless assistance programs, and also changed the scope of funding. The Emergency Shelter Grant is renamed the Emergency Solutions Grant and will expand its scope to include homeless prevention and re-housing. The Supportive Housing Program will be consolidated with other housing programs to form the Continuum of Care Program. HUD's shift to homeless prevention and longer-term housing is likely to act as a barrier to new medical respite programs seeking funds for short term emergency lodging.

*Medicaid* is the nation's primary public health insurance program for low-income individuals and families, who must meet stringent categorical and resource requirements to qualify. In addition to having very low incomes, beneficiaries generally must be children, pregnant women, adults with dependent children, or people with disabilities. (Only a few states permit adults without dependent children to enroll in their Medicaid program.) In

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2007, only 22% of patients served by the Health Care for the Homeless program were covered by Medicaid, despite the fact that 91% of these patients had income at or below the federal poverty level.

The current environment regarding Medicaid is much too complex to cover adequately in this document. Regulations, eligibility requirements and delivery systems vary greatly from state to state. Some states with more inclusive eligibility criteria may offer more possibilities for covering homeless people, particularly non-disabled single adults. Although medical respite care is not specified as a covered service in the federal Medicaid statute, the acute care medical services provided by a qualified licensed practitioner to Medicaid beneficiaries while in respite care are billable under Medicaid. Managed care arrangements for Medicaid in some states may complicate coverage of services provided in respite care settings, but this is worth negotiating with your State Medicaid Agency.

Certain Medicaid waivers are available to states to expand Medicaid eligibility and covered services. Convincing a State Medicaid Agency to submit a waiver application to expand services and/or eligibility can be difficult, however. The State Medicaid Agency will need very convincing evidence of cost savings to the Medicaid program that can be realized through the provision of medical respite care (e.g., as an alternative to hospital care). Waivers that could expand Medicaid eligibility to include medical respite care are the Section 1115 Research and Demonstration Waiver and the expanded Home and Community-Based Waiver (Section 1915 (i)) under the Deficit Reduction Act of 2005.

A state may also expand Medicaid eligibility and services without obtaining a federal waiver if it is not requesting federal matching funds (using state-only funds). Due to tightened budgets and competing priorities, however, convincing State Medicaid administrators to reimburse a service without federal matching funds is challenging.

Current health care reform discussions seem to favor an expansion of public health insurance (under Medicaid and/or Medicare) to cover all individuals and families falling below a specific poverty threshold. Such expansion, if it occurs, is very likely to include nearly all people who are homeless. However, Medicaid or Medicare eligibility expansions would not necessarily entail an expansion of covered services or increase the likelihood that “medical respite care” will be a reimbursable service. Medical respite programs will still need to convince their state government or the federal government to include “medical respite care” as a reimbursable service under Medicaid.

***Federal drug discount programs*** Medical respite programs that provide medications as a service to their clients will want to take advantage of available programs that provide discounted pharmaceuticals. Section 340B of the Public Health Services Act limits the cost

of covered outpatient drugs to certain federal grantees, Federally Qualified Health Center look-alikes, and qualified disproportionate share hospitals. More information about 340B drug pricing programs is available online at <http://www.hrsa.gov/opa/introduction.htm>.

### **Local (city/county) and state governments**

Funding from local and state governments for medical respite care varies from program to program. In some counties, the medical respite program is an extension of the local public health department. Other programs receive funding from their municipal or state department of family services/human services/social services. State and local governments can also support medical respite programs by designating some of their HUD funds to support the housing component of a medical respite program. Programs seeking governmental funding should consider involving decision makers (e.g., governmental officials, policymakers, agencies that coordinate HUD Continuum of Care funding) in volunteer committees or other program activities, in order to get buy-in. At a minimum, program administrators should meet with these decision makers and educate them about program services and outcomes, including actual or potential cost-savings to public programs attributable to medical respite care.

### **Private donations**

Funding from private sources (individual or corporate donations or in-kind contributions, foundation grants) is extremely valuable and may offer greater flexibility than is possible with government grants. A challenge for many medical respite programs is the amount of staff time needed to solicit and maintain private funding. Unless the funding is renewable or can be sustained—for example, ongoing foundation funding with no time limitations—it may be wise to use private funds for one-time start-up or capital costs, such as facility purchase, renovations or equipment.

### **Making the case for funding**

The case for funding medical respite services for homeless people can and should be made on multiple fronts. Start with the ethical stand that “it’s the right thing to do.” It should be obvious that discharging a person who has recently undergone surgery or is experiencing a risky pregnancy to the streets is *not* the right thing to do. Be practical—propose concrete ways in which medical respite care can be mutually beneficial to service recipients and funders, recognizing that today’s medical environment is heavily influenced by dollars and that moral imperatives alone frequently take a backseat to the influence of managed care organizations, Medicaid/Medicare or other governmental regulations, and the expectations of donors and grantmakers that the program can be shown to be efficient, cost-effective and sustainable.

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For example, use the cost-savings information presented in the *Introduction* of this publication to make the case that medical respite programs can reduce costs to hospitals in the following ways:

- **Diversion from the ER/ED** – Among the reasons for frequent use of emergency services by homeless people is their limited access to primary and preventive care and a place to recover from illness or injury, which medical respite services can provide. Lack of health insurance, limited resources, fragmented health care delivery systems, and preoccupation with meeting basic survival needs partially explain why persons experiencing homelessness tend to seek health care only in emergencies.
- **Reduced hospital admissions** – Medical providers often admit homeless people to the hospital for conditions that could be resolved through outpatient treatment and a safe place to recuperate; however, the higher acuity of health problems experienced by homeless people often requires more intensive services that can only be provided in a hospital. Lacking a place to recuperate following hospital discharge increases risk for medical complications that often result in avoidable re-admissions and more uncompensated care.
- **Decreased hospital length of stay** – Despite financial pressures to shorten the duration of inpatient care, hospital patients without stable housing may be retained somewhat longer than domiciled patients when hospital personnel do not have an adequate discharge plan. Medical respite care facilities provide a cost-effective alternative. Hospital staff frustrated by the lack of safe places to which they can discharge homeless patients can be great allies in supporting the case for funding respite programs.

An additional argument can be made from the public health perspective that caring for homeless people with communicable diseases in medical respite programs helps to prevent the spread of those diseases in emergency shelters and the community.

If you are appealing to funders with a broader vision who would like to have a greater impact on homelessness, focus on the opportunity that medical respite programs create for linking people with services that can help to prevent or end homelessness. Mental health or substance abuse treatment services accessed following time spent in a respite program can prevent future homelessness. Case management services can assist respite clients with applications for SSDI/SSI and other entitlement programs, which can enable them to move into housing and qualify for health insurance (Medicare and/or Medicaid). An additional advantage of helping clients qualify for these entitlements is that costs can be shifted from the state or local level to the federal level.

When making the case for funding, it is crucial to identify who your audience is and why they should have an interest in seeing medical respite services established in your community. You also need to learn to speak the language of that audience. For example, if your funding plan includes making a case for Medicaid reimbursement, use language that is consistent with current Medicaid terminology, such as “recuperative” or “subacute care”

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(instead of “respite care,” which refers to caregiver relief in the Medicaid statute). Special advocacy will be needed to negotiate realistic capitation rates in managed care systems, based on the actual cost and utilization of covered services by homeless populations, to assure that the medical respite services provided are fairly reimbursed.

Though challenging, medical respite programs that contract with hospitals should attempt to keep a record of hospital costs that were avoided due to the program. At the end of the fiscal year, the program can use these data to determine the hospital’s Return on Investment (ROI) and even make the case for increased support in the next fiscal year. ROI data for one hospital can also be used to seek support from other local hospitals, propose funding from a foundation or the United Way, and advocate for local, state, and federal funding of medical respite care.

Some medical respite programs offer intensive primary and acute care services as well as ancillary services that promote stability. The cost of running such programs can be similar to that of hospital or nursing home care. Program administrators and advocates might make the case for funding based on staff expertise in homeless health care as well as the benefits of the ancillary services (case management, housing placement, benefits acquisition, etc.) that are available in a medical respite setting as compared to a hospital setting.

### **Marketing the Program**

Ongoing marketing is crucial to a program’s success. A brochure describing the respite program can be very helpful to inform stakeholders about the program’s mission, activities, and benefits. Marketing is important to maintain productive relationships with key stakeholders that rely on the respite program, and to foster a spirit of goodwill when these programs experience frustration in having to wait for a bed at the respite program. Continually clarifying admission criteria and improving relationships with programs that refer patients and those that accept patients after discharge is essential. The respite program administrator should consider meeting with:

- Care coordination directors and discharge planners from area hospitals
- Emergency department leadership
- Nursing homes
- Treatment programs
- Referring clinics
- Shelters

The importance of building and maintaining relationships with these individuals and agencies cannot be underestimated. Ideally, respite programs should meet regularly with staff from referring and discharge agencies to nurture these relationships for the benefit of

clients and the program. There will always be frustrations on both sides in managing patients who are homeless and who have limited resources. The demand for respite beds is high, and meeting the needs of referring agencies can be challenging. Hospital discharge planners are under increasing pressure to discharge patients quickly; it is frustrating for them when a medical respite bed is not immediately available, and hospital administrators cannot agree to keep the patient until a respite bed becomes available. Developing relationships with staff that refer patients and being available to problem solve with them and listen to their frustrations can improve care management for clients, to the long-term mutual benefit of the respite program and referring agencies.

The relationship between hospitals and the respite program is mutually beneficial and interdependent. The hospital benefits from having an appropriate discharge option for patients, and the medical respite program has a continual stream of patients being referred for care. Medical respite staff need to communicate and work with hospital staff to ensure effective coordination of services. Often this requires that respite staff meet with hospital discharge workers to discuss the medical respite program's policies and procedures and to streamline the referral and admissions process. Once a respite program is established, there may be ongoing perceptions in the community that there are never enough beds to meet community needs. Respite programs need to build and improve their relationships with hospital discharge planners continually. A committee of hospital staff and medical respite program staff might meet regularly to develop care plans for the homeless patients who are frequent users of the emergency department or of in-patient services. Medical respite program staff must understand the limits of care that can be provided in the respite program and communicate this clearly to hospital staff.

### **Collecting data and evaluating the program**

In today's cost-conscious world, programs are expected to establish measurable program outcomes and report on progress. The outcomes that a program tracks are dependent on its goals as well as contractual obligations with funding agents and regulatory bodies.

Outcomes that a medical respite program might track include:

- Improved client health and ability to function as a result of the successful resolution of acute conditions and stabilization of chronic conditions.
- Improved health and ability to function as a result of successful scheduling of elective surgery with a safe place to prepare for and recover after surgery.
- Improved continuity of care through establishing a medical home—an ongoing relationship with a primary care provider.
- Improved continuity of care as a result of linkage to specialty services, including podiatry, ophthalmology, oncology, radiology, and neurology.

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- Successful linkages to other needed services for respite clients, including substance abuse/mental health services and a safe transition to available housing.
- Recuperation from physical illness and the emotional distress and isolation that accompany homelessness.
- Avoided hospital days as a result of medical respite care

Respite programs will undoubtedly have a difficult time measuring and documenting some of these outcomes. Perhaps the most sought after and unfortunately the most difficult outcome to track is avoided hospital days. A review of academic studies on the impact of medical respite programs on hospital utilization reveals a considerable amount of scientific inference that is involved in making such calculations. Without experienced staff to conduct such research, program and hospital administrators should agree upon the strategy used to determine avoidable hospital stays and cost-savings.

Outcomes should be tracked using appropriate data collection tools. Many of the outcomes a medical respite program can track are documented in written progress reports in patient records. When a pre-test and post-test or other assessment scale is used, programs should consider using a standardized tool that has been demonstrated to be both reliable and valid. Staff should receive training regarding the types of outcomes to be documented, where and how to document these outcomes, and the kinds of information that auditors will look for when conducting a chart review. The consequences of not collecting outcomes data (loss of funding) should be stressed to staff members responsible for record keeping.

Though most respite patients successfully complete the program, some do not achieve program goals because they leave the program early or act against medical advice. Staff should track and document the reasons why patients do not meet their goals. If a significant number of patients are leaving early and not meeting treatment goals, the program might consider whether program policies or other factors can be modified to maintain client participation.

### **Issues and Challenges in Providing Respite Care**

Established respite programs have identified particular issues and challenges that frequently arise when providing respite care. Some are internal programmatic issues, while others involve external pressures on the program.

## **Internal programmatic issues**

***Environmental safety*** The first challenge for a respite program is maintaining a safe, structured and monitored environment. Whether your organization operates its own respite unit or uses loaned space from another agency, constant vigilance is necessary to guarantee safety for both clients and staff. This is especially true when your organization does not actually control the space where services are provided. Effective and tactful negotiation may be necessary in collaborative ventures, stressing the importance of health and safety measures to the success of respite services. Developing clear policies for staff and clients regarding the management of behavior will support the safety of the environment.

***Staff coordination*** Another issue endemic to interdisciplinary homeless health care programs is that of the dynamic tension that exists among different program elements. The philosophies and perspectives of medical practitioners, case managers, mental health workers and substance abuse treatment staff will often vary greatly. Effective staff coordination, communication and collaboration—in conjunction with client input—is necessary to foster consensus among differing perspectives about what is best for the client.<sup>27</sup>

***Cultural competence*** Establishing a client-focused approach to care also entails a strong commitment to cultural competence of service providers. Issues of language, customs, spirituality/religion and particularly health beliefs and practices must all be taken into consideration to support the recuperative process.

***Scope of services*** Several issues will arise regarding client needs that may surpass your intended scope of services. You may find yourselves dealing with clients who need more care than you are able to give. For example, patients who are incontinent might be more appropriately placed in a nursing home. You may end up with clients who need detoxification, extensive rehabilitation services, or hospice care for terminal illness. All of these situations will raise questions regarding the program's scope of care and range of services offered, how much you can effectively provide versus what other appropriate resources exist in the community, and where you want your program to go in the future. As discussed earlier, clear policies and admission criteria are essential, especially when the number of people needing care exceeds available space. Clear guidelines for defining the acuity of health problems that can be adequately cared for are also essential, both to avoid admitting people who need more intensive care than you can provide, and to avoid filling up valuable beds with people who are not as sick as others awaiting care.

***Safe discharge from respite care*** Once respite clients are ready to be discharged, additional questions may arise related to the availability of transitional or permanent housing. A safe discharge from respite care entails follow-up services, which may or may not be available in

your community. Discharging someone back to life on the streets, which may have been the source of the health problem requiring medical respite care, is clearly not an attractive option. But it is sometimes the only option. Your organization may find itself in the position of having to advocate for these needed community services, using your respite services data as evidence.

***Finances*** Two final internal issues deal with finances. The first issue is the obvious challenge of simply maintaining sufficient funding to keep the program going. Secondly, programs that depend on Medicaid reimbursements may have additional difficulty in states where Medicaid is operated through managed care organizations (MCOs). Dealing with the administrative, clinical and fiscal requirements of an MCO is not a particularly welcome challenge to most non-profit health care organizations that have decided to provide respite services for homeless people, many of whom have been abandoned by the mainstream health care system. New skills are needed by both administrative and clinical staff to successfully navigate the MCO waters.

### External pressures

***Health needs of homeless population*** In general, any approach to respite care will need to contend with the changing needs of homeless people resulting from changing trends in population characteristics and health problems. For example, as more homeless people with hepatitis C infection are identified, respite programs may have to shift their focus to accommodate patients going through treatment or to provide care for those who are not receiving treatment.

***Health care delivery system*** Continued changes in the health care environment affect respite programs as hospitals and health systems merge or downsize and lengths of stay continue to decrease in response to cost-cutting initiatives. As the range of health care services provided in the home increases, medical respite services become more intensive, since the respite program is the place where homeless patients receive “homecare.” All these events challenge and pressure respite programs to expand their scope of care and capacity to provide it, even when there is insufficient funding to do so.

***Community resistance*** Respite programs planning to occupy a freestanding facility will sometimes meet with resistance from adjacent neighborhoods, and sufficient time must be devoted to creating community acceptance of the program. Including representatives of neighborhood associations or other community members in both the planning process and the program’s governing body may help to reduce resistance. Once established, the respite program should continue to nurture relationships with neighborhood communities and be available to listen to and address concerns that are brought to the table.

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*Turf issues with other service providers* Respite program staff must tread lightly as they “trespass” in territory traditionally belonging to other organizations. For example, shelter staff may feel resentful or defensive if respite program staff—whether from the shelter itself or from another agency—project an attitude of taking over or having superior expertise. Many long-time shelter staff may feel that they have been caring for their guests for years—often without the help they needed from health care providers—and the “new kids on the block” need to respect that.

## **CONCLUSION**

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In all organizations serving homeless people, advocacy becomes an essential part of almost everyone's job description. This is true both in the development stages and in the ongoing operations of medical respite programs. There are licensing and zoning regulations to deal with that may need to be challenged. As mentioned earlier, advocacy in the neighborhood where the program will be sited is a necessary step toward gaining community support. Advocacy regarding the discharge policies of hospitals is an ongoing challenge, not only to prevent discharge of homeless patients to the streets and into other systems, but also to prevent the event that may precipitate homelessness in the life of someone previously housed. Advocating for adequate, affordable housing helps to prevent homelessness, while also creating options for people who are being discharged from medical respite programs.

And until such time as universal health care becomes a reality in this country, organizations providing medical respite care will need to continue advocating for changes in Medicaid and managed care systems so that homeless people are more fairly and justly served. As advocates and caregivers developing medical respite programs for homeless people, we must realize that these are ultimately insufficient, interim measures, and we must continue working for the day when everyone has access to appropriate, affordable health care and a home in which to get well. That will be the day when medical respite programs for homeless people are no longer needed.

**APPENDIX A**

Patient Treatment Agreement – Barbara M. McInnis House, Boston MA

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**Generic Treatment Contract for Substance Misuse and Behavior**  
**Date**

I understand that in order to stay at the Respite Program, I agree to comply with all of the following:

1. I will respect all of the staff members who work here.
2. I will cooperate with my plan of care developed by my team.
3. **I will not seek, use or deal in drugs** while I am at the Respite Program.
4. **I will cooperate with random urine tox screens.**
5. I will not go to any off site appointments while I am a patient at the Respite Program.
6. If I do not follow and cooperate with the plan for my care, I may be discharged.

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Patient

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Provider

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Case Manager

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Nurse

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Director

## APPENDIX B

### Conditions & Guidelines for Patients – Barbara M. McInnis House, Boston MA

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#### Conditions & Guidelines for Patients

Welcome to the Barbara M. McInnis House, the in-patient program of the Jean Yawkey Place! This is a brief summary of the conditions for admission to McInnis House Clinic. These conditions help us to have a community of care and respect among our patients and staff. We have established the following guidelines with the goal of making the McInnis House a safe and dignified environment for you to receive medical and nursing care. Thank you for your cooperation. If you have special needs or requests, please ask a member of your team of caregivers. All patients have the right to be treated with respect and dignity by the staff and by the other patients.

1. **Staying in at Barbara McInnis House:** In order to meet with your nurse, your health care provider and your case manager, and to receive medical care, you are required to remain in the building. **You are not allowed to leave the facility except for scheduled medical and other appointments.**
2. **Admission:** Upon admission, we ask you to shower and put on clean clothes. Please continue to care for yourself in this way throughout your stay.
3. Please **dress appropriately** by wearing street clothes rather than pajamas or johnnies while on the floor. Also, we do not permit sunbathing or tanning on the premises.
4. For the health of yourself and others, please **do not share food**, razors, and articles of clothing with other patients.
5. **Alcohol and Drugs:** Alcohol and illegal drugs interfere with both your medical recovery and the safety of the building. Any use or possession of alcohol, drugs or drug paraphernalia violates the conditions of your stay and can cause your immediate discharge. If you do use drugs or alcohol, the medical director may decide that future admissions may not be possible. If we suspect that you have been drinking alcohol or using drugs, we will request a urine sample or other test to check for substances. If you refuse, or your test is positive for substances, you will be discharged.
6. **Violence: To maintain a community of care and respect, violence, threats, inciting others, verbal, sexual, ethnic or racial harassment, and crude language will not be tolerated.** These behaviors may be considered reason for immediate discharge. NO weapons are allowed in the building. If found, they will be confiscated and you may be discharged.
7. **You may be discharged immediately if you violate the safety or security of the McInnis House. This includes, but is not limited to threatening harm, actual violence, remarks of a sexual nature, harassment of others, racial or ethnic slurs, and inciting others.**
8. **Medical Recovery:** Altering your medical recovery plan could lead to serious physical consequences. We ask that all patients take their medications only as prescribed and keep all medical appointments. Please make sure to be ready 2 hours before your appointment time.
9. **Prescriptions:** If prescriptions are given to you when you are out on a medical appointment, you must give these prescriptions to your nurse or provider as soon as you return to the McInnis House. You must turn in all medications, sample medications and prescriptions to the nursing staff or your provider. We will only administer medications to you if they have been prescribed by our staff and packaged by our pharmacy. Your provider will work with your specialist and or primary care provider, but will not always prescribe all medications they recommend. Controlled substances (such as Percocet, Valium, Klonopin, etc.) and prescriptions for these types of medications that you bring to the facility will be destroyed. We will hold other non-narcotic medications (such as blood pressure pills, etc.) in storage until your discharge. You will be

## Medical Respite Services for Homeless People: Practical Planning

*discharged with prescriptions for appropriate medications. We can provide you with written documentation that controlled substances have been destroyed.*

10. Pain medicines, which are ordered on a PRN basis, can not be given earlier than ordered so please do not ask the nurse for the medication early.
11. **Smoking:** *For the health, safety and comfort of patients and staff, cigarette smoking is only allowed during free time in the outside patio area (from 6:00 a.m.-8 a.m. and 10:45 a.m. – 10 p.m.). Smoking anywhere else inside the facility, especially bedrooms and bathrooms, is prohibited.*
12. **Food:** **Please consume all food in the dining room. There is to be No Eating in the Dave Walker lobby. You are not allowed to order food from outside. Please do not ask kitchen staff to wrap food for you. You may not bring your meals or snacks from the vending machine upstairs. Do not ask nurses or aides to refrigerate or reheat food for you. Food is not allowed upstairs on the floors!**
13. **We do not provide soda as a beverage. We have soda machines available downstairs in the lobby.**
14. **Searches:** *To insure the safety and security of all, we will search you and your belongings upon admission, on your discharge and on your return from appointments. Also, we periodically will conduct **room searches**. You are allowed to be present during searches if you wish. We also reserve the right to search visitors for things that they bring in for you.*
15. **Storage and Valuables: You are responsible for your personal belongings.** *We discourage patients from borrowing or lending money or personal items. We will not be held responsible for any items lost. We provide a safe for patient's valuables such as cash, checks, jewelry, food stamps, cell phones and beepers. **Valuables may be deposited or withdrawn between 10:45 to 11:30 a.m. Monday through Friday.** See the Manager of Clinical Support Services located on the second floor in the director's office. Cell phones are permitted but the use is limited to the second floor, in the smoking area and in the atrium. Cell phones must be turned off while patients are standing in line for medications cell phones are not to be used on the patient floors, patient bedrooms where other patients might be sleeping or resting and having quiet time, cannot be used in the clinics and other areas where patients receive care. Cell phones may not be used in patient bedrooms and you will be asked to turn yours in for safekeeping and it will be locked in the Patient Valuables Safe until you are discharged. If you are admitted on a weekend or evening, these items will be locked up for you by the nursing staff. We are not able to accommodate parking for a vehicle in the Jean Yawkey Place.*
16. **Quiet time:** *To ensure your recovery, you are encouraged to be quiet and respectful when other patients are sleeping. Please use headphones while watching your television or listening to a radio or other personal device. Between 8:00 a.m. and 10:45 p.m. you are asked to stay on your floor to be ready to receive medications and to be seen by your provider (nurse practitioner).*
17. **Laundry:** *On admission you will be given two towels and a face cloth. Please wash these with your other laundry and keep them with you until you leave. Please wash your clothes in the laundry room on the second floor. The laundry room is closed from 8:00 a.m. – 10:45 a.m. Monday through Sunday. You may wash your clothes daily from 6:30 a.m. – 8:00 a.m. and from 10:45 a.m. – 8:30 p.m. Your last load of clothes must be in the washer by 7:40 p.m. Make sure your clothes are out of the dryer by 8:30 p.m. so that they are not locked in the laundry overnight.*
18. **Clothing:** *We rely on donations for clothing and have a very limited supply. Therefore, it is very difficult to provide you with specific items. After a patient is admitted, a respite aide will assess the patient's clothing, shoes and storage needs in his/her room and at that time they will provide the patient with a BMH admission kit which includes, toiletries, socks, 2 towels and 2 wash cloths. This Admission kit will also include an informative Cheat sheet referring to patient's services provided at the BMH.*

## Medical Respite Services for Homeless People: Practical Planning

*If any clothing is needed, a clothing form will be filled out and clothing will be distributed as available. The respite aide is responsible for distributing clothes. It is the patient's responsibility to keep their own clothes clean. Do not ask for more clothes or specific colors, styles, etc. If your clothes do not fit, please report to the respite aide and every effort will be made to locate proper fitting items. However, we cannot guarantee that we will be able to as we rely on donations. Please do not give your clothes to others or share clothes.*

- 19. Other belongings:** *We realize that you may have many of your belongings with you when you come to the McInnis House. However, we have **NO storage space here**. Please, limit belongings to two bags only at all times. If you leave or are discharged, you must take your belongings with you. After 72 hours any personal belongings left on the premises after you leave will be recycled or thrown away. We will obviously make exceptions to this rule if we transfer you to a hospital. Valuables and documents which are already stored in the valuables safe will be kept for up to three months. If your personal laundry is damaged in the house washers or dryers, you will be offered a selection of replacement clothing or we will try to replace it with clothing from donor programs, such as Goodwill.*
- 20. Visits:** *Visiting hours are from 1:00 p.m. to 4:00 p.m. on a daily basis. Please allow no more than ½ hour per visit and limit yourself to two visitors at a time. Visitors must remain in the Dave Walker lobby area. Visitors are not allowed to smoke while they are visiting you.*
- 21. Room to room visits and floor to floor visits are not allowed.** *McInnis House Clinic is not responsible for any missing items or belongings. Patients are allowed only on their assigned floors.*
- 22. Fire Alarm or other Emergency:** *In the event of a fire alarm or other mishap, please follow staff's instructions. If you are on the 3rd or 4th floor, report directly to your room. If you are on the 2nd floor, go to the Dave Walker Lobby and follow the instructions of the security guard or staff member in charge.*
- 23. Confidentiality:** *You have the right to confidential care. We will release no information to an outside agency without your consent unless an emergency exists. Similarly, please respect other patients' confidentiality. Disclosure of another person's presence, care or treatment to anyone else inside or outside our facility is considered to be a breach of trust and confidentiality. Some patients' safety depends on others not knowing of their presence here.*
- 24. We do not allow sexual activity.**
- 25. Please be ready** and take responsibility to be available for medications, treatments, appointments, etc. **Be ready for appointments at least TWO hours in advance.** *You will be seen by your medical provider only once a day. Please keep lists of questions you would like to ask your provider for the next day.*
- 26. Television:** *Each patient has a personal television at their bedside. You are given a set of earphones to listen to the sound on the television. You may not use a boom box or other personal radio unless you use earphones. There is also a large screen television in the Patient Activity Room on the second floor. This television is used for group movies, sports events or scheduled videos by volunteers.*
- 27. Please clean up** after yourself in the dining room area, in your room, and in the common areas.
- 28. Telephone:** *The pay phone is available from 9:00 a.m. – 10:00 p.m. Please respect a five minute limit so that other patients can reach their friends and family members.*  
**The 2nd floor pay phone numbers are: 617 266-2757 and 617 266-2918**  
**The 3rd floor pay phone numbers are: 617 236-1508 and 617 266-0873**  
**The 4th floor pay phone numbers are: 617 236-1528 and 617 262-0179**
- 29. Transportation:** *We provide transportation to medical appointments and other appointments approved by your team. Please let us know at least 24 hours in advance of any medical appointments that you have scheduled. Our staff will also schedule appointments with other health care providers for you. The staff will*

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give you paperwork or referral information to bring to your appointment. When you return to the McInnis House you must immediately deliver paperwork that is given to you at your appointment to the secretary and return any correspondence that you are given. Court appearances and interviews at a placement site must be coordinated with the case manager **with at least 24 hours notice and must be approved by your team.**

**Please remember that you must wear a seat belt when you are transported in McInnis House transportation.**

**As soon as your appointment is completed, call back to the McInnis House Clinic to notify us that you are ready for pick-up. Patients are not allowed to run errands etc. after appointments. You must return to McInnis House Clinic immediately, using our transportation by calling your floor secretary:  
3rd floor (857) 654-1706, 4th floor (857) 654-1708**

*Conditions and guidelines for patients' acknowledgement form*

**I understand the conditions and guidelines I have received. By signing below I accept and agree to follow these conditions of admission to the Barbara M. McInnis House.**

\_\_\_\_\_

Patient

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_

Witness

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Barbara M. McInnis House  
Jean Yawkey Place  
Boston Health Care for the Homeless Program  
780 Albany Street,  
Boston MA 02118  
Telephone: 857 654-1706

## **APPENDIX C**

### **Additional Resources**

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For more information on planning programs for homeless people, see *Organizing Health Services for Homeless People: A Practical Guide* by Marsha McMurray-Avila, available from the National Health Care for the Homeless Council, (615) 226-2292.

For assistance with licensing/regulations, contact your state department of health, your city or county department of health and your city government's office that handles zoning issues.

For medical respite resources including program profiles and examples of program policies and tools, visit the Respite Care Providers' Network website at [www.nhchc.org/Respite/](http://www.nhchc.org/Respite/).

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25. The SSI/SSDI, Outreach, Access, and Recovery (SOAR) program provides training for case managers to increase access to Social Security disability benefits for their clients. For more information visit <http://www.prainc.com/SOAR/default.asp>
26. The reauthorization of the HUD McKinney- Vento Homeless Assistance programs on May 20, 2009 designated 30% of funding for permanent housing for individuals with a disabling condition.
27. See article in August 1999 issue of *Healing Hands*, on "Making Interdisciplinary Teams Work," available on the National Health Care for the Homeless Council website [http://www.nhchc.org/Network/HealingHands/1999/hh.08\\_99.pdf](http://www.nhchc.org/Network/HealingHands/1999/hh.08_99.pdf).

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The Respite Care Providers' Network is operated by the National Health Care for the Homeless Council under a cooperative agreement with the Health Resources & Services Administration.