



Medical Respite Care for People without Stable Housing

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Introduction

The experience of homelessness both causes and exacerbates poor health. Homeless people are at higher risk for chronic, uncontrolled medical conditions such as asthma (4–6 times higher), cardiovascular diseases (2–4 times higher), and diabetes (up to 2 times higher) than are people in stable housing (Bonin et al. 2004, Zerger 2002). In national studies, overall prevalence rates of chronic medical illnesses range from one-third to one-half of surveyed homeless populations, compared with less than one-quarter of the housed population (Zerger 2002).

Health conditions requiring regular, uninterrupted treatment—including tuberculosis, HIV, substance dependence, and mental illness—are extremely difficult to manage for people without a stable residence. Poor diet, exposure to the elements, lack of health insurance, irregular access to primary care, and the multiple stressors associated with homelessness increase risk for complications of acute and chronic illness. It is therefore unsurprising that homeless individuals often go without critically needed care, that they tend to require high levels of health services, and that they often obtain these services through hospital emergency departments (Gundlapalli et al. 2005, McMurray-Avila 1999).

Increasing use of managed care in hospitals is resulting in shorter hospital stays and more procedures provided on an outpatient basis. The impact of this trend is especially harsh for homeless individuals, who are often discharged from the hospital with prescriptions for medication they cannot afford to have filled, and/or with instructions for follow-up care they are unable to heed, such as bed rest, nutritious food, or preparations for tests or surgery that are impossible for them to carry out. This gap in health services between hospitals and the streets has negative consequences for individuals who are homeless and for overall healthcare systems. The inability to follow up with specific discharge instructions may lead to poor health outcomes, unnecessary and costly emergency room visits, and additional inpatient hospital stays.

One response to this healthcare gap has been the development of medical respite services for people who are homeless. Respite care refers to recuperative or convalescent services for those who may not meet criteria for hospitalization, but who are too sick or vulnerable to be discharged to the streets. Respite programs provide medical services, including a minimum of daily nursing care (Zerger 2006). Several research studies have demonstrated the benefits of respite care for clients and the healthcare delivery system.

Respite care has been shown to reduce future hospitalization for homeless individuals, representing a significant savings to the healthcare system. A study in Chicago compared the use of health services following hospital discharge by homeless individuals who received respite care with health service use by those referred for but denied respite care because beds were unavailable. This study found that

respite care recipients subsequently spent 4.9 fewer days in the hospital (a 58 percent reduction) and had 36 percent fewer ER visits than did homeless persons who did not receive respite care (Buchanan et al. 2003, Buchanan et al. July 2006). Individuals with HIV/AIDS who received respite care services experienced the greatest reduction in hospital days (11 fewer days). Similarly, a Boston study of hospitalized homeless persons by post-hospitalization placement site found that over a 90-day period following hospital discharge, those placed in respite care had a 50 percent odds reduction of early readmission or inpatient days, compared to those placed in nursing homes or discharged to self-care – i.e., to shelters or the street (Kertesz et al. 2003).

Respite programs not only address the acute health care needs of people who are homeless, but often improve their overall health and quality of life by connecting them with much needed community services. While respite programs differ with respect to size, location of services, staff make-up, and funding resources, a hallmark of all respite programs is the development of individualized service plans that address the holistic needs of each client. For example, while clients are recuperating in respite care from a medical illness, case management staff may also be working with them to apply for food stamps, disability benefits, public health insurance, and/or subsidized housing. To be effective over the long term, stable housing and continued access to health and social services must be available to clients discharged from respite care. Without these resources in place, many will have to return to a homeless shelter or to the street.

The National Respite Care Provider's Network, representing 38 known respite care programs in 27 States, estimates that the need for respite care is vast and remains largely unmet (Zerger 2006). These respite care providers are completing a national pilot study to better quantify and understand the population of current respite service users, as well as those who are referred to respite care but not admitted. Study results are expected to provide a more accurate basis for estimating the unmet need for respite care in this country.

Respite care provides a unique opportunity to offer a variety of important services to homeless individuals who may not have encountered the healthcare system for years, except in emergencies. The respite team can often build rapport and trust with homeless clients, successfully engage them in critically needed medical and behavioral healthcare, and help them achieve stability through supportive housing. This is especially important for individuals who have experienced prolonged homelessness, as illustrated by the following case studies.

This case report is intended for clinicians working with homeless people, particularly for those who provide respite care or are interested in initiating such services.

Case 1: Respite care averts re-hospitalization, resolves chronic homelessness – Robert Donovan, MD

Respite Program Description: The Cincinnati Center for Respite Care (CRC) is a 14-bed facility for homeless people who are either too sick to be in a shelter or have been recently discharged from a hospital and need a safe place for recuperation. CRC provides basic short-term medical and recuperative care, as well as social services for sick, homeless people while they recover. Located downtown near the largest homeless shelter, the respite facility is open 24 hours per day, 7 days a week. Patients requiring medical recovery are referred from area hospitals or are admitted directly from homeless shelters by medical staff.

Key elements of the program include: 1) initial diagnostic medical assessment and development of a plan of care for patients upon admission, 2) implementation of the plan of care, 3) coordination of care with a primary care physician and/or hospital staff, 4) application for entitlement programs or coordination of plan with outside case manager, 5) referrals to community housing and job placement services, 6) referrals to appropriate medical agencies for ongoing care and substance abuse/mental health services as needed, and 7) discharge placement to stable housing or treatment facilities.

CRC receives funding from local hospitals, government grants, foundations, individuals, and faith-based organizations. Collaborative partners in this project include: The Health Resource Center of Cincinnati, Inc.; the Health Care for the Homeless Program through the Cincinnati Health Network, Inc.; three major hospital networks (The Health Alliance of Greater Cincinnati, TriHealth, and Mercy Health Partners); The Health Foundation of Greater Cincinnati; the University of Cincinnati Department of Family Medicine; and The Drop Inn Center emergency shelter.

Client Background: Mr. G. is a 44-year-old African American male who has been without housing for many years. He developed severe frostbite injury to his hands in October 2005 and was seen at a homeless clinic in Northern Kentucky. Subsequently, the clinic referred him to a local hospital where he was seen repeatedly at the wound care clinic. A partial amputation of his right second finger was performed and the infection in his hands improved. The hospital discharged Mr. G. in February 2006. Having no housing, however, his hygiene was poor and his hands again became infected. He returned to the wound care clinic, but due to his homeless situation, Mr. G. was unable to care adequately for his hands. The surgeons who performed his hand surgery expected further amputations to be necessary at some point. Mr. G. returned to the homeless clinic and was referred to the Cincinnati Center for Respite Care (CRC) where he was admitted on 3/29/06. When he arrived at CRC, he was intoxicated on alcohol. A review of systems showed poor near vision.

Medical history: Mr. G. has a history of diabetes, diagnosed in 2005, which was well controlled with glipizide and diet. Diagnostic tests conducted at CRC were negative for HIV and hepatitis B&C, and positive for hepatitis A and syphilis (RPR test). The client had previous treatment for syphilis but did not return for follow-up. He was referred to the city Health Department's STD clinic for follow-up; no further treatment was indicated.

Psychosocial history: The client was diagnosed with paranoid schizophrenia around 1998. On admission, Mr. G. was no longer taking psychotropic medications because he felt he did not need them although he continues to hear voices. He self-medicates with psychoactive substances including alcohol. He has had eight felony convictions and over 30 felony arrests. For many years, he has slept on the streets of Cincinnati with occasional shelter stays and has no relatives or close friends in the immediate area. When he first came

to CRC, Mr. G. exhibited severe social isolation and paranoia, including anger outbursts. CRC referred him to the PATH program¹ for behavioral health care and a PATH outreach worker visited Mr. G.

Course of Treatment: At CRC, Mr. G. was continued on clindamycin and cephalexin, originally prescribed by his hand surgeons, along with soaks three times daily. His hands were dressed with polysporin and dry sterile dressing. The client's hands continued to heal well and CRC referred him for physical therapy. He was eventually discharged from physical therapy, having regained near-normal use of his hands, and the hand surgeon felt no further amputation would be necessary.

His fasting blood sugars were generally in the low 100s (70–99 mg/dL is normal). As there was some question of episodes of hypoglycemia when the client was away from the center for medical and social service appointments, he was changed to metformin, which is much less likely to cause hypoglycemia, and the dosage was gradually increased. He was also referred to a clinic for primary care, and went to several service agencies to access benefits. The client was seen at the local homeless dental clinic for treatment. Arrangements were made for him to be seen by an optometrist and his vision was evaluated.

Following admission to CRC, Mr. G. had trouble adhering to the Center's rules, particularly to the requirement that residents get permission to leave for medical appointments and other services, but was easily calmed with discussion. Years ago, he was on antipsychotic medications but did not like how they made him feel. When a sufficient level of trust was established, staff discussed with him advantages that medication might provide. On 4/27/06, he saw a psychiatrist and began aripiprazole (Abilify). As he did not tolerate this, he was changed to olanzapine (Zyprexa) which he tolerated well; olanzapine controlled the voices he was hearing and helped him control his temper.

Outcome: While at CRC, Mr. G.'s socialization skills continued to improve and he became able to instruct other newly admitted clients about the Center's rules. He also helped with clean-up at the Center. On 9/5/06, he was discharged to his own apartment with supervision by his case manager. During remodeling of a new building where the CRC would be moving, Mr. G. addressed the volunteers about how CRC had helped him. His ability to maintain stable housing and engage in these activities was indicative of the extent to which his health problems had been stabilized.

In summary, the services provided by the Respite Program had the following impact on Mr. G.'s health and well being:

- prevented readmission to the hospital by providing a clean environment for his wound care;
- prevented further debilitating amputation of his fingers;
- improved his socialization skills; and
- enabled him to obtain stable housing – which, in the estimation of clinicians working with homeless people, is essential to effective health care.

¹ The Projects for Assistance in Transition from Homelessness (PATH) program funds community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services, for people who are homeless and have serious mental illnesses. The PATH program provides these services through a formula grant to each State, the District of Columbia, Puerto Rico, and eligible U.S. territories. The program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Greater Cincinnati Behavioral Health Services is the PATH Provider in Cincinnati. More information about the PATH Program is available at: <http://www.pathprogram.samhsa.gov/>

Case 2: Respite care facilitates access to primary and preventive care – Dawn Dee, RN, PHN

Respite Program Description: The 15-bed medical respite program is a program of the Hennepin County Health Care for the Homeless Project in Minneapolis, initiated in January 2005, which serves homeless adults residing in a local shelter or recently released from area hospitals who are recovering from acute medical problems. Now in its second year, this program is primarily based in an existing shelter that receives on-site HCH clinic services. One, full-time public health nurse (PHN), the author of this case study, serves as lead Respite Nurse for the HCH project and provides care coordination and medical case management to respite clients. The Respite Nurse conducts a health and social needs assessment of each client entering the respite program and works with the client to develop a plan of care and follow up strategies. Initially the sole respite service provider, she now heads a respite team, developed in May 2006, which also includes a part-time PHN, a nurse practitioner, a financial worker, and a social worker. These positions are currently funded by the HCH grant, supplemented by a small grant from the State of Minnesota to cover a portion of the lead PHN's salary.

Client Background: In 2003, Mr. T., a 48-year-old man, lost his job and subsequently his savings, car and home. He had no friends or family in the area, so he came to a secure waiting space in Hennepin County, which offers 250 homeless men dinner and a mat to sleep on during the night. Almost every homeless shelter in Minneapolis, like this one, closes early in the morning and opens again for the night. During the day, people who are homeless must walk the streets, work, visit drop-in centers, ride buses, or find other activities. Many of them have no place to rest or a safe place to heal, which can be especially challenging to those who are sick or disabled.

Medical History: When he first came to the shelter, Mr. T. was basically healthy and could find odd jobs during the day. He did, however, suffer from common ailments associated with homelessness: frequent upper respiratory infections, athlete's foot, scabies, dyspepsia related to poor diet, and injuries secondary to minor trauma after being hit by a car. He had no chemical dependency, but he did smoke a pack of cigarettes a day.

Psychosocial History: Unkempt and depressed, Mr. T. maintained employment for only short periods of time during his stay at the secure waiting space. He had problems with social interaction and often felt lonely and isolated. He complained of weight loss related to situational anxiety. From 2003–2005, Mr. T. had no health insurance and received services from the Hennepin County Healthcare for the Homeless (HCH) clinic.

Assessment and Referral: In 2005, a HCH nurse practitioner noticed a small, painful lump in Mr. T.'s breast. To rule out the possibility of cancer, she encouraged him to see a primary care doctor. Based on previous experience with the client, she knew he would not make medical appointments on his own, so she referred him to the respite nurse who made an appointment for a physician to see him. The next week, the respite nurse found him on outreach, and Mr. G. told her that he missed the appointment because he had to work and did not want to risk losing his employment. After weeks of prompting and education, the client finally agreed to keep his medical appointment, receive respite case management, and accept a voucher into the only shelter in Minneapolis that allows men to stay inside during the day. (The various models of respite care include use of 24-hour emergency shelter beds with medical support.) During his shelter stay, Mr. T. was referred to a cancer center, received mental health case management, and applied for health insurance and public benefits.

Course of Treatment: The medical care plan included a mammogram, chemotherapy with tamoxifen (for treatment/prevention of cancer), and close monitoring of the breast lump. During one visit, Mr. T. told the respite nurse that he had stopped taking his medicine, unbeknownst to the cancer center, because of the side effects. The Respite Nurse consulted the cancer center to manage his side effects and convinced him to resume chemotherapy. Upon reviewing a dictation by the client's oncologist, the respite nurse learned that the oncologist had recommended an excisional biopsy but had not made a referral. The nurse called the cancer center, a surgical consult was ordered, and a mammoplasty reduction was performed. The final diagnosis was "benign fibrous breast mass," and there were no post-operative complications.

Outcome: While in respite, a mental health social worker helped Mr. T. complete an application for supportive housing and social security. Housed now for almost a year, he was approved for Social Security Disability Insurance (SSDI) benefits due to a diagnosis of chronic depression. His physical appearance has changed remarkably; he smiles frequently and is well dressed and well groomed. The client notes a marked improvement in "spirit" and "attitude," explaining, "I've got plans and goals now." He is involved in a neighborhood organization and is considering joining a peer mentorship program. During a discussion about respite, he stressed the importance of outreach because "there are other people like me who are unaware of what they need . . . and they need someone to find them." When asked about his experience with the respite program, Mr. T. stated, "They truly care and don't pass judgment, which helps the spirit; and by getting the spirit squared away, you can get the medical squared away, and vice versa."

As HCH providers, all respite workers do outreach beyond the clinic. If they find someone on outreach who needs respite care, they connect him or her to the respite center. Mr. T. learned about the respite program when the PHN came to the shelter where he was staying, which is located in the same building as the respite center and a number of other programs. The respite team routinely seeks out shelter residents to inform them about the availability of respite care.

Through participation in the Respite Program, Mr. T:

- was successfully referred for medical evaluation of a tumor that could have been life threatening;
- received case management services resulting in health insurance and other disability benefits; and
- improved his health, income, and housing stability as a result of referrals made and supervised by program staff.

Case 3: Respite care promotes treatment of acute and chronic illness –Lisa Thompson, RN, ND

Respite Program Description: The Medical Respite Care program of the Colorado Coalition for the Homeless (CCH) is one branch of medical services provided through Stout Street Clinic, a designated Health Care for the Homeless clinic in downtown Denver. The respite program collaborates with three different facilities to provide respite beds and services throughout the city. Respite staff are based in a shelter where 15 of the total 33 beds are located. Clients admitted to the respite program meet with both nursing and case management staff to identify specific needs and goals to address while they reside in this temporary housing program. Referrals to the program are made by area hospitals, clinics, shelters, churches, VA programs, Adult Protective Services, and detox facilities. The Respite Care Program provides nursing care, medical treatment, case management including assistance with benefits application and discharge planning, medication monitoring, 24-hour staff supervision, meals, a laundry facility, housekeeping, and referrals and transportation to other needed care. Staffing for the program includes a full-time program coordinator who is a registered nurse, a clinical case manager (.65 FTE), two additional registered nurses (.75 FTE), and an administrative assistant (.5 FTE).

Client Background: Mr. H. is a 70-year-old single, retired male who was admitted to the Colorado Coalition for the Homeless (CCH) Respite Care Program in August 2006 for multiple venous stasis leg ulcers on his right lower extremity. Mr. H. reported a prior 14-year history of homelessness and stated that he frequently travels around the country via Greyhound bus following “God’s plan” for his life.

Medical History: According to paperwork received by the respite care program from the referring hospital, Mr. H. was seen in the emergency room with complaints of lower extremity edema and mild, foul smelling drainage from his stasis ulcers. He reported a long history of chronic lower extremity edema and untreated hypertension, but denied other significant medical history. Mr. H. was started on 500 mg of Cephalexon QID for 10 days and was instructed to follow up with the HCH clinic for treatment of hypertension. He was referred to the respite care program for daily dressing changes and case management assistance. There he could remain indoors during the day and elevate his legs.

Psychosocial History: Although the client denied a history of mental illness or psychiatric treatment, it was apparent to respite care staff that Mr. H. suffered from some form of mental illness. He denied current alcohol or substance use, and any involvement with the legal system. Mr. H. reported that he had arrived in Denver on a Greyhound bus from Washington, DC, in early August and was robbed of his belongings, including identification documents, traveler’s checks, and ATM card while standing in front of the bus station. The client had been traveling from shelter to shelter and walking significant distances during the day, attempting to meet his basic needs, and this had led to worsening of his stasis ulcers. He reported having received Social Security retirement benefits; however, he was unable to access the funds in his bank account because his wallet and identification papers were stolen.

Course of Treatment: Upon arrival at the Respite Care Program, both nursing and case management staff evaluated the client and established a comprehensive, individualized care plan. After establishing specific treatment goals with Mr. H, the respite nurse met with him daily in the respite shelter to monitor his blood pressure and change dressings on his venous stasis ulcers. The respite nurse provided education on proper foot and skin care, and the client was able to remain inside during the day, elevate his legs, obtain three meals a day, and tend to hygiene needs.

Mr. H. was referred to the HCH clinic (Stout Street Clinic) for treatment of hypertension and to establish a primary care provider. Respite staff communicate with health care providers at Stout Street Clinic on a daily basis, and medical information is shared back and forth to ensure client progress and recovery. Respite

clients are able to receive ongoing health services at Stout Street Clinic once they are discharged from the respite program. Over the next several weeks, the client's leg ulcers slowly healed. Although he initially followed up at the clinic, he reported one day to the respite nurse that "God had instructed him" to stop taking his blood pressure medications. He subsequently refused to take his blood pressure medications.

The Respite Care Program staff continued to build trust with the client and attempted to refer him to mental health services. Nevertheless, Mr. H. adamantly denied mental health issues and refused evaluation in the outpatient mental health clinic. The respite case manager worked with the client on a weekly basis and helped him obtain his birth certificate, Social Security card, state identification, and ATM card so that he could access his disability benefits. In addition, the case manager helped him develop relationships at a resource center for seniors where he could obtain ongoing support and assistance once discharged from respite care.

Outcome: Once Mr. H had healed physically and had met the identified goals he and the respite case manager had initially specified, he was discharged from the respite program. Mr. H. moved into a transitional housing program following his discharge from respite and agreed to meet with a PATH case manager on a weekly basis to locate permanent housing. (The Colorado Coalition for the Homeless, an HCH grantee, is also the PATH Provider for the Denver area.) The PATH case manager continues to build trust with this client with the objective of eventually engaging him in ongoing mental health services and case management support.

As a result of his stay in Respite Care Mr. H.:

- received medical care that enabled his venous status ulcer to heal;
- met regularly with a case manager who helped him obtain documentation required to access his disability benefits;
- moved into a transitional housing program following his discharge from respite care; and
- continued his relationship with a PATH case manager to help build readiness to address his mental health issues and seek more permanent housing.

Discussion

Respite care for individuals who are homeless offers numerous benefits. As these cases illustrate, respite care provides a safe, recuperative environment for a person to heal, and offers supportive medical, nursing and case management services. Respite care serves as an entry point for homeless individuals to benefit from multiple services that may be available in the community (including those provided through the HCH and PATH programs), while encouraging the building of trusting therapeutic relationships with medical and social service providers. In so doing, respite care provides an opportunity to minimize harm to persons unable to advocate for themselves who are at high risk for serious health complications resulting from fragmented systems of care.

Research shows that respite care is beneficial both to the individual and to the overall health care system. Respite care services may be provided at a free-standing medical facility designed specifically for this purpose or provided within a homeless shelter or a larger transitional or treatment facility. Regardless of the type or model of respite care, it is critical to have 24-hour facilities available where homeless people who are experiencing health crises can rest and recuperate. In such environments, medical and nursing staff are able to care for clients in a clean, safe environment and contribute positively to overall health outcomes. In addition, case management staff may assist people in overcoming barriers that may be contributing to the situation of being homeless.

Optimally, in order to maximize the long-term effectiveness of these interventions, to reduce unnecessary hospitalizations, and to provide lasting solutions to homelessness, respite care programs should be directly linked to permanent housing with supportive services that include medical and mental/behavioral healthcare and social services. Unfortunately, due to the scarcity of permanent supportive housing (PSH), such linkage is not always possible. (A limited number of permanent supportive housing units are available in Cincinnati, Denver and Minneapolis, although the clients featured in this Case Report either did not require or were unable to obtain admission to PSH following discharge from respite care.) Building strong relationships with key representatives in public benefit offices, subsidized housing programs, and other community resources is essential for staff working with homeless individuals who have complex and multifaceted social service needs. Medical respite care is an essential part of the continuum of services that should be offered to people without homes. Additional research on the outcomes of respite care is expected to provide a basis for the expansion of these much needed services within the spectrum of homeless healthcare.

Take-Home Messages for Respite Care Providers

- ***Stabilize acute health conditions and develop a care plan to address chronic conditions.***
 - Document changes in the client’s health status between admission and discharge from respite care.
 - Assign a case manager to facilitate referrals to specialists and other health and social services, as needed.
 - Evaluate clients for potential mental health conditions, including PTSD, and provide treatment or referrals as appropriate.
 - Help clients with substance dependence access needed care.
- ***Help clients obtain income supports for which they are eligible.***
 - Assist with applications for entitlements such as food stamps, SSI/SSDI, and Medicaid.
 - Inquire whether those injured on the job are eligible for Workers Compensation.
- ***Help clients obtain documentation that may be required for employment, housing, or eligibility for public benefits.***
 - Assist with applications for birth certificates, state IDs, and Social Security cards.
 - Consider providing financial resources to clients who may not otherwise be able to afford fees required to obtain these documents.
- ***Collaborate with community service agencies that offer ongoing support following discharge from respite care.***
 - Consider resources that offer continuous support to people who are homeless or at risk for homelessness, such as senior centers, veterans’ resource centers, and PATH programs.
 - Begin considering discharge needs immediately upon intake into respite care.
- ***Enable clients better manage their health upon discharge from respite care.***
 - Help clients obtain a regular source of primary care and health insurance, where possible.
 - Help clients learn how to self-administer their medications and obtain prescription refills.
 - Teach clients how to make follow-up appointments for primary and specialty care.
- ***Help clients obtain stable housing upon discharge from respite care.***
 - Assist with applications for subsidized housing, including permanent supportive housing, where needed.
 - Promote reunification with family members whenever possible.
- ***Work to expand the availability of respite services in your community.***
 - Develop relationships with homeless service providers, hospitals, and others likely to benefit from the availability of respite care.

(Zerger 2006)

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Resources

- Respite Care Providers Network website: <http://www.nhchc.org/respitecareprovidersnetwork.html>
Information available on this website includes defining characteristics of respite care and practical models, respite care programs and providers, respite program policies and tools, resources to advocate for respite care in your community, and research and evaluation results.

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