

## What would you do?

*You're a hospital social worker responsible for discharge planning. Your patient just had surgery for cancer, resulting in a large incision held together with staples. He has been instructed to rest and told how to care for the incision. The hospital protocol says he's ready to go home, but he has no home to go to. The local shelters are closed during the day, so he says he'll just stay on his normal park bench every day until the shelters open. It's winter and the daily temperatures are below freezing. What do you do?*

*You're pregnant and the doctor has just told you that you risk having a miscarriage unless you spend the next several weeks home in bed. But you have no home, no bed. The only women's shelter in town limits stays to three weeks, and is also not open during the daytime. You have another child who is two years old and still in diapers. You're afraid of losing your two-year-old to Child Protective Services if you can't take care of her. And you're afraid of losing the child in your womb if you can't take care of yourself. What do you do?*

*You're a physician in a Health Care for the Homeless clinic. You have just diagnosed a patient with severe frostbite. He is a 49-year-old Vietnam vet who has been living in a tent by the river for over a year. He has severe post-traumatic stress syndrome and refuses to stay in shelters because he says he's not treated with respect. He is unable to walk and needs a safe, warm place to stay day and night or he will lose his feet. What do you do?*

## Introduction

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 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 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 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 include 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 support. All of these elements are necessary for successful convalescence.

In addition to the cost-consciousness of today's health care environment, there is also an increased emphasis on tracking outcomes of care. It should be noted that lack of appropriate recuperative options for people without homes is likely to result in various negative outcomes.

- 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, ranging from difficulty following recommended medication schedules to inability to rest, eat appropriately and drink plenty of liquids.
- The patient's inability to adhere to the recommended treatment may then result in complications and emergencies, which in turn result in increased costs to the medical system.
- Patients and providers are both frustrated and dissatisfied when medical treatment seems ineffective, due to incomplete recuperation.

***It is an obvious understatement that medicine alone will not cure illness or heal wounds. The human body needs rest, proper nutrition and fluids in order to heal itself. Exposed to the elements on a sidewalk or under a bridge, without the strength to seek out food or water, or the ability to comfortably lie flat, a seriously ill person without a home is unlikely to heal easily. Even minor illnesses or health conditions are exacerbated by the harsh conditions of homelessness, resulting in frequent complications and longer periods of ill health. Therefore, even when homeless people with medical problems are identified, diagnosed and treated by [health care] providers... the care is not complete if convalescence is needed and the patient has nowhere to safely recuperate.<sup>19</sup>***

**Organizing Health Services  
for Homeless People:  
A Practical Guide**

*Successful outcome when working with homeless people depends on more than just accurate diagnosis and quality treatment. Frequently, success hinges on the client's ability to follow through with the recommended treatment.*<sup>20</sup>

**Balancing Act:  
Clinical Practices that  
Respond to the Needs  
of Homeless Persons**

On the positive side, successful outcomes that are likely to result from availability of appropriate recuperative options include:

- Successful resolution of acute conditions and stabilization of chronic conditions, leading to improved health and ability to function.
- Improved continuity of care.
- Decreased spread of communicable diseases to other homeless people.
- Successful linkages to additional needed services for respite clients, including substance abuse/mental health services and social services.
- Development of case management plans focused on positive long-term changes in respite clients' lives.
- Recuperation from not only physical illness, but also the emotional distress and isolation that accompany homelessness.

Although the term “respite” is commonly used to refer to providing a break for a caregiver of a disabled child or elderly adult, the term has taken on a new meaning over the last two decades for providers of health services to homeless people. In this context the term “respite care” has emerged to describe recuperative or convalescent services needed by homeless people with medical problems – in essence, providing sick or injured homeless people a respite from the dangers of life on the streets. In order to distinguish respite services from simply providing 24-hour shelter beds, the provision of medical services – with nursing as a minimum – must be emphasized as the defining factor.

This resource manual is designed for organizations and communities interested in developing such services. A framework of models and suggestions for program implementation are offered through the following sections:

- I. Medical respite care models**
- II. Intermediate approaches to respite care**
- III. Planning your program**
- IV. Daily operations**
- V. Costs and budgeting**
- VI. Sources of funding**
- VII. Making your case for funding**

## **Medical respite care models**

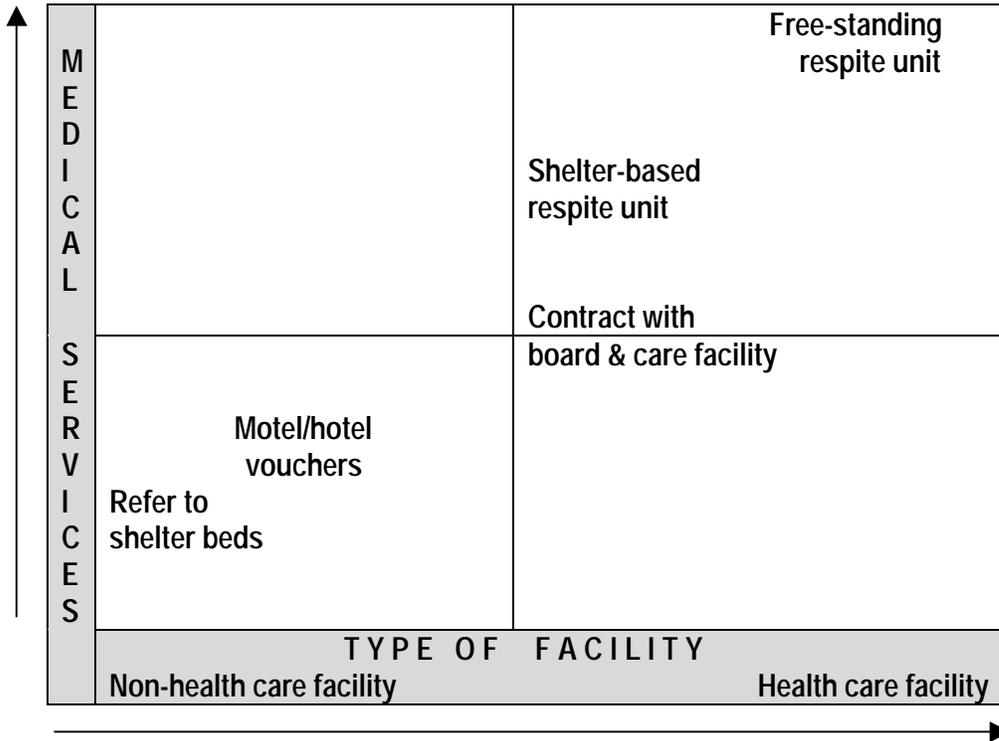
Concerned communities across the country have been developing a variety of innovative respite care solutions, ranging from collaborative models that share space and services to freestanding full-service medical respite units. There is no one model that works best for every community, given differences 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.

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

This is followed by a discussion of intermediate approaches that are being used to provide at least some minimal support in those communities where more fully developed medical respite services are not yet in place, due to funding or other limitations.

Models for medical respite services can be placed along a rough continuum of 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 the client characteristics, type of health condition and resources available. In a survey of 28 Health Care for the Homeless (HCH) projects during the spring of 1999,<sup>21</sup> 23 projects provided some type of respite services either directly, through collaborative arrangements, through contract or by referral. Of those 23, the majority had three or four arrangements in place. Several organizations were using more minimal approaches, while noting that they were working towards developing more comprehensive programs.

### ***Freestanding medical respite unit***

The ideal medical respite care model is the freestanding respite unit. In this model one organization, such as a homeless health care project, 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, discharges, and health and safety guidelines -- creates an opportunity to design a program best-suited to the needs of homeless patients. 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 mental health, substance abuse, case management, dental and other services can enhance the potential for full physical and emotional recovery and a return to housing.

Programs of this type are exemplified by McInnis House and Betty Snead House in Boston and Christ House in Washington, DC, (see Appendix for descriptions). These programs offer additional services on-site, ranging from substance abuse detox to dental care to case management. These are also the kinds of programs requiring the most administrative support, with policies and procedures clearly spelled out in all areas (see section below on daily operations).

Five of the 28 HCH projects surveyed in 1999 reported operating their own respite facility. Seven additional projects worked with respite facilities through collaborative agreements or contract. Ten projects reported the ability to refer clients to other existing respite facilities.

<b>ADVANTAGES:</b>	<ul style="list-style-type: none"><li>• More comprehensive services possible – medical and non-medical</li><li>• Respite program controls policies and procedures, including admissions and discharges</li><li>• Respite program controls environment (health and safety issues)</li><li>• Can be designed to meet specific needs</li></ul>
<b>CHALLENGES:</b>	<ul style="list-style-type: none"><li>• Identifying adequate funding to support needed services</li><li>• Finding and funding 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***

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. (See Appendix for description of Stout Street Clinic/Colorado Coalition for the Homeless approaches to shelter-based care.) Some shelters have set aside areas within their facilities for medical respite units in which they provide 24-hour nursing care and other services. 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 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 same location.

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 contagious. However, shelter staff need easy access to 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.

Eleven HCH projects of the 28 surveyed in 1999 were utilizing shelter beds through formal collaboration or contractual agreements in some variation of the descriptions above.

<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></ul>
<b>CHALLENGES:</b>	<ul style="list-style-type: none"><li>• Shelters and health programs may have differing philosophies</li><li>• Possible conflict over admissions policies and control</li><li>• Health program has little control over health and safety issues in shelter environment</li></ul>

## **Intermediate approaches to respite care**

Not all communities have adequate resources to develop medical respite units such as those described above. This should not imply that nothing can be done to begin developing responses to the need for these services. Many organizations have employed creative strategies to make up for the lack of a medical respite unit in their community. In addition, programs that are just starting out may want to consider an approach that is fairly easy to implement and less costly than a full medical respite model, and that also allows for generating valuable data and experience that can be used to expand the program.

The following approaches may serve either as initial steps toward the development of a more comprehensive program, or can also 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.

### ***Referral to shelter beds***

The most basic response to the need for respite services involves a simple referral to shelter beds that are set aside for people needing 24-hour recuperation. This arrangement will usually require clients to be ambulatory and capable of self-care. In addition, because of the possibilities of exposure to other shelter guests, referrals of clients with contagious diseases are not appropriate. Almost half of the 28 HCH projects surveyed in 1999 reported using this type of referral. Although this is preferable to having no place at all in which to recuperate, it should be remembered that without the presence of at least nursing services, this arrangement is barely more than a guaranteed shelter bed and does not meet the definition of medical respite care being utilized here.

### ***Motel/hotel vouchers***

Another intermediate approach is a voucher system used to place clients needing respite into motels or hotels (see Albuquerque HCH and Stout Street Clinic descriptions in Appendix). In the 1999 survey, ten HCH projects were using motel or hotel rooms for respite care, either directly renting rooms as needed or collaborating with other organizations in operating voucher programs. Three of those ten, plus an additional seven projects, also made referrals to other programs that place clients in hotel or motel rooms.

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 meal programs willing to deliver or the use of an established Meals-on-Wheels program, if available in the community.

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.

<b>ADVANTAGES:</b>	<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> </ul>
<b>CHALLENGES:</b>	<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 – minimal human contact to support healing</li> <li>• Relationship with motel/hotel owners often needs nurturing</li> </ul>

### ***Board and care contracts***

Another relatively inexpensive approach is to contract for beds in board and care homes, which somewhat addresses the issues of 24-hour nursing care, 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. Eight HCH projects in the 1999 survey reported using board and care homes through direct placement, collaboration or contract. Another nine make referrals to other organizations for placement in board and care homes.

<b>ADVANTAGES:</b>	<ul style="list-style-type: none"> <li>• 24-hour nursing care</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>• Little opportunity for connection to other needed services</li> </ul>

## **Planning your program**

With so many alternative models for respite care, how does an organization decide which road to choose? Planning is essential for making the right decision. The most ideal flow would be from an assessment of client needs to a final configuration of program elements. However, not all situations are ideal and numerous factors – ranging from cost to timing to community support or lack of it – will all play a role in which model is chosen. As stated previously, 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 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.

Although it is tempting to begin the planning process as an energetic individual or small group, it is important to expand the involvement to include more stakeholders from the earliest planning stages. A planning group for respite services would be wise to include:

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

One advantage of involving other community members – whether from hospitals or local government – is the opportunity to encourage buy-in to the project, which could conceivably result in additional resources and/or funding for the project.

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

- What is the approximate size of the homeless population and how many people usually need respite services during any 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.?

The answers to these questions will lead to a decision regarding the most appropriate model for your situation by determining the extent and nature of each of the following program elements:

1. Scope of medical care
2. Range of services
3. Staffing
4. Facility
5. Ownership/sponsorship

### ***Scope of medical care***

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. However, we know that 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. For this reason, the scope of medical care that your program can afford to make available will determine the range of patient conditions that can safely and successfully be treated. With basic nursing care a program can safely care for injuries or non-infectious illnesses. With more medical coverage a program can provide care for individuals with serious or infectious diseases, such as TB or AIDS. Programs with sufficient medical and nursing staff can provide palliative care at the end of life to people with minimal family support systems.

### ***Range of services***

In addition to medical care, what other services will be necessary in order to promote healing/health and escape from homelessness? Understanding the population you plan to serve will help you answer this question. A program serving homeless youth, such as MedRest in Seattle (see Appendix for description) may include different services than one serving primarily single adult males with chronic conditions. Homeless people who are mentally ill and/or addicted to alcohol or drugs will need access to mental health and substance abuse services. The majority of homeless people need access to social services either through appropriate referrals or intensive case management. All of these services can either be provided on-site as part of the respite program, or through referrals to the parent organization or other agencies.

### ***Staffing***

Decisions regarding scope of medical care and other services to be offered will determine the staffing pattern, including: type of staff to be hired; whether they will work on-site or visit the respite site; scheduling decisions; and use of volunteers. Use of shelter personnel will need to be considered if a collaborative shelter-based model is to be employed.

## ***Facility***

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 TB 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. For example, collaborations should be avoided with shelter facilities that have a poor reputation with homeless people. 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 looking 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 or hospital wing 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.

## ***Ownership/sponsorship***

Who decides who gets admitted? Who runs the program? Who controls access to the respite beds? What kind of collaboration with other agencies is feasible? There is no one right answer to these questions. But the answers will play a pivotal role in determining the type of respite model to be used. Many well-intentioned collaborative efforts are sabotaged down the road by conflicts over these issues of control. The fewer hidden agendas there are and the more up-front discussion of the issues, the better.

### ***Other determining factors***

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 rules and regulations for “personal care homes,” which appear to be quite similar to what we have described as respite services.<sup>22</sup> In the state of Washington, the MedRest program serving homeless youth had a pro-bono analysis done of legal requirements for serving youth in shelters under 18 years of age, and worked to change some state licensing regulations as a result.<sup>23</sup>

In addition, 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 determination of 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.

#### **Additional resources:**

- 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 examples of reports that involved gathering data on homelessness, go to the National Coalition for the Homeless website <http://nch.ari.net>, click on “Library” and search under “population assessment” or other relevant categories.
- 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.

## Daily operations

Once it is decided which respite services model to implement, there are still a multitude of other decisions which need to be made regarding policies and procedures for operating the program, as well as numerous challenges to be faced.

### *Policies and procedures*

The impetus for developing policies and procedures can come from several arenas: government regulations (federal, state, city, county); funder regulations/requirements; practical needs of patients and staff; and avoiding mistakes that have already been made.<sup>24</sup>

The categories for policies and procedures will vary based on the type of model chosen, with a freestanding respite unit needing the most extensive policies and procedures. A list from the Boston HCH Program describes these categories as:

<b>Clinical policies and procedures</b>
Clinical protocols
Nurse practitioner/physician's assistant protocols
Infection control
Medical or psychiatric emergencies
Medications

<b>Administrative policies and procedures</b>
Admissions criteria and referrals
Waiting lists
Discharge criteria
Administrative discharge (barring people)
Patient grievance (and abuse reports)
Supervision
Fire/evacuation plans
Billing

## ***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***

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 the services are provided. Effective and tactful negotiation may be necessary in collaborative ventures to stress the importance of health and safety measures to the success of the respite services.

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, mental health workers and substance abuse staff will often vary greatly. Effective staff coordination – in conjunction with the client’s input – is necessary to bring these differing perspectives together into a consensus regarding what is best for the client.<sup>25</sup>

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

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 what 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 extensive rehabilitation services or hospice care for terminal illness. Many clients will need detoxification. All of these situations will raise questions regarding your 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.

It is essential that you have clear policies regarding admissions, especially in those situations where the number of people needing care exceeds the space available. Clear guidelines are essential for defining the acuity of health problems that can be adequately cared for, both to

avoid admitting people who need more intensive care, as well as to avoid filling up valuable beds with people who are not that sick. These policies will be particularly important for staff responsible for admissions, so that they can ask the appropriate questions when referrals are called in and have the support of the policies to send back clients who have been inappropriately discharged from hospitals, i.e., “dumped” (see “External pressures” below).

Once your clients are ready to be discharged, additional questions emerge related to 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 their health problem originally, 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 services in the community, using your respite services data as evidence.

Two final internal issues deal with finances. The first issue is the obvious challenge of simply maintaining the funding to keep the program going. Secondly, those programs that depend on Medicaid reimbursements may have additional difficulty in states where Medicaid is operated through managed care organizations (MCO’s). 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*

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

Changes in the health care environment will also impact respite programs as hospitals and health systems merge or downsize, and hospital beds and length of stay decrease in response to cost-cutting initiatives. These events can put pressure on respite programs to expand their capacity, even when there is insufficient funding to do so.

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 buy-in to the program. Including representatives of neighborhood associations or other community members in both the planning process and resulting governing body may help to ease the resistance.

Respite program staff will need to learn to 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 in areas related to health – and the “new kids on the block” need to respect that.

Hospitals are another example of organizational territory that must be treated carefully. Hospital staff – particularly social workers responsible for discharge planning – will probably welcome the respite program with open arms. In some cases they may be too anxious to refer clients for respite care who are either still too sick to be discharged or need another level of care, such as a nursing home. Your admissions policies need to directly address how to handle inappropriate referrals such as these, while still maintaining the effective referral relationships with hospitals.

**Additional resources:**

- For examples of policies and procedures for respite care programs, go to the HCH Information Resource Center website at <http://www.prainc.com/hch> and look under “Clinical Tools” or “Sample Policies and Procedures.”
- For more information or training on managed care, check the website of the National Health Care for the Homeless Council at <http://www.nhchc.org> for updated resources related to managed care and homelessness, or contact the National Association for Community Health Centers at (202) 659-8008 or <http://www.nachc.org>.

## **Costs and budgeting**

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***

As described earlier, the cost of providing medical respite services is greatly impacted by the type of facility chosen for the program. A freestanding facility would be the most expensive, unless of course 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***

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, substance abuse, 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.

### ***Medications and supplies***

A homeless health care program that is expanding into respite care will likely already have an idea of costs of medications and supplies for an outpatient setting. However, adjustments will probably need to be made to cover 24-hour care.

## **Sources of funding**

Organizations or communities seeking funding for medical respite services should carefully investigate all of the following possibilities:

### ***Hospitals***

Local hospitals have much to gain from supporting medical respite programs. If the case can be made strongly enough (see “Making your case for funding” below), it may be possible to get hospitals to support the respite program on an on-going basis as a way to reduce their own costs. Denver’s Stout Street Clinic operated by the Colorado Coalition for the Homeless is an example of a program that has been successful in obtaining support from a local hospital.

### ***Federal government (HUD, HHS)***

Funding that is traditionally considered targeted to shelters may be an appropriate resource to support respite facility costs, for example HUD funding such as Emergency Shelter Grant (ESG) or other funding available through the HUD SuperNOFA process. Programs that have used HUD funding to help support their respite activities can be found in Seattle, Milwaukee, Denver, Baltimore and Manchester, NH, among others. Some projects that focus on respite services for people with HIV/AIDS have been able to access HOPWA funds (Housing Opportunities for People with AIDS), also available through HUD.

At the time of this writing, no funding was available through the Department of Health and Human Services to specifically support medical respite programs. However, federally-funded HCH projects have been able to use staff paid through grant dollars to provide services in a variety of outreach locations which may include visits to shelters or motels/hotels where their respite clients have been placed.

### ***Medicaid***

The current environment regarding Medicaid is much too complex to cover adequately in this document. Suffice it to say that regulations, eligibility requirements and delivery systems will vary greatly from state to state. Some states with broader eligibility may offer more possibilities for covering homeless people, especially single adult males without disabilities. Although respite care in general is not a covered service, the acute care medical services provided to eligible Medicaid beneficiaries while in respite care should be billable. Managed care arrangements for Medicaid in some states may complicate coverage for services provided in respite care settings, but it is worth negotiating.

### ***Local (city/county) or state government***

HCH projects sponsored by public health departments (for example, Seattle/King County Health Department and San Francisco Department of Public Health) have been able to access public health funding for medical respite services. Albuquerque HCH is an example of a respite program where motel vouchers are supported by funding from city government.

### ***Federal drug discount programs***

Respite programs that provide medications as a service to their clients will want to take advantage of programs available for discounted pharmaceuticals. Contact the federal Office of Drug Pricing at (301) 594-4343, or the National Association of Community Health Centers at (202) 659-8008 or <http://www.nachc.org> for more information.

### ***Private donations***

As a general rule, funding from private sources – either individual donations or foundation grants – is extremely valuable and may offer flexibility not available through government grants. However, unless the funding is renewable – 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. Although it is tempting to use private funding for ongoing expenses such as staff or rent, the prospects of continuing to receive that support should be scrutinized carefully to avoid jeopardizing your program.

## **Making your case for funding**

The case for funding medical respite services for homeless people can and should be made on multiple fronts. We would always like to start with the ethical stand that “it’s the right thing to do.” It should be obvious that discharging a person to the streets who has recently undergone surgery or who is experiencing a risky pregnancy is not the right thing to do. Unfortunately, today’s medical environment is heavily influenced by dollars, with the moral imperative frequently taking a backseat to the influence of managed care organizations, Medicaid/Medicare regulations, other federal, state or city regulations, and the expectations of donors and grantmakers that the program can be shown to be cost-effective and cost-efficient.

Making the case that medical respite services for homeless people represents a cost-savings can be somewhat tricky, given the lack of empirical evidence to support this. However, a review of the literature related to utilization and costs of medical services by homeless people<sup>26</sup> provides us with some information that may be useful in beginning to build that case. From this literature review we do know that people without homes tend to have more frequent emergency department visits. A San Francisco study<sup>27</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. A two-year study in the Boston HCH Program<sup>28</sup> resulted in similar findings with 2.7 emergency or urgent care visits per year for homeless people utilizing BHCHP’s primary care clinics.

Other studies have found that homeless people have higher rates of hospitalization than comparable low-income populations with housing: four times higher for homeless mothers in Worcester, Massachusetts,<sup>29</sup> five times higher for homeless adults in Hawaii<sup>30</sup> and seven times higher for homeless veterans.<sup>31</sup>

Even more valuable for making the case are statistics on lengths of stay and costs of hospitalization. The Hawaii study<sup>32</sup> 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.<sup>33</sup> 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.

Although these are only a small handful of studies – and there are other studies that have resulted in different conclusions – this information could form the foundation for making the case that medical respite programs can reduce costs to hospitals in the following ways:

- Diversion from the ER/ED – Part of the reason for greater use of emergency departments may be that many homeless people repeatedly return for conditions that are unresolved due to their inadequate living conditions on the streets or shelters and/or their inability to adhere to medical advice.
- Diversion from hospital admissions – The greater number of hospital admissions may be due to the tendency for medical providers to admit homeless people for conditions they would normally treat and send home, given that there is no home to send them to, in addition to the greater extent of illness and injury among homeless people in general.
- Decreased hospital length of stay – Despite the pressure to shorten lengths of stay in general, people without homes may be held somewhat longer when hospital personnel do not have an adequate discharge plan. (Hospital staff who are frustrated at the lack of safe places to which they can discharge homeless people can be great allies in supporting your case for funding.)

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

If you are appealing to funders with a broader vision and a desire to have a greater impact on homelessness, you may want to focus on the opportunity that medical respite programs create for linking homeless people with more services. Mental health or substance abuse treatment accessed as a result of time spent in a respite program could prevent future homelessness. Case management or social work services may assist respite clients in accessing SSI benefits which could help them move into housing. The additional benefit of helping clients access their SSI entitlement is that costs are moved from the local to the federal level.

In general, it is crucial that you identify who your audience is and why they should have a stake 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, you may need to change your language to coincide with current Medicaid terminology, such as “recuperative” or “sub-acute care.” Special advocacy will be needed for those programs hoping to negotiate realistic capitation rates in managed care systems, if the goal is to assure that the services provided are fairly reimbursed.

## **Conclusion**

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 "dumping" of homeless patients into other systems, but also to prevent the initial event which 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.

## Endnotes

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- <sup>19</sup> McMurray-Avila, 1997.
- <sup>20</sup> McMurray-Avila et al., 1999.
- <sup>21</sup> McMurray-Avila, M. 1999. Unpublished survey by National Health Care for the Homeless Council.
- <sup>22</sup> Authority Ga. L. 1964, pp. 499, 612; O.C.G.A. Secs. 31-2-4, 31-7-2.1. History. Original Rule entitled "Physical Plant Standards" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Amended: Filed January 6, 1981; effective February 6, 1981, as specified by the Agency. Repealed: New Rule entitled "Services" adopted F. Oct. 22, 1993; eff. Nov. 11, 1993.
- <sup>23</sup> Contact Jeannie Macnab of the Seattle Health Care for the Homeless Network at (206) 296-4338 or Jeannie.Macnab@METROKC.gov for more information or a copy of the analysis.
- <sup>24</sup> Presentation by Barry Bock at National HCH Conference, Washington, DC, 1999.
- <sup>25</sup> 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>.
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