



Assessing the Needs of Women in Medical Respite Q&A

I want to know how we find out where a local respite may be available. I am an RN working at a clinic in Chicago, wanting to know if there is one close by. thank you.

Yes, The Boulevard in Chicago provides medical respite services. For more information about medical respite programs across the country please visit our national directory.

Are there structure activities during the day or residents can rest/in bed all day?

At the WMR in Springfield, we do not have structured activities. We encourage our clients to rest and recuperate. When they feel able, they are encouraged to access information about housing and other issues related to their long-term stability. They are encouraged to obtain a PCP while with us and we work with them to “make” this happen before their time is up with the WMR. Clients are encouraged to only maintain their living space (bed, etc.), do their personal laundry which is free; we provide all meals and maintenance of the apartment, so no chores. They are free to remain in bed as desired. We discourage shopping, because if one can go to the mall for 6 hours...they probably do not need respite beds. As the guest nears time to leave the WMR, they are given as much access to apartment hunting tools and set up of housing as needed. We feel being gone from the respite for more than 4 hours at a time should be discouraged, so ask that they call in if going to be out longer than 4 hours. We do have restrictions on leaving the respite from 9 p.m. - 7 a.m. specifically out of safety concerns.

At UCS, there are not regularly scheduled structured activities. And we also have similar guidelines as WMR. Home health or therapy may visit, and case management will assist in housing searches, etc.



How is funding sustained to keep the shelters open?

WMR response: Sustainability of shelter funding is our biggest problem. We are frequently writing grants for assistance. Because few of us are big fundraisers, we have had a few, but have only had 2 or 3 significant fundraisers in the past. Developing sustainable donors is a need that we have identified but are finding it hard to find.

UCS response: With great difficulty at times and little certainty from year to year. 40% of the direct costs are covered by local hospitals. Each's case management staff are fantastic and very supportive of the program. Insurance companies have placed little, sustained interest in supporting this endeavor. 60% of the expenses are covered through grants or private fundraising. Such an arrangement as it is right now not sustainable given that the financial burden is on a small nonprofit and not those who experience the financial benefits.

Can you send the desired definition of medical respite that was recited by Julia at the beginning?

Homelessness exacerbates health problems, complicates treatment, and disrupts the continuity of care. Challenges such as obtaining food, clothing and shelter or achieving or maintaining sobriety can compromise adherence to medications, physician instructions, and follow up appointments thus increasing the probability of future hospitalizations.

Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital.

Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows homeless individuals the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive/wrap around services.

MR care closes the gap between acute medical services provided in hospitals and clinics and the unstable environment of emergency shelter and the streets. It is an essential component of the continuum of homeless health care services



I am a new Community Health Worker at Mercy Hospital in Festus. We not only need respite services, but are in need of homeless shelters in our county. With limited space, how do you determine who can come to you for care? Do the case managers at the hospitals have a heads up of available beds? (sorry if this was answered already)

WMR response: Our definition of who can come was spelled out early with the help of NHCHC respite guidelines as outlined in their program directory and looking at what other agencies were requiring. Our admission requirements: homeless with no immediate safe and appropriate housing; having an acute medical illness which requires short term care; being psychiatrically and medically stable (that is hard to define!); being independent in activities of daily living; having medical needs that requires more than an emergency shelter bed for the night; being ambulatory or able to use an assistive device; being clean and sober.

Case workers from the hospitals in Springfield, MO, refer clients/guests to us. We also take referrals from outpatient surgery units, dialysis, One Door (which is a clearing house of social services to the area), other shelter populations (like Harmony House which is domestic violence shelter, and Safe to Sleep which is a 12 hour night shelter for women). We do not take self-referrals. If someone feels that they are not able to recover on the streets after having been turned away from the hospital, then we ask they go to One Door and let One Door make that referral.

At UCS, we also do not take self-referrals. We receive referrals hospital case management and relationships with some other outpatient services. I would hope all case management are aware of the medical respite. We have an intake process and guidelines. We also have similar admission requirements. See here: <http://www.unitedcaringservices.org/homeless-medical-respite/>



Do you reach out to the religious organizations in your communities to assist with funding opportunities? Would it be realistic to partner with local nursing homes to secure a bed or two for women experiencing homelessness to heal before returning to a shelter or other housing? I work for an Integrated Healthcare clinic that also has a healthcare for the homeless program and so we work with this population for medical and other services such as signing up for Medicaid SNAP behavioral health services, etc. But I think our community in Colorado still needs Respite services because we do have folks continually ending up in the ER or hospital due to chronic illnesses, injuries or conditions.

WMR response: Yes, we have some good support from religious organizations in our community. They have offered weekly meals, financial support, backpacks with hygiene products and blankets for “giving” to our clients, remodeling/painting of our old facility, etc. A local nursing home would be a great place to partner, but there might be some issues of cost. In our case we do not charge anyone for services and could not afford to pay for that fee with a nursing home. That is an issue that I feel we could look into, but we have not done so previously. From feedback that we have received from guests as well as community workers with the homeless population, the thing that draws attention to the WMR is that we allow dignity to build trusting relationships and healing. Once a guest has had time to recuperate, they are more willing and able to work with other case managers in coming to an awareness of their housing needs and assistance in obtaining medicaid, medicare, SSI, or other funds...even getting their name on the list for housing assistance is key. But it goes back to listening to their fears, their needs, and their understanding of the possibilities for them as individuals. It is my impression, that the staff plays a key role in helping the guests to find their own solutions in their own time of recovery. Yes, we utilize services of home health in addition to multiple other agencies providing services from mental health care, wound care, to free medical clinics, etc.

At UCS, we have several faith community partnerships providing financial and in-kind support for respite services. Carol’s response is right on for everything else as far as dignity and support provided that lines up well with a faith community mission to serve and that guests leading in finding their own solutions. As for the nursing home, we do make referrals out to places like assisted living so partnerships on that end of the spectrum exist. We have had some discussions on other types of relationships with skilled nursing for referral, but it is a matter of financial support for respite and positive outcomes for the guest to do what is in their best interest.



Question for Jason: I would like to know about how you obtained funding from providers. Who are these providers, and do you receive the funding?

At UCS we receive flat fee funding for a standing bed reservation from our local hospitals every year. If/when they utilize more than their reserved beds, then they pay a per diem rate. All other referrals pay a per diem rate. We accept entrance to respite via hospital referral. That per diem rate is prearranged based on the provider and their flat fee contract. Unfortunately, (most of) our provider funding comes out of providers' "community outreach or foundation" areas and that budget line is not directly tied to the impact of the program's impact. If only so much community outreach funding is designated, and providers certainly receive countless yearly requests for event/fundraising support, then the respite is really only seen as a sponsorship (limited in much the same fashion) and an integral part of the community's continuum of healthcare which it is -- providing unique services for vulnerable people. This has proven to be a large hurdle to leap. Still, our community is fortunate that local providers are willing to do anything. We homeless and respite advocates wish more could be done given that respite is often estimated to have at least a 700% ROI. The mere tens of thousands it 'costs' is more than immediately returned and the downstream costs of better health, dignity, housing, and hope -- which would otherwise be absent -- is worth the investment.