

HEALING HANDS



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Medical Respite Care: An Integral Part of the Homeless Care Continuum

There is ample evidence that homeless people experience higher rates of serious health problems than do people with stable housing, that they have more limited access to appropriate health services, that they tend to use the costliest services to meet their healthcare needs, and that they are frequently unable to adhere to treatment even when they are able to access health services (Bonin et al. 2004). Mainstream healthcare delivery systems have struggled to adapt to this population's many complex needs, but their efforts are complicated by increases in outpatient procedures and decreases in the length of hospital stays. These practices assume that discharged patients have a home and sufficient support from family members or friends for basic care. For patients without these supports, early hospital discharge can increase health risks and even be traumatic. Lack of a safe place to rest, adequate hygiene, nutritious food, clean water, secure storage for medications or assistance with dressing changes impedes ability to comply with common discharge instructions.

Increasingly, homeless individuals who are discharged from hospitals when they are not sick enough to justify continuing inpatient care have inadequate alternatives for recuperation. Emergency homeless shelters are seeing steady increases in the number of individuals entering directly from hospitals, often with health problems they are ill equipped to address. Recent incidents in Los Angeles drew attention to an extreme consequence of this service gap. In February, a homeless man wearing a hospital gown and colostomy bag was witnessed being dropped off by a hospital van onto the streets of Skid Row.

WHAT IS MEDICAL RESPITE CARE? Medical respite care for homeless individuals is one response to this service gap. For the purposes of this discussion, medical respite is defined as *acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury while living on the streets, but are not ill enough to be in a hospital.* The box on this page describes defining characteristics of medical respite care, developed by a group of respite providers across the country.

A GROWING PHENOMENON Although medical respite services have been provided formally in the U.S. since the mid-1980s by programs in Washington DC and Boston, the last decade has seen a surge in the number of respite programs attempting to address a growing

DEFINING CHARACTERISTICS OF RESPITE CARE

- A short term specialized program **focused on homeless persons who have a medical injury/illness** and may also have mental illness or substance abuse issues
- Comprehensive residential care providing residents the opportunity to rest while enabling **access to hospitality, medical and supportive services** that assist in completing their recuperation
- **Length of stay restricted** to the period of time required to complete medical recovery and to access community services
- **Whole person care** through collaboration with other local providers who offer a variety of services to residents during their stay in respite care and also provide continuity of care when the resident moves into the community
- **Respect** for human dignity of all residents and staff
- Active **participation by residents** in the process of their recuperation and discharge planning
- A **bridge that closes the gap** between acute medical services currently provided in hospitals/emergency rooms, homeless shelters that do not have the capacity to provide needed recuperative care, and more permanent housing options
- **Low cost**, high quality and innovative recuperative services which result in significant savings to communities
- **Various service delivery models** incorporating the basic characteristics of a respite care program developed to meet the needs of local homeless populations and resources available in local communities
- **An integral component of the continuum of care for homeless services in any community**

Respite Care Providers' Network, 2000

need for these services. The map on page 2 pinpoints the locations of 41 known respite programs; several more are under development. A national group of respite providers started convening annually in 2000 and has developed into the Respite Care Providers' Network (RCPN), a standing committee of the National Health Care for the Homeless Council. (See more on the RCPN in the Respite Resources on page 5). In 2000, the Health Resources and Services Administration funded 10 HCH grantees to participate in a Respite Pilot Initiative to assess respite program characteristics and the impact of this care on the patients served in these programs.

MODELS OF RESPITE CARE Medical respite programs and the services they develop are diverse, varying in response to geography, community needs and resources. They also reflect creative collaborations with community partners. Many HCH programs, for example, collaborate with homeless shelters, motels, or hotels to provide beds for homeless clients and allow clinicians to tend to them. Others collaborate with treatment facilities, nursing homes, or assisted living facilities to provide not only beds, but meals and medical services. A handful of free-standing facilities offer medical respite care, including those first developed in the mid-1980s, but these services are most costly to provide. While most respite programs are able to accommodate families, few are explicitly designed to do so.

BENEFITS OF RESPITE CARE Evidence of myriad benefits associated with medical respite is building, from both experience in the field and a growing body of research (Buchanan et al. 2003 & 2006, Gundlapalli et al. 2005, Kertesz et al. 2006). Following is a brief summary of the two most frequently mentioned benefits of this service:

Respite care improves quality of life. The evaluation of the Respite Pilot Initiative mentioned above demonstrated that many respite clients arrive with multiple, severe and complex health needs, as well as psychosocial needs. Some of these needs only emerge after a client has been admitted to respite care. Respite coordinators speculate that the combination of being vulnerable and resting in a safe environment



leads some clients to meet needs they may not otherwise have been prepared or able to address.

Renee Krueger, MPH, Program Director of Interfaith House in Chicago, says clients come into her respite facility “broken in a lot of ways — physically, emotionally, and spiritually. Respite offers an opportunity to heal the whole person.” In addition to resolving medical problems diagnosed on admission, respite staff educate clients about managing chronic illness and link them with primary health care to improve their health over the long-term. Many respite programs also succeed in helping clients access income benefits, treatment for mental health or substance use disorders, and even housing by the end of their stay.

Respite care prevents unnecessary, costly hospitalizations. Cost-savings have been the focus of respite research from Boston and Chicago. Researchers compared homeless patients who received respite care following hospital discharge with patients with similar diagnoses denied access to respite care due to a lack of beds. The group that received respite care averaged five fewer inpatient days and a 36 percent reduction in emergency room visits during the year following their respite stay (Buchanan et al. 2006). These data helped HCH administrators in Austin, Texas, project savings for local hospitals that would result from their proposed 32-bed respite program. They calculated their program’s capacity to be 834 admissions per year, averaging 14 days per admission. This provided the basis for the net savings projections of \$2,053,400 if their program reduced three inpatient days per respite admission, and \$4,889,000 for five inpatient days.

EXAMPLES OF RESPITE PROGRAMS The following examples illustrate how some communities are responding to the needs of homeless people who need a safe place to heal. These programs were selected for their geographic diversity and for their varying stages of development. Each of these respite providers was asked to offer advice to communities in the early stages of developing respite care.

Two strong and interrelated themes emerge from this diverse sample of respite programs: the need for *awareness* of what resources are already available for homeless persons in their communities, and *flexibility*. All of these programs are expert at conforming to their community’s ever-changing resources and needs.



Kevin O'Hagan of Chicago Prosthetics assists a client from Interfaith House. Mr. O'Hagan volunteered his time and donated parts to make this basic prosthetic.

Even established respite programs are constantly changing.

INTERFAITH HOUSE, CHICAGO, IL, was a pioneer in medical respite care when it was established in 1994, but this 64-bed freestanding facility remains responsive to its homeless population by changing with the ebb and flow of community resources. In its first year it served close to 1,000 homeless clients. As housing options in Chicago have changed and as the program began to provide additional social and supportive services, the length of stay increased to a 90-day average (median of 60 days) and the annual number of clients served approached 300. In addition to supporting clients during their medical recovery, a major goal of the program is to place clients in appropriate stable housing. Over the past two years, Interfaith House has more than doubled the number of clients placed in permanent housing.

Network, Network, Network. Renee Krueger, who has worked at Interfaith House for 8.5 years (as Program Director for the last year and a half), has experienced these changes firsthand. Her advice to those interested in developing and maintaining a responsive respite program in their community is to be involved in collaboratives that work on issues related to homelessness and health care, and to stay active in networking with other homeless service providers: “Make sure you know what’s being provided, and be on the lookout for opportunities to develop partnerships.”

PARTNERSHIP HEALTH CENTER (PHC), MISSOULA, MT This small respite program has also responded to ever-changing resources in over 5 years of providing care. **Mary Jane Nealon, RN**, Director of Ancillary Services at PHC, a community health center with a Health Care for the Homeless component, describes some of the unique features of homelessness in Montana. A large proportion of people experiencing homelessness are working poor and transient, moving between cities via bus and train. Because Missoula is in an inversion valley, air quality during fire season can be bad (lung cancer rates are very high), and indoor options for homeless persons are scarce. A hospice/respite house for homeless persons closed for financial reasons just before Ms. Nealon arrived 5 years ago. PHC’s collaboration with the one local shelter is currently the only source of respite care for this city of over 100,000 people. In addition to one bed reserved solely for medical respite, the shelter provides as-needed access to 4–5 beds in a “sick room.”

Case Manager **Erica Tribble, MSW**, says some of the challenges for this collaboration include the shelter’s sobriety requirement (passing a breathalyzer test at the door), and its “30-day in/30-day out” policy, which imposes a maximum 30-day stay followed by a minimum 30-day absence. The shelter will also ban clients permanently for behavioral reasons. Hope is on the horizon, however, as a veterans’ 18-bed/apartment facility opened recently, and the city is discussing assuming management of the local shelter.

Use the Beds You Have. Ms. Tribble and Ms. Nealon hope to advocate for medical respite as a key component of the city’s new shelter facility. Their advice to newly developing respite programs is to identify what beds and services are already available in the community and strive for all beds to be made available 24/7. “Having a peaceful place to sleep is really important to people.”



A respite client at Interfaith House receives assistance from a mobile van

New programs establish networks and build support.

COMMUNITY MEDICAL RESPITE PROGRAM, RALEIGH, NC Housed in the Raleigh Rescue Mission homeless shelter, this program served its first respite client in March 2006. Eight beds for women are available at the Mission, and 8–10 beds are available for men in several locations, including shelters, a treatment facility with apartments, and a Catholic worker home. This respite program began when **Dr. Jim Hartye**, a physician at the HCH clinic, arranged for key stakeholders to meet face-to-face: heads of discharge planning and mental health/substance abuse services at local hospitals, directors of the homeless health clinic, and representatives of shelters and other facilities with available beds.

Brooks Ann McKinney, MSW, Medical Respite Coordinator, now facilitates monthly or bimonthly meetings of this advisory group, and says the involvement of these administrators is key to the respite program’s capacity to respond to patient needs. A mental health hospital in this community is currently being downsized and will eventually move to another city. This poses their latest challenge as they work with hospital administrators and other advisory group members to meet homeless peoples’ need for respite beds.

Listen to Clients. Ms. McKinney has noticed that just spending time with women waiting for emergency beds at the Mission has raised her awareness of the urgent need for respite care. For example, she recently found an elderly woman with edema who would have greatly benefited from being able to put her feet up, and another woman with a broken

wrist who had torn off her cast before it was healed. “Really listen to your clients, and focus your program on meeting both individual and community needs,” she urges.

Developing a respite program: looking for funding and overcoming barriers.

THE OASIS PROJECT, BANGOR, ME Though not yet officially begun, this brand new respite program already boasts successes that remain elusive for even established programs: financial support from local hospitals and a bill in the state legislature requesting Medicaid (MaineCare) reimbursement for homeless respite care. **Mary Jude, FNP-C, PA, MSN, MPH**, the Chief Research and Development Officer at the Penobscot Community Health Center in Bangor, spoke about the development of the Oasis Project.

Identify the Need. Ms. Jude sees a growing need for respite care in her community’s homeless population. Bangor’s two hospitals were discharging clients to the street or a local shelter, where they were allowed to sit in a common room with metal chairs. She allowed clients to lie on the floor of her exam room because they had no other place to rest and recover. One woman showed up at the clinic with her suitcase because the shelter was full. Congestive heart failure would have prevented her from climbing the flight of stairs to the shelter bed.

Find Mentors. Ms. Jude took advantage of her long history and strong network in the community, and started forging a broad base of interest and support. “Get really specific with anyone who will listen,” she advises. “Remind them of the last time they had a cold or flu to make the issue personal and relevant.” She found a strong ally in Executive Medical Director, **Dr. Bob Allen**, in educating the community about homeless respite. She and Dr. Allen visited the nearest respite program in Portland, ME, and then the much larger, well-established McInnis House in Boston. These interactions with experienced colleagues in the field convinced her that “you need a mentor.” Ms. Jude and her colleagues decided that the nursing home model employed in Portland would be a good place to start and found a local facility interested in collaborating. They hope someday to have a facility physically connected to the HCH program.

Seek Support from Hospitals. Ms. Jude emphasizes the need to “do your homework” before approaching hospital administrators; know their costs and their frustrations. She identified some of her clients for whom a gap in the continuity of care had resulted in negative outcomes and used them as case examples. She asked one such client to sign a release form and learned the hospital had spent over \$50,000 on this patient. Most of this cost could have been avoided, had a respite program been in place.

Ms. Jude and colleagues were able to point out the various ways hospitals could benefit from supporting their respite program: A safe discharge alternative prevents longer stays than necessary; clients visit hospitals with issues that could have been prevented. Her colleague Dr. Allen was instrumental in communicating these benefits directly to hospital administrators. “We played on what their needs were.” They also argued the importance of the hospital’s role in the community to

help address increasing homelessness. Convincing hospital administrators is difficult and time-consuming, warns Ms. Jude; the key to success is to “bite into it like a terrier and don’t let go.” In the end, the Oasis Project negotiated a stipend of \$2500 per respite client from the hospitals.

A CLIENT’S PERSPECTIVE Doreen Johnson spent 15 of her 42 years battling a drug addiction, but only headed back to Chicago, her childhood home, when she became homeless and decided to seek help. After a year on the streets and a suicide attempt, she spent 3 months in a Chicago inpatient drug treatment program. But her health complications from years on drugs, including a heart attack and strokes, overwhelmed program staff. (“They couldn’t handle the medical side of things.”)

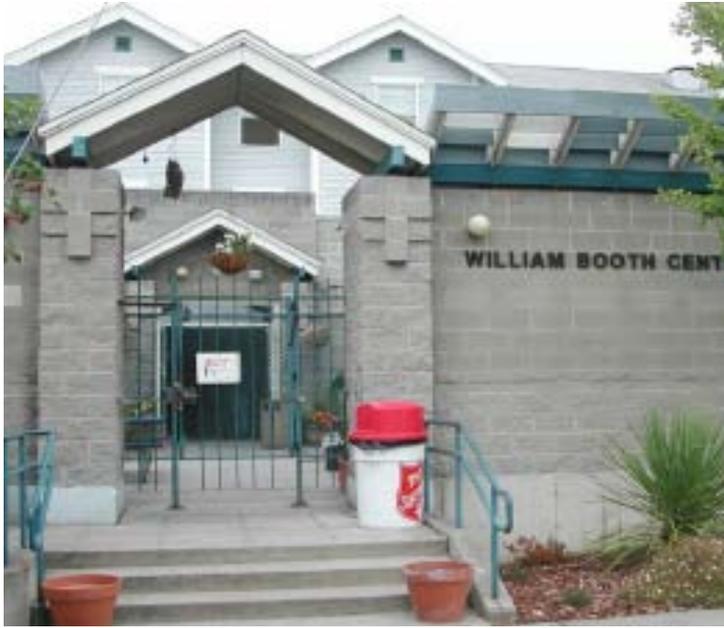
She was referred to Interfaith House, a medical respite facility for homeless persons. Ms. Johnson still recalls her first day there, noting how welcome she felt among staff and clients and how wonderful it felt just to be allowed to rest, undisturbed. She cannot say enough about the excellent doctors and other staff, the host of support groups, “awesome” food, cleanliness of the facility, the birthday celebrations, and how important Interfaith House was in helping her to heal.

Less than four months later, Ms. Johnson is registered for college and packed for a move to her own SRO apartment. Her respite stay, she says, was “like a door opening, a pathway to freedom.” While acknowledging the amount of hard work she put into her recovery, she credits the respite staff with supporting and motivating her to achieve change in her life. Although she had made up her mind to make changes, it was respite which “truly gave me an opportunity to do some healing.”



A Seattle respite client with a skin infection

“Respite has been a Godsend for me.”



William Booth Center — a Salvation Army shelter with 17 respite beds for men in Seattle, Washington



Respite nurse near patient beds and lockers at William Booth Center



Interfaith House, a 64-bed respite care center for homeless men and women in Chicago, Illinois

RESOURCES ON MEDICAL RESPITE CARE

The Respite Care Providers' Network (RCPN) is a national group of clinicians and administrators interested in medical respite care for homeless persons. **Its mission: to improve the health status of individuals who are homeless by supporting programs that provide medical respite and related services.**

RCPN supports the development of new and existing medical respite programs through education, advocacy, networking and research. RCPN maintains a regularly updated web page on the National Health Care for the Homeless Council website:

<http://www.nhchc.org/respitecareprovidersnetwork.html>

Here you will find:

- Descriptions of respite programs across the country
- Contact information for respite care providers
- Research and evaluation findings on respite
- Sample policies and forms for respite program planning
- Resources to help you advocate for respite in your community, including presentations geared for hospital administrators
- A Respite Case Report
- This issue of the *Healing Hands* newsletter
- Information on joining the Respite Care Providers' Network
- Respite Pre-Conference Institute and respite-related workshops associated with the HCH Conference June 13-17, 2007 (for more information, see <http://bphc.hrsa.gov/hchirc/conference/default.htm>)

Coming Soon (June 2007):

- A Respite Brochure for individual programs to download and print, and/or to customize for their needs
- Respite Program Directory 2007-2008 (downloadable free from the web page)
- Findings from a National Respite Data Collection project
- A national Respite Policy statement developed by the RCPN and the National Health Care for the Homeless Council

BIBLIOGRAPHY

1. Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2004. <http://www.nhchc.org/practiceadaptations.html>
2. Buchanan D, Doblin B, Sai T, Garcia P. The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health*, July 2006, 96(7), 1278–1281. (research abstract) <http://www.nhchc.org/Respite/TheEffectsofRespiteCareforHomelessPatients.doc>
3. Buchanan D. Respite care research update. Presentation, National Health Care for the Homeless Conference, June 2006. <http://www.nhchc.org/Respite/RespiteResearchUpdate0606.ppt>
4. Buchanan D, Doblin B, Garcia P. Respite care for homeless people reduces future hospitalizations. *Journal of General Internal Medicine*, April 2003, 18(S1), 203. (research abstract) <http://www.nhchc.org/RespiteCareOutcomes.doc>
5. Donovan R, Dee D, Thompson L, Post P, Zerger S. Medical respite care for people without stable housing. *Homeless Health Care Case Report: Sharing Practice-Based Experience*, 2(3). HCH Clinicians' Network, February 2007. <http://www.nhchc.org/Clinicians/CaseReportRespiteCare.pdf>
6. Goetcheus J, Gleason M, Sarson D, Bennet T and Wolfe PB. Convalescence for those without a home: Developing respite services in protected environments. In Brickner PW et al (Eds.), *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: WW Norton, 1990, 169–183.
7. Gundlapalli A, Hanks M, Stevens SM, Geroso, A M, Viavant CR, McCall Y, Lang P, Bovos M, Branscomb NT, Ainsworth AD. It takes a village: A multidisciplinary model for the acute illness aftercare of individuals experiencing homelessness; *Journal of Health Care for the Poor and Underserved*, May 2005:16(2), 257–272.
8. Hearne K (Ed.). (September 2005). Respite Care for Homeless Persons: Descriptions of Respite Care Programs in the US and Canada. Ordering information at: <http://www.nhchc.org/publications.html#respiteprograms>
9. Kertesz SG, Posner MA, O'Connell JJ, Compton A, Swain S, Schwartz M, Ash A. Hospital discharge to a homeless medical respite program prevents readmission. University of Alabama at Birmingham, Boston University/Boston Medical Center, Boston Health Care for the Homeless Program, 2001–2003 [as cited in Buchanan D, June 2006]. <http://www.nhchc.org/Respite/RespiteResearchUpdate0606.ppt>
10. McMurray-Avila M. *Medical Respite Services for Homeless People: Practical Models*. National Health Care for the Homeless Council, December 1999. 37 pages. <http://www.nhchc.org/Publications/MedicalRespiteServices.pdf>
11. Zerger S. *An Evaluation of the Respite Pilot Initiative*. National Health Care for the Homeless Council, March 2006. 113 pages. <http://www.nhchc.org/Research/RespiteRpt0306.pdf>

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