ABOUT THIS DIRECTORY

*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 who are not ill enough to be in a hospital. This directory contains descriptions of all known medical respite programs in the United States and Canada; these programs offer safe shelter, clinical care, and aftercare planning assistance that homeless people need to recover from illnesses.

The Respite Care Providers’ Network, a component of the National Health Care for the Homeless Council, assembled these descriptions to inform others about the vital services these programs offer, and to facilitate communication among them.

Free individual membership in the Respite Care Providers’ Network is available: [www.nhchc.org/resources/clinical/medical-respite/respite-care-providers-network/](http://www.nhchc.org/resources/clinical/medical-respite/respite-care-providers-network/)

ACKNOWLEDGEMENTS

The Respite Care Providers’ Network thanks the Boston Health Care for the Homeless Program and staff at the Barbara McInnis House for creating the first edition of this publication in 1999.

DIRECTORY ADDITIONS OR REVISIONS

This directory and submission forms can be found online at: [www.nhchc.org/resources/clinical/medical-respite/tool-kit/medical-respite-programs-united-states-canada/](http://www.nhchc.org/resources/clinical/medical-respite/tool-kit/medical-respite-programs-united-states-canada/)

CITATION

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DISCLAIMER

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Listed alphabetically by state/province

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SUMMARY

Total number of known medical respite programs in the U.S.: 62
Total number of known medical respite programs in Canada: 3
Average length of stay: 35 days
Median length of stay: 25 days

Figure 1: Number of U.S. medical respite programs by operating agency

Figure 2: Number of U.S. medical respite programs by beds available (program capacity)

*Programs may have more than one operating agency or agency status

*A small number of programs have a fluid number of beds available and may not be accounted for in this data.
Figure 3: Number of U.S. medical respite programs by clinical services provided

Figure 4: Number of U.S. medical respite programs by support services provided

*Case management includes services such as benefits acquisition and housing referrals
Figure 5: Number of U.S. medical respite programs by funding source

- Hospital: 30
- HRSA: 19
- HUD: 11
- Medicaid: 9
- Medicare: 8
- Private donations: 29
- Loc. Govt: 29
- Religious foundations: 15
- United Way: 21
- Other: 10
- Other: 11

* Most programs have multiple funding sources
ALASKA

Juneau Homeless Respite Care Program

Agency: State of Alaska, Advisory Board on Alcoholism and Drug Abuse/Alaska Mental Health Board
Address: 413 N. Franklin St., Ste. 200, Juneau, Alaska 99801
Contact: Scott Ciambor, State of Alaska Planner
Phone: (907) 465-5114
Email: scott.ciambor@alaska.gov
Web: http://www.jedc.org/juneau-homeless-coalition

Description
The goal of the Juneau Homeless Respite Care program is to 1) provide hotel stays (3 to 7 days) for homeless persons too ill/injured to return to the streets, and 2) to collect data on the needs of homeless persons being discharged from the hospital. This information may lead to potential long-term solutions for medical respite for homeless persons as well as potentially identify areas of cost savings for the hospital.

The entire program is based on in-kind services and interagency collaboration: Bartlett Regional Hospital and Front Street Clinic refer and enter patients into the program, communicating with all the participating partners including the taxi service and hotels; the Glory Hole Emergency Shelter provides meals; Catholic Community Service Hospice and Homecare nurses monitor and provide follow up care; and the Juneau Economic Development Council provides administrative services by managing funds, paying bills, collecting data, and keeping the group connected.

Profile
Operating agency
- Front Street Clinic (SEARHC) (HCH)
- Bartlett Regional Hospital (Hospital)
- Juneau Economic Development Council (Non-profit)
- City & Bureau of Juneau (Local government)
- The Glory Hole Emergency Shelter, Catholic Community Services Hospice and Home Care (Non-profit)
Year program was established: 2010
Site of respite beds: Motel/hotel
Number of respite beds: varies
Hours of operation: 7 days per week
Average length of stay: 3-7 days

Clinical Services Provided
Nurse (onsite and offsite)

Support Services Provided
Meals
Transportation

Funding Sources
Hospital
Private donations
Local government
Circle the City Medical Respite Center

Agency: Circle the City
Address: 333 W. Indian School Rd., Phoenix, AZ 85013
Contact: Brandon Clark, Chief Administrative Officer
Phone: (602) 776-9000
Email: bclark@circlethecity.org
Web: www.circlethecity.org

Description
Circle the City (CTC) is Phoenix’s first medical respite center for homeless individuals. CTC collaborates with local healthcare systems to provide a comprehensive set of medical and social services to homeless patients as they transition out of the inpatient hospital setting. While admitted to CTC, patients benefit from 24/7 physician oversight, daily nursing care and non-licensed caregiver support, psychiatric consultation, physical therapy, case management, room and board, etc. In this way, Circle the City fulfills its mission of providing “a time and a place to heal” to people experiencing homelessness. CTC’s 17,000 square foot medical respite center at 333 W. Indian School houses 50 beds, including a dedicated 8-bed women’s unit, an on-site clinic with two private exam rooms, shared living and dining spaces for patients, a physical therapy room, salon, as well as CTC’s administrative offices. CTC employs approximately 25 staff members including nurses, patient aides, case managers, a driver, 24/7 security, housekeeping and other administrative staff.

On a typical day at CTC, a patient can expect to receive a comfortable night’s sleep in a semi-private dorm setting, three full meals served to them by a CTC staff member, visit(s) with one of our on-site physicians and case managers, and if indicated, appointments with a staff physical therapist, psychiatrist or other specialist. CTC’s core outcomes include the full completion of a patient’s medical treatment plan, a safe discharge to permanent or transitional housing, a connection between each patient and a primary care physician, and a clearly defined plan for supporting the patient’s ongoing medical, psychiatric and prescription needs.

Profile
Operating agency
- Circle the City (Non-profit)
Year program was established: 2012
Site of respite beds: Stand-alone facility
Number of respite beds: 50
Hours of operation: 24-hours per day/7 days per week
Average length of stay: 4-6 weeks

Admission Criteria
- Age 18 or over
- Homeless or imminently homeless
- Needs recuperative services but has no other option for obtaining them
- Has potential for improvement/discharge within approximately 6 weeks
- Does not require more than minimal assistance with ADL’s
- Does not require ventilator care
- Does not require the administration of IV therapy with special supervision (e.g., chemotherapy)
- Is psychiatrically stable (i.e. not a danger to self or others, not requiring physical restraints)
- Does not require management of alcohol, benzodiazepine or opiate withdrawal
- Does not need secured environment for dementia care
- Willing to come to the Medical Respite Center, abide by facility rules, and participate in own care
Clinical Services Provided
Physician (onsite & offsite)
Nurse (onsite)
Social Worker (onsite)
Psychiatrist (onsite)
Community Health Worker (onsite)

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital
HUD
Private donations
Foundations
CALIFORNIA

Clinica Sierra Vista La Posada Respite Program

Agency: Clinica Sierra Vista Homeless Healthcare Clinic
Residence Address: 520 Monterey Street, Bakersfield, CA 93305
Administrative Address: P.O. Box 1559, Bakersfield, CA 93305
Contact: Bill Phelps, Chief of Programs
Phone: (661) 635-3050
Email: phelpsb@ClinicaSierraVista.org
Web: www.ClinicaSierraVista.org

Description
La Posada Rest & Recovery is a twelve-bed unit independently housed on the grounds of a sober living facility. Homeless men and women are provided a safe place to rest and recover from illness or injury. Program participants are provided with meals, snacks, laundry facilities, nursing supervision, case management services, transportation, and access to medical care through Clinica Sierra Vista’s Homeless Healthcare Clinic.

Profile
Operating agency
- Clinica Sierra Vista Homeless Healthcare Clinic (HCH)
Year program was established: 1999
Site of respite beds: Transitional Housing
Number of respite beds: 12
Hours of operation: 24-hours per day/7 days per week
Average length of stay: 10 days

Admission Criteria
Clients must be verifiably homeless, be ambulatory without assistance, be able to manage medications and personal hygiene needs independently, and not require oxygen therapy.

Clinical Services Provided
Physician
Nurse Practitioner/Physicians’ Assistant
Nurse
Dental
Medication storage
Substance abuse/mental health
Screening for /connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
HRSA 330(h) funds
HUD (Supportive Housing Program)
Private donations
Religious organizations
## CALIFORNIA

### Clinica Sierra Vista – Fresno Medical Respite

Agency: Clinica Sierra Vista Homeless Healthcare Clinic  
Administrative Address: 1945 N. Fine Ave, Suite 116, Fresno, CA 93727-1528  
Contact: Kevin Hamilton, Chief Program Officer  
Phone: (559) 457-5800  
Email: kevin.hamilton@ClinicaSierraVista.org  
Web: www.ClinicaSierraVista.org

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**Description**  
Fresno Medical Respite consists of 10 beds, 8 male and 2 female located in the Fresno Rescue Mission Homeless Shelter. Administrative, Medical and Social Worker support services are provided by Clinica Sierra Vista, an FQHC and 330h grantee.

**Profile**  
Operating agency: Clinica Sierra Vista Homeless Healthcare Clinic (HCH)  
Year program was established: 2011  
Site of respite beds: Shelter  
Number of respite beds: 10  
Hours of operation: 24-hours per day/7 days per week  
Average length of stay: 8 weeks

**Admission Criteria**  
Clients must ambulatory, and not require special diets, IV therapy, or extensive wound care.

**Clinical Services Provided**  
Physician  
Nurse  
Medication dispensing & storage  
Substance abuse/mental health  
Screening for /connection to a primary care provider

**Support Services Provided**  
Meals  
Transportation  
Case Management

**Funding Sources**  
Hospital (grant)  
HRSA 330(h)
CALIFORNIA

Contra Costa Respite & Interim Housing Program

Agency: County of Contra Costa
Address: 2047-C Arnold Industrial Way, Concord, CA 94520
Contact: Cynthia Belon, Behavioral Health Services Director
Phone: (925) 957-5201
E-Mail: Cynthia.Belon@hsd.cccounty.us

Description
The Contra Costa Respite Interim Housing Program is a 24 bed stand-alone facility that is open 365 days per year, 24/7, and provides a total of 8760 bed nights. Program participants have private and/or semi-private accommodations, medical and psychiatric services and follow-up, meals, case management, benefits and housing search assistance. The overall goal of the program is health stabilization and promotion of recovery. Long-term goals include ongoing connection to health and social services, and assisting clients towards transitioning into permanent supportive housing.

Upon admission, a diagnostic medical assessment and treatment plan are developed. In implementing the care plan, onsite medical providers coordinate with primary care physicians and/or hospital staff. Simultaneously, case management services are provided, including benefits assistance; referrals to appropriate medical resources; referrals to substance abuse/mental health resources; and housing search assistance and placement. The average length of stay is 14-21 days. Individuals stay in the program until it is determined that they are medically stable and can transition into the general emergency shelter population, where they will continue to receive shelter and comprehensive case management services until housing has been achieved.

Profile
Operating agency
- County of Contra Costa (Public)
Year that the program was established: 2010
Site of respite beds: Stand-alone Facility
Number of respite beds: 24
Hours of operation: 24/7
Average length of stay: 14-21 days

Admission Criteria
- Homeless
- Independent in ADLs including taking medication
- Does not require >6 weeks stay
- Independent in mobility
- Behaviorally appropriate for group setting
- Continent of urine and stool
- Patient agrees to respite admission
- Has not received benzodiazepine for alcohol withdrawal in past 24 hours
- Willing to comply with C.C.C. Respite/Shelter rules
- Alert and Oriented
- Independent in wound care or Home Health Nurse supplied or needs assist less than 4x/wk.
Clinical Services Provided
Nurse Practitioner/Physicians’ Assistant
Nurse
Medication storage
Substance abuse/mental health services
Screening for /connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management
Job training/placement

Funding Sources
Hospital
Local government
HRSA 330(h) (onsite FQHC satellite clinic 20 hrs/wk)
Medicaid
Medicare
CALIFORNIA

Illumination Foundation – Recuperative Care Centers of Orange County & Los Angeles

Agency: Illumination Foundation
Administrative address: 2691 Richter Ave, Suite 107, Irvine, California 92606
Contact: Aiko Tan, Executive Director of Health Services
Phone: (949) 273-0555
Email: atan@ifhomeless.org
Website: http://www.nhfca.org/Recup/Home.aspx

Description
The Recuperative Care Center of Orange County provides post-hospitalization healthcare services to homeless patients transitioning out of an acute care hospital. Patients receive basic medical oversight in a clean, safe environment in order to recover from minor physical injuries or illnesses. Patients entering recuperative care have been medically discharged from an acute care hospital and have been deemed appropriate to return to a residential or home environment. Recuperative Care is not designed to address the ongoing chronic medical conditions, but rather to provide the basic medical and custodial care necessary to stabilize the patient after hospital discharge, and then connect them to social service and temporary/permanent housing programs.

The Recuperative Care Program of Los Angeles provides post-hospitalization healthcare services to homeless patients transitioning out of an acute care hospital. Patients receive basic medical oversight in a clean, safe environment for an average of 10 days in order to recover from minor physical injuries or illnesses. Patients entering recuperative care have been medically discharged from an acute care hospital and have been deemed appropriate to return to a residential or home environment. Recuperative Care is not designed to address the ongoing chronic medical conditions, but rather to provide the basic medical and custodial care necessary to stabilize the patient after hospital discharge, and then connect them to social service and temporary/permanent housing programs.

Profile
Operating agencies
- Hospitals (in Los Angeles and Orange County)
- Illumination Foundation (Non-profit)
- National Health Foundation (Non-Profit)
Year programs were established: January 2010
Site of respite beds: Motel/hotel
Number of respite beds: 35 beds (Orange County), 20 beds (Los Angeles)
Hours of operation: 8am-7pm, Monday-Friday; 9am-6pm, Saturday-Sunday
Average length of stay: 15 days (Orange County), 10 days (Los Angeles)

Admission Criteria
- Homeless and have an acute medical condition with an identifiable end point of care
- Independent in mobility, ADL’s and medication administration
- Continent of bladder and bowel
- Medically and psychiatrically stable

Clinical Services Provided
Nurse (onsite)
Social Worker (onsite)
Support Services Provided
Meals
Transportation
Case Management
Behavioral Counseling

Funding Sources
Hospital – The Recuperative Care Center is a joint effort between The National Health Foundation and The Illumination Foundation. 40 Los Angeles County hospitals have signed a Letter of Agreement to participate in the program (Hospital Rate: $250/day for an average of 10 days of recuperative care). 23 Orange County hospitals have signed a Letter of Agreement to participate in the program (Hospital Rate: $250/day for an average of 15 days of recuperative care).
CALIFORNIA

Open Door Health Systems – Healing Ring

Agency: Open Door Health Systems
Address: (contact) Telehealth Visiting Specialist, 2426 Buhne St, Eureka, CA 95501
Contact: Karen O’Connell
Phone: (707) 672-6675
Fax: (707) 442-4039
Email: koconnell@opendoorhealth.com
Web: www.opendoorhealth.com

Description
Our program is a collaborative effort between Open Door Health Systems, an HCH grantee, and Saint Joseph Hospital. The hospital pays for five beds in a Clean and Sober house. Open Door screens patients to ensure admissions are appropriate and provides outpatient medical care for patients without a PCP. Saint Joseph Hospital provides case management.

Profile
Operating agencies:
• Open Door Health System (HCH)
• Saint Joseph (Hospital)
Year program was established: 2006
Site of respite beds: Transitional Housing
Number of respite beds: 5; 3 male and 2 female located in a clean and sober house
Hours of operation: Referrals are taken M–Th 9 a.m. – 3 p.m.
Average length of stay: 2 weeks

Admission Criteria
• Open only to patients from Saint Joseph Hospital and clients of Open Door Clinics
• Approved by an Open Door Health System Case Mgr and C&S Mgr
• Must be ambulatory (may use walker/crutches)
• Able to perform Activities of Daily Living
• If home health services are not involved then the participant must be able to perform own dressing changes etc.
• Agree to remain clean and sober while in the respite house

Clinical Services Provided
Physician (referrals)
Nurse (RN case management by St Joseph Hospital)
Social Worker (from St. Joseph Hospital)
Screening for/connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital
JWCH Institute, Inc. – Recuperative Care Program

Agency: JWCH Institute, Inc.
Address: 515 E. 6th Street, Los Angeles, CA 90021
Contact: Marcus Hong
Phone: (323) 263-8840
Fax: (323) 263-8348
Email: mhong@jwchinstitute.org

Description
The mission of the JWCH Institute is “to improve the health status of underserved segments of the population of Los Angeles County through the direct provision or coordination of health care, health education services and research.” The JWCH Institute is a Federally Qualified Community Health Center, with dual designation as a Community Health Center and Health Care for the Homeless Grantee from the Health Resources and Services Administration HRSA.

The Recuperative Care Program is operated and staffed by the JWCH Institute, Inc., and provides transitional housing, meals, case management and medical care to homeless persons who are recovering from an acute illness or injury. The program offers short-term care to patients with conditions that would be exacerbated by living on the street, in shelters or other unsuitable places. The program maintains 71 beds between 3 locations (23 beds at the Weingart Center in Downtown Los Angeles, 30 beds at Bell shelter in the City of Bell, and 18 “lower level” beds at PATH in Los Angeles).

The Recuperative Care Program at Bell Shelter is a joint effort between JWCH Institute, Inc. and the Salvation Army to provide recuperative care for homeless persons recently discharged from area hospitals with nowhere to go to recover. This location maintains 30 beds along with 24-hour nursing care and other supportive services and is located at the Salvation Army’s Bell Shelter in the city of Bell. A continuum of services is offered to each client including, as appropriate.

The Recuperative Care Program at Weingart is a joint effort between JWCH Institute, Inc. and the Weingart Center to provide transitional housing and recuperative care for homeless persons recently discharged from area hospitals with nowhere to go to recover. The program maintains 23 beds along with 24-hour nursing care and other supportive services and is located at the Weingart Center in downtown Los Angeles’ Skid Row area. A continuum of services is offered to each client including, as appropriate.

Profile
Operating agency:
- JWCH, Inc. (HCH)
Number of years in operation: over 10 years
Site of respite beds: Homeless Shelter, Transitional Housing
Number of respite beds: 30 beds at Bell Shelter, 23 at Weingart Center, 18 “lower level” recuperative care beds at PATH (71 total beds)
Hours of operation: Monday thru Saturday (except 2nd Saturday) 8am – 5pm.
Average length of stay: 30 days

Admission Criteria
Patient must be Homeless, have an acute medical illness, be independent in the activities of daily living and medication administration, must be bowel and bladder continent, be medically and psychiatrically stable, have a condition with an identifiable end point of care for discharge.

Clinical Services Provided
Physician
Physicians’ Assistant
Nurse
Medication dispensing and storage
Screening for/connection to a primary care provider
Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital: Receive a payment per patient referred
Medicaid/Medicare
HUD
Foundations
CALIFORNIA
Homeward Bound of Marin – Transition to Wellness

Agency: Homeward Bound of Marin  
Address: 1385 N. Hamilton Pkwy, Novato, CA 94949  
Contact: Mary Kay Sweeney  
Phone: (415) 382-3363  
Fax: (415) 382-6010  
E-Mail: mksweeney@hbofm.org  
Web: www.hbofm.org/Homeless-Adults.html

Description
Transition to Wellness utilizes six medical beds at Homeward Bound’s Next Key Center and one bed in the community (hotel voucher). A nurse case manager and a program coordinator provide medical follow-up services, a medical home, as well as linkages to substance abuse services and entitlements.

Patients who have a substance abuse disorder or addiction disorder must abstain from alcohol/drugs while in the program. Patients with addictive disorders are encouraged to attend on-site relapse recovery or AA/NA meetings. The program does accept individuals with mental illness if they are psychiatrically stable and taking prescribed medications.

Profile
Operating agency  
- Homeward Bound of Marin (Non-profit)
Year program was established: November 2008
Site of respite beds: Homeless Shelter, Transitional Housing, Apartment Units
Number of respite beds: 5
Hours of operation: Monday – Friday, 9am – 5pm
Average length of stay: 21 days

Admission Criteria
Patients must be referred by a local funding hospital and demonstrate a medical need for respite. There must be a discharge diagnosis with an identifiable end point to care while at respite. Patient must be behaviorally appropriate for a homeless shelter setting and agree to follow a code of conduct. Patients must be independent in ADLs, wound care and medication management as well as ambulatory and continent.

Clinical Services Provided
Nurse Practitioner
Screening for/connection to primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital, Local government
CALIFORNIA

Temporary Emergency Shelter for Medically Fragile Homeless

Agency: Transitional Food and Shelter, Inc.
Address: 3770 N. River Rd., Paso Robles, CA 93446
Contact: Pearl Munak, President
Phone: (805) 238-7056
Email: president@nowheretogo.com
Web: www.nowheretogo.com

Description
TESMFH provides temporary, emergency shelter to homeless individuals who are too ill, injured or disabled to be in an overnight homeless shelter. Families stay with the patient in apartments and motels. No medical care is provided; clients get medical care from community resources. We accept only referrals from hospitals and social service agencies, with doctor's letters.

Profile
Operating agency
   • Transitional Food and Shelter, Inc. (Non-profit)
Year program was established: 1999
Site of respite beds: Motel/Hotel; Rented apartments
Number of respite beds: 6
Hours of operation: 24/7 (information and referrals accepted Mon – Fri 9:00am – 5:00pm)

Admission Criteria
Must be referred by hospital or social service agency.
Must have form from doctor saying too ill, injured or disabled to be in overnight shelter.

Clinical Services
Social worker (offsite)

Support Services
Case management

Funding Sources
Private donations
Local government
Foundations
United Way
CALIFORNIA

COTS – The Mary Isaak Center

Agency: Committee on the Shelterless
Address: 900 Hopper Street, Petaluma, CA 94952
Contact: Bill Hess
Phone: (707) 520-4377
Fax: (707) 776-4711
Email: billh@cotts-homeless.org
Web: www.cots-homeless.org

Description
The Mary Isaak Center Medical Respite Unit is a free-standing 5 bed respite unit located inside a 100-bed emergency shelter. Contracted health services are available three days a week to assist the coordination of health and the treatment of acute illness. Additional services available on-site include mental health specialists, S.O.A.R certified SSI/SSDI benefits specialists, Wellness program with full curriculum, Case Management, Drug and Alcohol Recovery services. Respite Unit members can transition to the emergency shelter and therefore may stay up to six months.

Hospitals may refer patients to the Medical Respite Unit. Patients are accepted on a space-available basis and must meet Admission Criteria.

Profile
Operating agency
- Committee on the Shelterless (Non-profit)
Site of respite beds: Homeless shelter
Year established: 2004
Number of respite beds: 5
Hours of operation: 7 days a week, 24-hours per day

Admission Criteria
The Mary Isaak Center is a clean and sober facility. Applicants are required to be 18 years or older. They must be homeless or at risk of being homeless. Upon intake, applicants are required to take and pass on-site drug and alcohol screenings. We do not accept registered sex offenders or arsonists. Applicants must be able to perform ADLs.

Clinical Services Provided
Nurse Practitioner (onsite)
Social Worker

Support Services Provided
Meals
Transportation
Case Management
S.O.A.R. certified SSI/SSDI benefits specialist

Funding Sources
Private donations
CALIFORNIA

The Effort, Inc. – Interim Care Program

Agency: The Effort, Inc.
Address: 1820 J Street, Sacramento, CA 95814 (executive office)
Contact: Amber Salazar, Program Manager
Phone: (916) 709-4650
Email: asalazar@theeffort.org
Web: www.theeffort.org

Description
The Effort leads a collaborative of the hospital systems in Sacramento, community based organizations, and the county government—all of whom have come together to create a respite care shelter for homeless patients discharged from hospitals. Kaiser Permanente, Mercy, Sutter Medical Center, Sacramento, U. C. Davis Medical Center, and the County of Sacramento provide on-going funding for the program.

Eighteen beds in the Salvation Army shelter are designated for the Interim Care Program, where clients have three meals a day and a safe, clean place to recover from their hospitalizations. The Effort provides on-site nursing and social services to support clients in their recuperation and help them move out of homelessness. The Effort case manager links clients with mental health services, substance abuse recovery, housing workshops and provides disability application assistance.

Patients are referred from the hospitals to the Interim Care Program when they are well enough to go home but need on-going rest and follow-up treatment. Patients come for various reasons including a wound that needs to heal, recovery after surgery, or injury from an accident. Clients can stay in the program up to six weeks, depending on their medical condition.

Profile
Operating agency
- The Effort, Inc. (HCH)
Year program was established: 2005
Site of respite beds: Homeless Shelter
Number of respite beds: 18
Hours of operation: Monday–Sunday, 24/7
Average length of stay: 24 days

Admission criteria
Must meet hospital discharge criteria, but are not yet ready to resume activities.

Clinical Services Provided
Physician
Nurse
Substance abuse/metal health
Screening for /connection to a primary care provider
Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital (annual grant with 4 participating hospitals)
Local government
CALIFORNIA

San Diego Rescue Mission – Recuperative Care Unit

Agency: San Diego Rescue Mission
Address: 120 Elm Street, San Diego, CA 92101
Contact: Tavis Walker, Director
Phone: (619) 819-1760
Fax: (619) 234-4101
Email: twalker@sdrescue.org
Web address: www.sdrescue.org

Description
Recuperative Care is a program operated by the San Diego Rescue Mission that provides housing, meals, case management, counseling, and supportive services to homeless persons who are recovering from acute illness or injury. The program offers short-term care to patients with conditions that would be exacerbated by living on the street, in shelters, or unsuitable places. The program facilitates connection to medical services and follow-up care to assist patient recovery and decrease reliance on emergency department services and hospitals; however it is not a medical facility or skilled nursing unit. The goal of the RCU is to aid patient recovery, increase self-sufficiency, and facilitate placement in more permanent housing. The program maintains 28 beds.

Profile
Operating agency
• San Diego Rescue Mission (Non-profit)
Year program was established: 2009
Site of respite beds: Homeless Shelter
Number of respite beds: 28
Hours of operation: Open daily 24/7
Average length of stay: 6 to 8 weeks

Clinical Services Provided
Medication storage
Substance abuse/mental health
Screening for/connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management (including benefits acquisition)

Funding Sources
Hospitals (Referring hospitals pay per patient, per day based on level of care required)
United Way
CALIFORNIA

San Francisco Medical Respite & Sobering Center

Agency: San Francisco Department of Public Health
Address: 1171 Mission Street, San Francisco, CA 94103
Program contact 1: Tae-Wol Stanley, Program Director, (415) 734-4201, tae-wol.stanley@sfdph.org
Program contact 2: Alice Moughamian, Nurse Manager, (415) 734-4202, Alice.Moughamian@sfdph.org
Program contact 3: Michelle Schneidermann, Medical Director, (415) 206-4462, mschneiderman@medsfgh.ucsf.edu
Fax: (415) 734-4218

Description
The mission of the Medical Respite and Sobering Center is to provide recuperative care, temporary shelter, and coordination of services for medically and psychiatrically complex, homeless adults in San Francisco.

The San Francisco Medical Respite Program provides recuperative services for hospitalized homeless persons who are too medically frail to return to the streets but who do not require further hospitalization or skilled nursing facility care. The medical respite program offers temporary shelter, three meals a day, transportation, as well as medical and psychosocial services. Clinical staff at the medical respite program provide basic follow-up of acute problems, bridging primary care, and medication management and adherence. Patients are transported for necessary follow-up appointments, including primary care, specialty care, mental health, methadone treatment, and outpatient IV antibiotic/infusion treatment. Patients are followed by on site social workers and case managers who address discharge planning and assist with entitlements and housing applications. Patients receive referrals to behavioral health care and case management, when appropriate.

In addition to providing respite care, we also run the Sobering Center for the city. Only some of the following answers pertain to the Sobering Center or its clients. For more information on the Sobering Center, please contact Tae-Wol Stanley or Shannon Smith-Bernardin (Sobering Coordinator 415-734-4209).

Profile
Operating agency
- San Francisco Department of Public Health (Public)
- Community Awareness & Treatment, Inc. (Non-profit)
Year program was established: 2007
Site of respite beds: Stand-alone Facility
Number of respite beds: 45
Hours of operation: 24/7 (only accept new clients between 9 a.m. – 3 p.m.)
Average length of stay: 5 weeks

Admission Criteria
The San Francisco Medical Respite Program provides recuperative services for hospitalized homeless persons who are too medically frail to return to the streets but who do not require further hospitalization or skilled nursing facility care. The program prioritizes and accepts referrals from inpatient medical and surgical services. However, the program occasionally accepts community referrals (outpatient surgery, oncology or community clinics, etc.) on a case by case basis. All referred patients must be at least 18 years old.

Admission criteria include details about specific infectious disease requirements, including TB screening, influenza, infectious diarrhea, wounds, lice/scabies. In addition, they also include details about requirements for independence with ADLs and preparing patients for methadone maintenance.

Inpatient clinicians must complete a referral form via eReferral or another pre-approved referral method. Referring clinicians must provide a pager number and identify a backup person to whom questions may be addressed. The medical respite program accepts patients based upon bed availability, seven days a week.
Patients must be discharged to the medical respite program with a week’s supply of medications and any DME in hand as well as a discharge summary. Before referring, clinicians must insure that the patient does not meet exclusion criteria.

**Exclusion Criteria**

**A. Patients referred to respite must be ready for hospital discharge by standard criteria.** They must not meet criteria for skilled nursing care. Medical respite care staff must be able to care for them.

*Exclusion criteria based on the above statement include that the patient must not:*
1. Have unresolved medical or surgical issues that would necessitate daily physician follow-up or that would necessitate continued stay in an acute care hospital based on standard criteria
2. Need IV antibiotics more than once daily (once daily ok if infusion services set up prior to arrival)
3. Need acute physical rehabilitation services at the SNF level
4. Need total care (for basic ADLs)
5. Be incontinent
6. Need full assistance with transfers
7. Have decubitus ulcers requiring special beds

**B. Patients must not have behavioral issues that require staffing beyond respite’s capacity**

*Exclusion criteria based on the above statement include that the patient must not:*
1. Have their primary reason for hospital admission be psychiatric
2. Require a sitter
3. Require physical restraints
4. Have severe cognitive impairment that makes patient unable to consent to care, unable to perform basic ADLs, or at high risk of wandering.

**Clinical Services Provided**
- Physician – Medical Director 0.5 FTE
- Nurse Practitioner/Physicians’ Assistant
- Nurse
- Medication management and storage
- Connection to specialty care providers
- Screening for/ connection to a primary care provider
- Social worker

**Support Services Provided**
- Meals
- Transportation
- Case Management

**Funding Sources**
- Local government (City & County General Fund)
CALIFORNIA

County of Santa Clara Medical Respite Program

Agency: County of Santa Clara, Valley Homeless Healthcare Program
Address: 2011 Little Orchard Street, San Jose, CA 95125
Contact: Christine Finn, Assistant Nurse Manager, Valley Homeless Healthcare Program
Phone: (408) 885 3328
Fax: (408) 885 3377
Email: Christine.Finn@hhs.sccgov.org

Description
The Santa Clara County medical respite program serves homeless adults in need of recuperative care. The medical respite program is a collaborative initiative between seven hospitals in the county, local shelter provider EHC LifeBuilders, and the county’s Valley Homeless Healthcare Program (VHHP), which operates the program. Destination: Home – the task force charged with implementing the recommendations of the County’s Blue Ribbon Commission on Ending Homelessness – coordinated this government and private sector partnership. The 15-bed respite center is located at EHC LifeBuilders James F. Boccardo shelter in San Jose. The Valley Homeless Healthcare Program clinic also operates at that site, providing on-site primary and preventive care, medications, and mental health services to both shelter and respite clients. The medical respite program provides referrals for medical care, mental health care, and substance abuse services, as well as self-care planning and education, health education, patient support groups, transportation, and linkages to income, insurance, and housing benefits. The program will offer case management services for chronically homeless individuals in 2009.

Profile
Operating agency
• Valley Homeless Healthcare Program (HCH)
Year program was established: 2008
Site of respite beds: Homeless Shelter
Number of respite beds: 15
Hours of operation: Open daily 24/7. Medical respite staff available Monday through Friday 8:00 a.m.–5:00 p.m.

Admission Criteria
• Must have a medical condition that can be effectively addressed within a limited amount of time, ≤ 6 weeks.
• Must be homeless or lack adequate housing to support recovery.
• Must be ≥ 18 years old.
• Must be able to perform all activities of daily living independently, including storing and taking own medications.
• Must be independently mobile and able to self-transfer in and out of bed.
• Must be continent.
• Must be alert and oriented, and mentally competent.
• Must have been clean and sober for at least 72 hours.
• Must not require IV therapy or other skilled nursing care.
• Must be willing and able to comply with EHC BRC rules and agree to admission there.
• Must be behaviorally appropriate for a group setting.

Clinical Services Provided
Physician
Nurse Practitioner/Physicians’ Assistant
Nurse
Social Worker (onsite)
Medication dispensing & storage
Substance abuse/mental health (on-site and by referral)
Screening for/connection to primary care provider
Support Services Provided
Meals
Transportation
Case Management
Job Training or Placement (on-site)
Weekly Respite support group

Funding Sources
Hospitals
HRSA 330(h) funds: Funding for expanded clinical services at the on-site shelter clinic were provided through an
Expanded Medical Capacity Grant
United Way
Kaiser Permanente
CALIFORNIA

Venice Family Clinic – Respite Care Program

Agency: Venice Family Clinic
Address: Santa Monica, CA
Contact: Timothy Smith, Director of Communications, Venice Family Clinic
Phone: (310) 664-7910
E-Mail: tsmith@mednet.ucla.edu
Web: www.venicefamilyclinic.org

Description
The Respite Care Program is operated by OPCC and the Venice Family Clinic, in collaboration with Saint John’s Health Center. Ten beds are held for homeless patients referred from the Venice Family Clinic and two local hospitals, Saint John’s Health Center and Santa Monica-UCLA Medical Center and Orthopaedic Hospital. The program provides room and board, case management, and housing assistance. Venice Family Clinic provides on-site medical care. The goal of the project is to reduce unnecessary, costly re-hospitalization among members of the local homeless population.

Profile
Operating agencies
- Venice Family Clinic (HCH)
- OPCC (Non-profit)
Year program was established: 2008
Site of respite beds: Shelter
Number of respite beds: 10 (5 for men; 5 for women)
Average length of stay: 3 weeks
Hours of operation: Referrals: M, T, W, R, F, 9:00 am to 3:00 pm; clinic: M, W, F, 9:00 am to noon / T, R, 1:30 to 4:30 pm

Admission Criteria
- Homeless
- Single adults 18 or over
- Lack stable housing at discharge
- Acute problem that would benefit from short-term respite care
- Does not require more than 3 week respite stay
- Have a condition with an identifiable end point of care for discharge from respite bed
- Independent in ADL’s including medication administration
- Independent in mobility
- Continent of urine and feces
- No IV lines
- Cleared for tuberculosis (see separate criteria)
- Does not require private room/isolation. If MRSA, pt. has been on antibiotic for 2 days and affected area can be appropriately covered
- No evidence of scabies, lice, or other infestation
- Currently at low risk for alcohol withdrawal seizures/delirium tremens and does not require medical detox.
• Behaviorally appropriate for group setting (including no known suicidal or assaultive risks)
• Does not require supplemental oxygen
• Does not need SNF placement
• Patient agrees to respite admission
• Patient willing to refrain from alcohol/drugs while in respite program

**Clinical Services Provided**
Physician
Medication dispensing
Medication monitoring

**Support Services Provided**
Meals
Transportation
Case Management

**Funding Sources**
Local Government
CALIFORNIA

Nightingale Recuperative Shelter

Agency: Catholic Charities of Santa Rosa
Address: 600 Morgan Street, Santa Rosa, CA 95401
Contact: Erica Wooten, MSN
Phone: (707) 545-1850
Fax: (707) 545-1920
E-Mail: ericawoo59@gmail.com

Description
Nightingale Recuperative Shelter is a five bed stand alone shelter with a nearby clinic. Of the 5 beds available, three are reserved for male patients and two for female patients. Additional beds are being planned. Our Nurse Intake Coordinator has been with the program since May 2010.

Profile
Operating agency
- Catholic Charities of Santa Rosa (Non-profit)
Year program was established: May 2010
Site of respite beds: Stand-alone facility
Number of respite beds: 5

Admission Criteria
Patients must demonstrate a medical need for respite, be independent in activities of daily living (ADL), and not actively drinking or using drugs.

Clinical Services Provided
Nurse
Screening for/ connection to primary care provider

Support Services Provided
Meals
Case Management

Funding Sources
Unavailable
COLORADO

Ascending to Health Respite Care

Agency: Ascending to Health Respite Care, Inc.
Address: 123 West Rio Grande, Colorado Springs, CO 80903
Contact: Gregory Morris, PA-C, Executive Director
Phone: (719) 440-7872
Email: greg@athrc.com
Website: www.ascendingtohealthrespitecare.org/

Description
Ascending to Health Respite Care works with local hospital discharge teams to transition homeless patients to a safe environment for recuperation. The program places homeless patients who do not require significant medical oversight into motel rooms or transitional housing where they are able to access supportive services and on call clinical services. A second shelter-based program serves homeless individuals needing greater medical oversight. The program partners with a local shelter and FQHC to accept patients not necessarily needing hospital admission, but too ill for the streets.

Profile
Operating agency
• Ascending to Health Respite Care (Non-profit)
Year program was established: 2011
Site of respite beds: Motel/hotel, shelter, transitional housing
Number of respite beds: 14 (with ability to expand if needed)
Hours of operation: Monday-Friday 8:00am – 5:00pm (on call support)
Average length of stay: 6 nights

Admission Criteria
Admission is based on staff assessment at hospital discharge. Patients must be independent in ADLs, have no indwelling lines, and not at risk of detoxification.

Clinical Services Provided
Nurse
Substance abuse/mental health
Dental
Screening for/ connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Medicaid
Medicare
Other funding sources pending
COLORADO

Colorado Coalition For The Homeless Medical Respite Care Program

Agency: Colorado Coalition for the Homeless
Address: 2100 Broadway, Denver, CO 80205; 2301 Lawrence Street, Denver, CO 80205
Contact: Liz Solano-Galvan
Phone: (303) 587-6148
Email: lgalvan@coloradocoalition.org
Web: www.coloradocoalition.org

Description
The Coalition’s Respite Care program serves homeless persons who have no place to recover after they have been discharged from the hospital. In addition to providing daily visits from nursing staff, patients benefit from a safe, secure, restful environment where they can access supportive services such as housing assistance and treatment programs. Thirty beds are available for Respite Care at three locations: Beacon Place, the Samaritan House and The Crossing at Denver Rescue Mission.

Profile
Operating agency
- Stout Street Clinic (HCH)
- Colorado Coalition for the Homeless (Non-profit)
Year program was established: 2002
Site of respite beds: Homeless Shelter, Stand-alone facility
Number of respite beds: 30
Hours of operation: M–F 8:30 a.m. to 4:30 p.m.
Average length of stay: 2–3 months

Admission Criteria
- Patient has an acute medical condition that can be effectively addressed within a limited amount of time.
- Patient must be homeless;
- Must be alert and oriented to person, place, and time;
- Must be continent of bowel and bladder;
- Must be completely independent with all ADLs and able to function in a residential/shelter type setting;
- Clean and sober for 72 hours and not at risk for significant withdrawal.
- Over the age of 18
- Willing to comply with the rules of the facility in which the bed is located.

Clinical Services Provided
Physician (onsite)
Nurse (onsite)

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital
HRSA 330(h) funds
Local government
United Way
Catholic Charities of Central Florida – Pathways To Care

Agency: Catholic Charities of Central Florida, Inc.
Address: 430 Plumosa Avenue, Casselberry, FL 32707
Contact: Dawn Zinger, Administrator
Phone: (407) 388 0245
Fax: (407) 388 0478
e-Mail: dawn.zinger@cflcc.org
Web: http://www.cflcc.org

Description
Pathways to Care is a recuperative care program for poor or homeless men and women who are recovering from a acute illness or injury. Pathways to Care is also a state-licensed assisted living facility. Resident are referred by area hospital discharge planners and other health agencies for a short-term stay. Residents are provided a clean, safe and supportive environment, medication management, 3 meals daily and snacks, transportation to medical appointments, case management, even laundry services. Once initial healing is successful, the resident may be eligible to move to other shelter-plus programs. Pathways to care has a sister program, Pathways to Independence, on site, where independent living and social service programs continue to support the individual toward greater health, hope, and self-sufficiency.

Profile
Operating agency
- Catholic Charities of Central Florida, Inc. (Non-profit)
Year program was established: 2003
Site of respite beds: Assisted Living Facility
Number of respite beds: 60 Total, including 40 beds in Pathways to Care and 20 beds in Pathways to Independence.
Hours of operation: The facility is staffed 24 hours per day--365 days a year by "Resident Assistants/Medication Technicians. Administrative staff are in the facility from 8:00am to 7:00pm, Monday thru Friday and key staff are available 24 hours per day. Intakes generally take place 10:00am to 6:00pm, Monday thru Friday, unless re-arranged.
Average length of stay: Pathways to Care 37 days; Pathways to Independence 270 days

Admission Criteria
A Pathways to Care resident MUST:
- require care and treatment for a post-surgical or acute medical condition, and be expected to recuperate with 45 days or less.
- be sufficiently healthy so as not to require 24 hour nursing care.
- be ambulatory, and capable of self-preservation in a emergency situation involving immediate evacuation of the facility.
- be able to generally perform the activities of daily living independently.
- be able to participate in social and leisure activities.
- be capable of taking his/her medications without assistance, and operate any medical apparatus involved with the care of the condition without assistance.
• be free from signs of symptoms of any communicable disease which is likely to be transmitted to other residents of staff. However, a person who is HIV-positive may be admitted provided that he/she is otherwise eligible for admission according to all other intake criteria.
• have a current non-reactive nasal culture, if history of MRSA.
• be at least 18 years of age.
• be referred directly from a hospital, community health center/clinic, or surgical center.

A Pathways to Care resident MUST NOT:
• be bed-ridden or be determined to be incapacitated.
• have sores or skin breaks classified as a stage 2, unless home health care is provided. The resident can NOT be admitted with a stage 3 or stage 4 pressure sore.
• be incontinent
• require a special or therapeutic diet that cannot be met by Pathways to Care.
• Be violent or have an acute psychiatric or mental illness, or require use of restraining devices.
• have an active substance abuse condition.

A Pathways to Independence resident MUST first be admitted into Pathways to Care

Clinical Services Provided
Nurse (onsite)
Licensed Mental Health Counselor
Medication storage and monitoring

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital
HUD (HOPWA Grant – Housing Opportunity for Persons with Aids)
Private donations
Local government
Religious organizations
Foundations
FLORIDA

Pinellas Hope Medical Respite Services

Agency: Catholic Charities of St. Petersburg
Address: 5726 126th Avenue North, Clearwater, FL 33760
Contact: Joy McRae-Fox, Program Coordinator
Phone: (727) 244-5217
Email: jmcrae-fox@ccdosp.org
Web: www.ccdosp.org

Description
Pinellas Hope Medical Respite Services is a collaborative effort between BayCare Health System, Catholic Charities, and the Allegany Franciscan Foundation. Ten medical respite beds for set aside for individuals in need of recuperative care who are too medically frail to return to the streets but do not require further hospitalization or skilled nursing facility care. Clients receive nursing care through BayCare HomeCare when warranted and assistance with establishing a primary care provider, needed medication, case management, housing referral, meals and transportation.

Profile
Operating agencies
- Catholic Charities of St. Petersburg (Non-profit)
- BayCare Health System (Health System)
- Allegany Franciscan Foundation (Non-profit)
Year program was established: 2009
Site of respite beds: Homeless Shelter
Number of respite beds: 10
Hours of operation: 24-hours
Average length of stay: 54 days

Admission Criteria
Adult homeless person being discharged from a Pinellas County BayCare emergency room or an inpatient medical or surgical unit in need of recuperative services. Must meet the following criteria:
- Be ready for hospital discharge by standard criteria. They must not meet criteria for skilled nursing care.
- Be currently homeless
- Be continent
- Be free from a communicable disease (Does not require isolation)
- Be able to function without supplemental oxygen
- Be in stable mental health
- Be able to perform all activities of daily living independently
- Be free from active domestic violence issues (Does not require confidential shelter)
- Be able to secure required medications before entering Pinellas Hope
- No active warrants for arrest
- Not required to register on sexual offender registry
- Does not require electricity in accommodation.
Clinical Services Provided
Medication storage
Home health care provided on site
Screening for/connection to primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital (collaborative grant)
Religious organizations
Foundations
FLORIDA
Broward House

Agency: The Broward House
Address: 417 Southeast 18th Court, Fort Lauderdale, FL 33316
Contact: Dr. Edwige Jacques-Parent
Phone: (954) 522-4749 x3212
Email: ejacques-parent@browardhouse.org
Web: www.browardhouse.org

Description
The Broward House cares for homeless individuals who are discharged from a hospital or shelter with an acute condition, in need of 24 hr recuperative care, and meets AHCA Assisted Living Facility guidelines.

Profile
Operating agency
- Broward House (Non-profit)
Year program was established: 1998
Site of respite beds: Assisted Living Facility (ALF)
Number of respite beds: 26
Hours of operation: 24-hours
Average length of stay: 3 to 4 months

Admission Criteria
Homeless, medically fragile adults in need of acute recuperative care within an AHCA licensed Assisted Living Facility with 24 hour nursing care.

Clinical Services Provided
Nurse (24/7)
Medication dispensing
Medication storage
Substance abuse/mental health
Screening for/connection to primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding sources
Local government
North Broward Hospital District HCH Program

Agency: Broward Health
Address: 1101 West Broward Blvd., Fort Lauderdale, FL 33311
Contact: Julie Solomon-Bame, Respite Care Coordinator, at 954/605-1594 or Portia Anderson, Manager of Health Care for the Homeless, at 954/527-6049
Fax: (954) 527-6052
Email: jsolomon@browardhealth.org; panderson@browardhealth.org
Web: www.browardhealth.org

Description
Broward Health’s Health Care for the Homeless Program, the Bernard P. Alicki Health Center, provides health care services at fixed and mobile outreach locations to homeless people of Broward County. The health center deploys health care teams consisting of physicians, nurse practitioners, registered and licensed practical nurses, and other professional personnel to serve its various locations, including an assisted living facility used for medical respite care.

Profile
Operating agencies
- Health Care for the Homeless (HCH)
- Broward General Medical Center, Coral Springs Medical Center, North Broward Medical Center and Imperial Point Medical Center (Hospitals)
- Broward Health – Broward Health is one of the 10 largest public health systems in the nation. It includes 4 hospitals and 30 primary care sites. (Non-profit, Health System)

Year program was established: August 2000 – Respite program
Site of respite beds: Assisted Living Facility (ALF)
Number of respite beds: As needed by referrals and as available at ALF
Hours of operation: ALF has 24-hour staff. Respite Care Coordinator works Monday – Friday, 7:00 a.m.–3:30 p.m.
Average length of stay: 14 – 21 days

Admission Criteria
The Homeless Respite Program is designed to serve the “traditional homeless” population and is not meant for displaced persons in the general population. It is important to make this distinction since there are populations that do not qualify for the program. Many of these are individuals unable to immediately return to their prior residence after hospitalization, due to their need for more complex medical care. Persons with mental illness and substance abuse disorders are often displaced and need some type of supportive or rehabilitative housing. While these patient populations are important, programs to address their special needs. Consequently, the following general criteria are used to screen patients into homeless respite services:
- A resident of Broward County;
- Over 21 years old;
- Scheduled for discharge from a Broward Health hospital/ clinic;
- Requires post-hospitalization short term acute medical care;
- Homeless prior to hospitalization (e.g., has no permanent dwelling or lives in grossly substandard conditions);
- Does not have a primary diagnosis of alcoholism, substance abuse or psychiatric disorder;
- Not a present danger to self or others;
- Is free from communicable diseases as certified by a licensed physician or nurse practitioner;
- Does not require 24-hour skilled nursing care

**Clinical Services Provided**
Physician
Nurse Practitioner/Physicians’ Assistant
Nurse
Dental
Medication dispensing & storage
Substance abuse/mental health
Screening for/connection to primary care provider

**Support Services Provided**
Meals
Transportation
Case Management

**Funding Sources**
Hospital
HRSA 330(h) funds
Health Care System
FLORIDA

Sulzbacher Medical Respite Facility

Agency: Sulzbacher Center
Address: 611 E. Adams Street, Jacksonville, Florida 32202
Contact: John Bowls, Director of Health Services Operations
Phone: (904)394-8065
Email: johnbowls@tscjax.org

Description

The Sulzbacher Medical Respite Facility is a short-term transitional unit in which consumers who meet admission criteria are provided medical management and supportive care during their recovery from illness or surgery.

Consumers admitted to respite care typically fall into two categories:
(1) Those who are too sick for shelters but do not require hospitalization or
(2) Those ready for discharge from the hospital but do not have a stable living environment to return to.

The medical respite facility provides short term care until the consumer is well enough to care for themselves independently or it is determined the consumer needs to transfer to a long term care facility. The goal of the Sulzbacher Medical Respite Facility is to stabilize the consumer’s medical condition so that the consumer can transition safely to self-care.

Profile

Operating agency
- I.M. Sulzbacher Center for the Homeless (HCH)
Year program was established: 2013
Site of respite beds: shelter
Number of respite beds: 28
Hours of operation: 24/7
Average length of stay: 15 days

Admission Criteria

- 18 years or older
- Homeless, in danger of becoming homeless, or in unstable living conditions.
- Have inadequate resources or are financially ineligible for other step-down service.
- Must be independent in their activities of daily living.
- Must be ambulatory or mobile with assistive devices without staff assistance.
- Must have a primary medical diagnosis.
- Must need only short term care.
- Must be willing to participate in their treatment.
- Must be bladder and bowel continent.
Clinical Services Provided
Physician (onsite)
Psychiatrist (onsite)
Nurse practitioner (onsite)
Physicians’ assistant (onsite)
Nurse (onsite)
Social worker (onsite)

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital
HRSA 330(h)
Private donations
Local government
Foundations
P. John Darby Recuperative Care

Agency: Tampa Family Health Centers, Inc.
Address: 1229 E. 131st Avenue, Tampa, FL 33612
Contact: Stephanie Theaker
Phone: (813) 866-0930
Fax: (813) 866-0929
Email: stheaker@hcnetwork.org
Web: www.tampachc.com

Description
Provides recuperative care for homeless patients who are discharged from the hospital or ER.

Profile
Operating agency
- Tampa Family Health Centers, Inc. (HCH)
Year program was established: 2008
Site of respite beds: Stand-alone Facility
Number of respite beds: 16
Hours of operation: 24/7
Average length of stay: 30 days

Admission Criteria
Referrals are taken from hospital ERs and shelters. Patient must be ambulatory.

Clinical Services Provided
Nurse Practitioner/Physicians’ Assistant
Nurse
Dental
Medication storage
Substance abuse/mental health
Screening for/connection to primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Medicaid
Medicare
HRSA 330(h)
GEORGIA

Mercy Care Services Recuperative Care Program at the Gateway

Agency: Saint Joseph’s Mercy Care Services
Address: 275 Pryor Street, Atlanta, GA 30325
Contact: Anitra Peten, MSW, Director of Behavioral Health and Social Services
Phone: (678) 843-8950
Email: apeten@mercyatlanta.org
Web address: www.stjosephsatlanta.org

Description
Saint Joseph’s Mercy Care Services launched a 19-bed recuperative care unit at the Gateway Center in October 2008. The Gateway Center is a temporary/transitional housing facility for the homeless. It was developed by Regional Commission on Homelessness and provides comprehensive services including mental health, drug addiction, job training, relocation and other programs addressing the issues facing chronic homelessness. Mercy Care Services currently provides primary care, mental health case management and HIV/TB testing five days a week at the facility. The recuperative care unit is a partnership effort between Mercy Care, Gateway Center and Grady Health System. It is staffed by an RN, social worker and two personal care aides. Patients may stay up to 30 days in the unit and have both a medical and social treatment plans.

The main goals of the program are to:
- Reduce the length of stay and related hospital cost for homeless patients by providing them access to post-discharge care in a safe and secure environment.
- Reduce readmissions and emergency room visits for this patient population.
- Reduce the number of patients who remain homeless by arranging for transition from recuperative care to other programs at the Gateway Center or appropriate housing opportunities.

Profile
Operating agency
- Saint Joseph’s Mercy Care Services (HCH)
Year program was established: 2008
Site of respite beds: Transitional Housing
Number of respite beds: 19
Hours of operation: M–F (8:30 a.m. – 8:30 p.m.); Sat–Sun (8:30 – 5:00)
Average length of stay: 30 days

Admission Criteria
Patient being discharged from hospital and accepted into the recuperative care unit at 24/7 Gateway must be:
- Male
- 18 years of age or older
- Homeless, according to the HUD definition of homelessness
- Without income
- Medically ready (sufficiently well) for discharge from the hospital
- Able to function compatibly in group living setting
- Continent
- Alert and oriented to time, place, person and circumstances
- Independent in mobility with assistive devices such as walker, cane (exception: no wheelchair dependence)

The patient must be free of the following conditions:
- Active TB, evidenced by chest x-ray and/or negative sputum
- Infection with respiratory transmission in contagious phase
- Need for intravenous fluids or medications
- Need for oxygen therapy
- Need for inpatient detoxification program
- Acute mental health crisis (psychosis, delusions, paranoia, violence)
- Risk of harm to self or others
Referring hospital identifies needed length of stay for recuperation.
- Anticipated length of stay must ordinarily be 30 days or less.
- Referring hospital agrees to provide required medications for 30 days.

Patient agrees to the following:
- Contract for admission to recuperative care pilot program
- Commitment to participate in medical, mental health and social programs to enhance client’s progress toward self-reliance
- Compliance with behavioral expectations of 24/7 Gateway Center

**Clinical Services Provided**
Physician (offsite)
Nurse Practitioner/Physicians’ Assistant (offsite)
Nurse
Medication dispensing & storage
*Connection to primary care provider*

**Support Services Provided**
Meals
Case Management
Job Training or Placement

**Funding Sources**
Foundations
United Way
GEORGIA

Good Samaritan Respite Center

Agency: Coordinated Health Services, Inc.
Address: 2110 Broad Street, Augusta, GA 30904
Contact: Donna Moore, Director
Phone: (706) 364-2600
Fax: (706) 364-2602
Email: gsrc@knology.net

Description
GSRC is a freestanding 16-bed center. Admission to the center is by referral from participating hospitals. The program is designed to enhance recovery from acute illness or injury. Persons referred may have a co-existing mental health or substance abuse problem.

Profile
Operating agency
- Coordinated Health Services, Inc. (Non-profit)
Year program was established: 2006
Site of respite beds: Homeless Shelter
Number of respite beds: 16
Hours of operation: 24 hrs/ 7 days a week
Average length of stay: 21

Admission Criteria
Homeless (HUD definition), able to perform own ADLs, able to tolerate a group living situation, acute medical condition is the primary diagnosis

Clinical Services Provided
Nurse Practitioner/Physicians’ Assistant
Nurse
Medication dispensing & storage
Connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital (per diem amount for each admission)
Private donations
Local government
Foundations
GEORGIA

The J.C. Lewis Primary Healthcare Center

Agency: J.C. Lewis Primary Health Center
Address: 125 Fahm Street, Savannah, GA 31401
Contact: Aretha Jones, Executive Director, Primary Health Services
Phone: (912) 495-8887
Fax: (912) 495-8881
Email: ajones@unionmission.org
Web: www.unionmission.org

Description
Provide quality comprehensive health services to persons at risk of, experiencing or transitioning from homelessness, uninsured or underinsured so that each person can live in the community utilizing his or her greatest strengths.

Profile
Operating agencies:
- The J. C. Lewis Health Center of Union Mission, Inc (HCH)
- Union Mission, Inc. (Non-Profit)
Year program was established: 1999
Site of respite beds: Stand-alone Facility
Number of respite beds: 32
Hours of operation: 24-hour facility
Average length of stay: 18 days

Admission Criteria
A physician or nurse practitioner of the J.C. Lewis Health Center must refer client from any of the area hospitals

Clinical Services Provided
Physician Nurse Practitioner/Physicians’ Assistant
Nurse
Dental
Medication dispensing & storage
Substance abuse/mental health
Screening for/connection to primary care provider

Support Services Provided
Meals
Transportation
Case Management
Job Training or Placement

Funding Sources
Hospital
Medicaid
Medicare
Private donations
Local government
United Way
**Description**

Interfaith House is a 64-bed recuperative care center, providing residential support for homeless adults in need of recovery from acute medical illness or injuries; and is dedicated to empowering those they serve to break the cycle of homelessness. They support and inspire residents to restore their health and rebuild their lives through providing integrated services in a holistic healing community.

Interfaith House is committed to maximizing the care and treatment residents receive during their stay. Innovative and extensive use of interagency partnership allows them to provide an array of programs and services that would not otherwise be possible.

In FY 2012, 64% of residents had a physical disability; 41% suffered from mental illnesses; 26% reported they are living with HIV/AIDS; and 62% suffered from addiction. Residents were 79% African-American, 13% Caucasian, 7% Hispanic, 1% other; 76% of them were men and 24% women; 19% are age 55-years or older; and 21% are veterans. All of our clients live below the poverty level; 52% have no income at all.

**Primary Care**

Interfaith House, through a Health Services collaboration with Heartland Health Outreach and PCC Community Wellness Center, maintains an on-site health clinic that offers residents access to primary care services eight hours per day, five days per week. Other efforts that support the complete medical recoveries of our residents include education sessions that address health maintenance and disease prevention. These sessions, facilitated by staff and interns, include topics such as hypertension, diabetes, tuberculosis, nutrition, personal hygiene and sexually transmitted diseases. Particular emphasis is placed on HIV/AIDS prevention education, which takes place twice each week along with confidential testing and counseling.

Interfaith House's objective is to provide residential and support services for homeless adults with acute medical needs, and prepare each to return to independent living. The organization is structured into three primary programs to accomplish that end.

**Assessment-Respite**

The goal of our Assessment-Respite program is to assist ill or injured homeless adults to: complete their medical recovery, begin receiving support with social and psychological issues, and successfully relocate into permanent housing. A case manager is assigned to each new resident to help determine their needs and direct them through the following services:
Health Services - A medical assessment is completed by collaborative physicians and nurse practitioners working at our medical clinic. Based on their determination, and consultation with the client’s referring hospital or clinic, we devise a medical recovery plan; then monitor their recovery process and medical regimen. We assist residents in making and getting to off-site medical appointments when necessary.

Support Services - While at IFH, residents are provided nutritionally balanced meals and interim housing services, IFH’s team helps residents with daily needs and works with each of them to begin the process of returning to self-sufficiency. This includes aiding clients in signing up for benefit programs, exploring employment options and providing one-on-one and group education and life skills training sessions on a variety of topics.

Behavioral Health Services - Many of our residents come to IFH with untreated mental health issues and addictions. At intake, a social worker assesses them for psychosocial issues and develops an individualized action plan. On-site professional mental health services are provided in collaboration with Mt. Sinai Hospital. A substance abuse counselor works with individual residents and refers them to off-site treatment when necessary; recovery groups are held on-site.

Housing Services - The end goal of our program is to enable IFH residents who have completed their recoveries to establish themselves in permanent housing. Housing advocates on staff assess residents’ long term housing needs, identify placement options, and help secure permanent housing units, often working to help secure the funds for security deposits and first month’s rent. Interfaith House also maintains partnerships with several agencies that accept our residents into their permanent housing programs.

Health and Housing Outreach Team
IFH’s Health and Housing Outreach Team (HHOT) provides IFH clients who have successfully transitioned into independent housing and also clients referred to us by AIDS Foundation of Chicago’s Samaritan Project, with continuing support services for up to two years. These services are provided through weekly in-home visits from staff that check to make sure clients are maintaining their medication regimen, keeping their medical appointments, that their basic needs are being met, and assisting them in maintaining government benefits. 100% of clients have remained housed while enrolled in the program.

Alvin Baum Employment Project
For many residents, a job opportunity will be the key to gaining and keeping permanent housing. At IFH they are able to work toward the goal of obtaining employment by participating in the Alvin Baum Employment Project. The project helps our clients develop job skills and job search skills; as well as assists them in finding jobs or entering workforce development programs.

Profile
Operating agency
- Interfaith House (Non-profit)
Year program was established: 1994
Site of respite beds: Traditional Housing
Number of respite beds: 64
Hours of operation: 24 hours/day
Average length of stay: 90 days

Admission Criteria
Discharged from hospital
Homeless
Acute medical condition

**Clinical Services Provided**
- Physician (onsite)
- Nurse Practitioner (onsite)
- LPN (onsite)
- Medication dispensing & storage
- Substance abuse/mental health

**Support Services Provided**
- Meals
- Transportation
- Case Management
- Job Training or Placement

**Funding Sources**
- Private donations
- Local government
- Religious organizations
- Foundations/Corporations
INDIANA

Health Recovery Program Gennesaret Free Clinic

Agency: Gennesaret Free Clinic
Address: 2401 Central Avenue, Indianapolis, IN 46205
Contact: Janell Watson, PhD, MSW, Director
Phone: (317) 920-1554
Fax: (317) 454-0997
Email: jwatson@gennesaret.org
Web: www.gennesaret.org

Description
Gennesaret Free Clinic embarked upon an exciting new health service in July 2000. For years, we have witnessed homeless patients and those without family support suffer inadequate post-hospital care. Many stories of patients discharged to the downtown streets after major surgery or medical illness prompted Gennesaret to provide transitional recuperative housing. Our goal is to provide transitional housing after hospitalization for eight men. Clients will go on to continued programming, services, training or housing to be determined according to individual need. The Health Recovery Program is based on a residential model with private rooms for all. Caregivers live on-site giving assistance on a 24h / 7d basis.

Profile
Operating agency:
- Gennesaret Free Clinic (Non-profit)
Year program was established: 2009
Site of respite beds: Stand-alone Facility
Number of respite beds: 8
Hours of operation: Monday–Sunday, 24/7
Average length of stay: 45–60 days

Admission Criteria
- Homeless
- In-patient at Marion County Hospital
- Well enough to leave hospital, too sick for shelter
- Able to perform unassisted ADLs
- Continent of bowel and bladder
- No active communicable disease
- Able to function safely in group setting
- No prior sex offenses
- Interviewed and accepted by director

Clinical Services Provided
Physicians’ Assistant
Dental (as needed)
Eye care
Medication dispensing & storage
Substance abuse/mental health
Other: Follow-up referrals to specialty care as needed

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Various
KENTUCKY

Phoenix Health Center Respite Bed Collaborative

Agency: Family Health Center, Phoenix
Address: 712 E. Muhammad Ali Blvd., Louisville, KY 40202
Contact: Andy Patterson, Health Care for the Homeless Director
Phone: (502) 568-6972
Fax: (502) 569-6206
Email: apatterson@fhclouisville.org

Description
Family Health Center, Phoenix is the only clinic in Louisville to provide services exclusively to those who are experiencing homelessness. Phoenix Health Center helps to provide free and comprehensive care which includes: medical, psychiatric, dental, substance use, and pharmacological services for persons experiencing homelessness. We are centrally located within blocks of most hospitals and shelters in Louisville. A Hospital Liaison assists clients needing recuperative care in coordinating services with our clinic, medical providers and homeless service providers.

Six respite beds for men are available at Wayside Christian Mission; these beds are available for up to an initial one month stay with the possibility of an extension as needed. Phoenix provides one Emergency Overnight Bed that is used for overnight referrals from hospitals. Clients can remain in the Emergency Overnight Bed until they are assessed the following day by our Hospital Liaison.

Clients utilizing any of our beds can access medical services through the clinic or may request a weekly bedside visit from a provider on an as needed basis. Clients may also request help with laundry and have meals brought to their rooms. All of our clients receive supportive services from the Hospital Liaison during their stay. Free laundry and transportation are provided as needed. Clients may be referred to a shelter bed or may move directly into transitional or permanent housing upon discharge.

Profile
Operating agency
- Family Health Center, Phoenix (HCH)
Year program was established: October 2007
Site of respite beds: Homeless Shelter
Number of respite beds: 7
Hours of operation: 24 hours a day, 7 days a week
Average length of stay: 30 Days

Admission Criteria
Clients must be homeless and have an acute medical condition. They must be able to ambulate and perform their activities of daily living without assistance. The participating shelter requires a client to remain sober while utilizing the beds.

Clinical Services Provided
Physician (onsite & offsite)
Social worker (onsite & offsite)
Community Health Worker (onsite & offsite)
Nurse Practitioner (onsite & offsite)
Nurse (onsite & offsite)

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Foundations
MAINE

Penobscot Community Health Care – Oasis Project

Agency: Penobscot Community Health Care, Summer Street Community Clinic
Address: 1048 Union Street, Bangor, ME 04401
Contact: Robert Allen, MD, MHCM; Executive Medical Director, Penobscot Community Health Care
Phone: (207) 945-5247
Fax: (207) 992-2154
Email: rallen@pchcbangor.org

Description
Oasis Project is a medical respite care program that complements Penobscot Community Health Care’s existing Homeless Health Program. It serves patients discharged from the local hospitals or emergency rooms, and is designed for patients readying themselves for out-patient treatment in need of an appropriate setting to recover. Upon referral from the local hospitals or from PCHC’s homeless health care clinic, patients who are homeless or temporarily unable to care for themselves in their home environment are provided with a bed and basic nursing care at a local nursing home.

Profile
Operating agency
• Penobscot Community Health Care, Summer Street Community Clinic (HCH)
Year program was established: August 2008
Site of respite beds: Nursing Home
Number of respite beds: 4 (2 male; 2 female)
Hours of operation: 24/7
Average length of stay: 10 days

Admission Criteria
• Patients in the clinic or emergency room of local hospital not sick enough to be admitted to hospital but unable to care for oneself in a shelter, on the streets, or in one’s home environment
• Hospitalized patients preparing for discharge to outpatient treatment and needing a setting for recuperation
• Ambulatory outpatients in need of pre-hospital or pre-procedure treatment

Clinical Services Provided
Physician (as needed)
Nurse Practitioner/Physician Asst (as needed)
Nurse (24/7)
Dental (as needed)
Medication dispensing & storage
 Substance abuse/mental health services
Screening for/connection to a primary care provider

Support Services Provided
Case Management
Meals
Transportation
Job Training or Placement
Literacy support

Funding Sources
Hospital: A payment arrangement exists via memo of understanding with area hospitals (Eastern Maine Medical Center and Saint Joseph’s Hospital) for accepting patients from their social service departments in referral.
MAINE

City of Portland HCH – John Master’s Respite Program

Agency: City of Portland Health Care for the Homeless
Address: 20 Portland Street, Portland, ME 04101
Contact: Brendan Johnson, Respite Care Coordinator
Phone:
Email: blj@portlandmaine.gov
Web: www.portlandmaine.gov/hhs/phindigentcare.asp

Description
The John Masters Respite Care Program is a collaborative endeavor between the Healthcare for the Homeless (HCH) Program and the Barron Center, a city-run nursing care facility. Both of these programs are located in the City’s Department of Health and Human Services. The HCH Program is located in downtown Portland in a community center for homeless services. The nursing care facility is located four miles from the city center on a bus line and has a pleasant campus-like setting. Each component of the Respite Program has specific tasks and responsibilities. HCH provides screening admission, medical oversight, case management, and follow-up services. The nursing facility offers 24-hour-per-day nursing care, meals, a bed, and shower facilities. There is a maximum length of stay of 30 days.

The John Masters Respite Care Program has unique aspects:
- The program has purchased 400 bed nights per year at the nursing care facility; this allows flexibility and maximizes funding
- Clients needing long-term skilled nursing care and meeting Medicaid requirements may transition from respite to skilled nursing in a seamless manner
- All Respite clients have a Respite Outreach Worker, who offers time-limited case management to all respite clients
- Respite clients may receive substance abuse and mental health screenings, or ongoing care while in respite

Profile
Operating agency
- City of Portland Health Care for the Homeless (HCH)
Year program was established: 2000
Site of respite beds: Nursing Home
Number of respite beds: 2–3
Hours of operation: Monday–Sunday, 24/7
Average length of stay: 11 days

Admission Criteria
Medically stable, needing short-term respite (max. 30 days), mental status appropriate for living among nursing home residents

Clinical Services Provided
Physician (as needed)
Nurse Practitioner/Physicians’ Assistant (as needed)
Nurse (24/7)
Medication dispensing & storage
Substance abuse/mental health

**Support Services Provided**
Meals
Transportation
Case Management (limited)

**Funding sources**
HRSA 330(h) funds
MARYLAND

Convalescent Care Program

Agency: Health Care for the Homeless, Inc.
Address: 421 Fallsway, Baltimore, MD 21202
Contact: Chauna Brocht, Coordinator of Special Initiatives
Phone: (443) 703-1311
Email: cbrocht@hchmd.org
Web: www.hchmd.org

Description
The Health Care for the Homeless (HCH) Convalescent Care program is a collaboration between HCH, Baltimore Homeless Services, and Catholic Charities. The program serves a maximum of 25 individuals at any given time providing shelter, meals, nursing and case management services and 24/7 medical on-call services for those who require 24-hour shelter and support to recuperate from illness and/or injury. Convalescent care consumers must be able to complete their own Activities of Daily Living (ADL) and ambulate independently.

Profile
Operating agency
- Baltimore Health Care for the Homeless (HCH)
Year program was established: 1995
Site of respite beds: Homeless Shelter
Number of respite beds: 25
Hours of operation: 24/7
Average length of stay: 25 days

Admission Criteria
Convalescent Care consumers must be medically stable, able to complete their own ADLs and ambulate independently.

Clinical Services Provided
Physician (onsite & offsite)
Social worker (onsite & offsite)
Physicians’ Assistant (onsite & offsite)
Nurse (onsite)
Screening for/connection to primary care

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
HUD
Foundations
MASSACHUSETTS

Barbara McInnis House

Agency: Boston Health Care for the Homeless Program
Address: Jean Yawkey Place, 780 Albany Street, Boston, MA 02118
Contact: Sarah Ciambrone, Executive Director, Barbara McInnis House
Phone: (857) 654-1701
Fax: (857) 654-1421
Email: sciambrone@bhchp.org
Web: www.bhchp.org

Description
Since 1988, medical respite care has been an essential component of the continuum of healthcare services provided by the Boston Health Care for the Homeless Program (BHCHP). Originating as shelter-based medical beds, medical respite care for men and women is now provided in one freestanding facility, the 104-bed Barbara McInnis House which is housed in the top three floors of Jean Yawkey Place on Albany Street in Boston and located across the street from Boston Medical Center.

Jean Yawkey Place is home not only to the medical respite program but also the dental program, a busy ambulatory clinic, and administration for Boston Health Care for the Homeless Program.

The McInnis House provides care to men and to women, and provides comprehensive medical, nursing, behavioral, dental, and case management services in an environment sensitive to the needs of homeless adults.

The McInnis House offers three meals per day that are served in the dining room. Patients recuperate in private, semi-private or two to six bed-rooms. The program admits patients 24 hours per day, seven days a week from hospitals, shelters, emergency departments, outpatient clinics, and directly from the street by referral from the BHCHP Street Team.

Profile
Operating agency
• Boston Health Care for the Homeless Program (HCH)
Year program was established: 1993
Site of respite beds: Stand-alone Facility
Number of respite beds: 104
Hours of operation: Monday–Sunday, 24/7
Average length of stay: approximately 12 days

Admission Criteria
• Primary medical problem
• Psychiatrically stable
• Independent in Activities of Daily Living
• In need of short-term recuperative care
• If on methadone, must be enrolled in methadone maintenance program
• Disclosure of known communicable disease, including TB, VRE and MRSA

Clinical Services Provided
Physician (24/7 on call; 3 supervising MDs and one full time medical director)
Nurse Practitioner/Physicians’ Assistant (10 hrs/day, 7 days/wk [x 8 teams])
Nurse (24/7; 8 RNs and 1 Nurse Manager)
Dental (daily 5 days/week)
Eye care (weekly)
Medication dispensing & storage
Substance abuse/mental health
Specialty medical services on-site: Podiatry, Optometry
On-site full service pharmacy
Screening for/connection to a primary care provider

**Support Services Provided**
Meals
Transportation to medical appointments
Case Management
Pastoral care
Volunteers provide variety of recreational support services

**Funding Sources**
Hospital
HRSA 330(h) funds
HUD
Medicaid
Medicare
Private donations
Foundations
**MICHIGAN**

**Alliance Recuperation Center**

Agency: Caring Meadows Living Center  
Address: 1001 Lafayette Avenue S.E., Grand Rapids, MI 49507  
Contact: Marva Townsend, Administrator  
Phone: (616) 475-5433  
Fax: (616) 514-1288  
Email: marvatownsend1@hotmail.com

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**Description**

The Medical Respite Program is located in a wing of the Caring Meadows Living Center, an assisted living facility (ALF). The program provides a comfortable and safe place for people who are experiencing homelessness to recover from physical illness or injury. Program participants who are insured through Medicaid or Medicare receive onsite clinical care from ALF staff or other visiting clinicians. Uninsured program participants receive assistance accessing clinical care offsite from local health care providers.

**Profile**

Operating agency  
- Caring Meadows Living Center (Non-profit)

Year program was established: 2007  
Site of Respite Beds: Assisted Living Facility  
Number of Respite Beds: up to 20 beds  
Hours of operation: 24/7  
Average length of stay: 30-60 days

**Admission Criteria**

- Client is homeless  
- Client is recovering from acute medical illness or injury and in need for recuperative care  
- Client is continent  
- Client is alert, oriented and mentally stable  
- Client understand care plan and is compliant  
- Client agrees to clean and sober environment

**Clinical Services Provided**

- Physician (as needed)  
- Nurse Practitioner/Physicians’ Assistant (as needed)  
- Nurse (as needed)  
- Medication dispensing & storage  
- Screening for/ connection to a primary care provider

**Support Services Provided**

- Meals  
- Transportation  
- Case Management

**Funding sources**

- Private donations  
- Religious organizations
MINNESOTA
Transitional Recuperative Care Program

Agency: Catholic Charities of St. Paul and Minneapolis
Address: 819 2nd Ave. South, Minneapolis, MN 55402
Contact: Dawn Petroskas, Director of Health Services
Phone: (651) 647-3127
Email: dawn.petroskas@cctwincities.org

Description
Catholic Charities Transitional Recuperative Care (TRC) Program is a five bed program for homeless adults discharged from North Memorial Hospital in Minneapolis. The TRC Program offers private rooms with a shared bathroom, nursing care coordination, and social/housing case management services. It is based out of a "Health Supported" transitional housing program.

Profile
Operating agency
- North Memorial Hospital (Hospital)
- Catholic Charities of St. Paul and Minneapolis (Non-profit)
Year program was established: 2011
Site of respite beds: Transitional housing
Number of respite beds: 5
Hours of operation: Facility is open 24/7, RN and case manager available Mon – Fri (8am – 5pm)
Average length of stay: 70 days

Admission Criteria
- Patient agrees to TRC admission and is willing to comply with TRC rules and guidelines.
- Patient is homeless or facing homelessness (priority given to patients with history of homelessness)
- Patient needs a safe place to live with limited professional nursing services
- Patient is over 18 years.
- Patient has acute medical condition that can be addressed in a limited amount of time (e.g. 30 days or less – frostbite, wound care, flu, fracture, new diagnosis but needs time to adjust to self-management, hospice, chemotherapy/radiation, other diagnosis agreed upon by provider and TRC nurse)
- Patient is independent in all activities of daily living including medication administration, and able to ambulate or transfer independently with or without assistive devices
- Patient is continent of bowel and bladder, or he/she is able to independently manage catheter or ostomy
- Patient is not acutely intoxicated, and is not likely to experience alcohol or drug withdrawal symptoms
- Patient is medically stable and does not need 24 hr. care or a skilled nursing facility
- Patient has not been convicted of arson or a level 3 sex offense.
- Patient qualifies for Hennepin Co. GRH

Clinical Services Provided
Nurse (onsite)
Medication monitoring

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital, Local government, Private donations, Religious organizations
MINNESOTA
Hennepin County Health Care for the Homeless – Medical Respite Program

Agency: Hennepin County Health Care for the Homeless
Address: 525 Portland Ave South, Level 3, Minneapolis, MN 55415
Contact: Stephanie Abel, RN, Clinic Manager
Phone: (612) 348-8824
Fax: (612) 677-6299
Email: stephanie.abel@co.hennepin.mn.us

Description
The Medical Respite Program is a 15-bed medical respite program targeting homeless persons, currently in shelter or recently released from area hospitals and recovering from acute medical problems. The program is based in one existing shelter facility that already has on-site HCH clinic services. A respite team consisting of two Public Health Nurses (PHNs), one social worker and one financial worker provides a variety of services. The team conducts a health and social needs assessment on each client entering the respite program. The PHN and client develop a plan of care and follow-up strategies. The PHNs work closely with the social worker and the financial worker to connect clients to needed services.

Profile
Operating agency
- Hennepin County Health Care for the Homeless (HCH)
Year program was established: 1988
Site of respite beds: Homeless Shelter
Number of respite beds: 20 (14 male, 6 female)
Hours of operation: 24/7
Average length of stay: 32 days

Admission Criteria
- Client is homeless
- Recovering from acute medical illness or injury
- Needs short-term medically necessary recuperative/respite care
- Independent ADLs
- Client is mobile and continent
- Individual must be a Hennepin county resident (cannot have an active case open in another county due to shelter requirements).

Clinical Services Provided
Nurse Practitioner
Nurse
Medication dispensing & storage
Screening for/connection to a primary care provider
Care Coordination
On-site clinic (5 days/wk)

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
HRSA 330(h) funds
Foundations
MINNESOTA
West Side Community Health Services – Medical Respite Program

Agency: West Side Community Health Services
Address: 153 Cesar Chavez Street, Saint Paul, MN 55107
Contact: Helene Freint, Program Director
Phone: (651) 647-2363
Fax: (651) 290-6818
Email: freinth@westsidechs.org
Web: www.westsidechs.org

Description
West Side Community Health Services' Medical Respite Program serves homeless adults with 4 beds located in 2 separate transitional housing facilities offering SRO housing. Admissions come from HCH clinic visits and upon discharge from area hospitals of patients recuperating from acute medical conditions. Respite patients access HCH clinics for follow-up medical, mental health and social service linkages as appropriate.

Profile
Operating agency
- West Side Community Health Services (HCH)
Year program was established: 1997
Site of respite beds: Transitional Housing
Number of respite beds: 4
Hours of operation: Direct patient care is provided by the HCH clinics. Two beds are located one block away from the clinic which is open M-F 9-5. The other 2 beds have an on-site clinic open once a week from 7am - noon.
Average length of stay: 10 days

Admission Criteria
- Patient is homeless
- Recovering from acute medical illness or injury or acute exacerbation of chronic illness that will improve
- Independent in ADL's
- Client is mobile and continent
- Transitional Housing Program approves the patient to stay when free from violent/inappropriate behaviors

Clinical Services Provided
Physician (offsite)
Social worker (offsite)
Psychiatrist (offsite)
Nurse (offsite)
Substance abuse/mental health services
Complementary healing modalities

Support Services Provided
Transportation
Case Management

Funding Sources
HRSA 330(h) funds
Private donations
MISSOURI

Saint Luke’s Hospital and Salvation Army Interim Care Program

Agency: Saint Luke’s Hospital/Salvation Army
Address 1: 5100 E. 24th Street, Kansas City, MO 64127 (The Salvation Army Missouri Shield of Service)
Address 2: 4320 Wornall Medical Plaza II, Ste. 65, Kansas City, MO 64111 (Saint Luke’s Hospital)
Contact: LeVearn Hicks
Phone: (816) 483-2281
Email: LeVearn_Hicks@usc.salvationarmy.org

Description
The purpose of this program and partnership is to identify and provide short-term housing and/or home health care for patients with no residence as an alternative to hospitalization.

Saint Luke’s Hospital and the Salvation Army have combined resources for patients discharged from Saint Luke’s Hospital to receive 24-hour room and board, transportation to doctor’s visits as needed, home health care and access to social services, for a limited amount of time. Patients are screened and identified by Social Services with appropriate referrals and services arranged following inpatient or emergency department services.

Profile
Operating agency
- Salvation Army (Non-profit)
- Saint Luke’s Hospital (Hospital)
Year program was established: 2008
Site of respite beds: Homeless Shelter (Salvation Army Detox Facility)
Number of respite beds: 5 for Saint Luke’s
Hours of operation: Monday–Sunday, 24/7
Average length of stay: 3 weeks

Admission Criteria
- No residence of persons identified to care for patient, with ongoing medical needs.
- Patient must be stable and able to care for self.
- Oriented and cooperative.
- Independent and mobile with self-transfer ability necessary (may use durable medical equipment for assistance.)
- Voluntarily agrees to accept short-term medical care/housing for no longer than 6 weeks.
- Agreeable to contract with Salvation Army for no alcohol or substance abuse during stay.
- Must be on medication for dual diagnoses.

Clinical Services Provided
Physician (offsite)
Nurse Practitioner/Physician Asst (offsite)
Nurse (Home Health, if ordered – on-site)
Medication storage
Substance abuse/mental health (on-site detox)

Support Services Provided
Meals
Transportation

Funding Sources
Hospital grant
NEW MEXICO

Metropolitan Homelessness Project – Respite Care Program

Agency: Metropolitan Homeless Project
Address: 715 Candelaria Blvd., NE, Albuquerque, NM 87107
Contact: Jessica Casey, Program Director
Phone: (505) 344-2323
Email: jessicac@mhp-nm.org
Web: www.mhp-nm.org

Description
The Albuquerque Opportunity Center has 6 beds dedicated to medical respite care for homeless male veterans who are 18 years and older. Individuals accepted into the program must have an injury or illness that is acute and they must be ambulatory. Here in the Respite Care Program, we give these men a warm bed to sleep in 24 hours a day, seven days a week. They have access night and day to showers, three meals a day, clean clothes, linens, basic medical supplies and most importantly, a safe place to recover. The program is expanding in 2013 at which point additional beds will be available to a broader population.

Profile
Operating agency
- Metropolitan Homelessness Project (Non-profit)
Site of respite beds: Homeless shelter
Number of respite beds: 6 (expanding to 20 later in 2013)
Hours of operation: 24 hours a day; 365 days a year
Average length of stay: 14 days

Admission Criteria
Must be male, homeless, over the age of 18, self-ambulatory—with or without the use of props—whose condition will improve if given a respite care bed. Participants may have a colostomy bag, be dependent upon portable oxygen, or have a co-occurring diagnosis. We do not accept persons for long-term conditions, those who need 24-hour medical attention, those who cannot take care of themselves due to frailty or dementia, or those expected to need more than 30 days of recuperation.

Clinical Services Provided
Physician (onsite)
Nurse (onsite)
Medication storage

Support Services Provided
Meals
Transportation
Case Management

Funding sources
Private donations
Local government
United Way
VA
NEW MEXICO

St. Elizabeth Shelter – Respite Program

Agency: St. Elizabeth Shelter
Address: 804 Alarid St. Santa Fe, NM 87505
Contact: Deborah Tang, Executive Director
Phone: (505) 982-6611
Email: director@steshelter.org
Web: www.steshelter.org

Description
In cooperation with Christus St. Vincent Hospital, State Health Department and Healthcare for the Homeless, St. Elizabeth’s Respite Program provides care for those who are not so ill they continue to need hospital care, but are too sick to live on the street. Medical respite patients can reside in our program for as long as the doctor determines is needed for their recovery.

Profile
Operating agency
- St. Elizabeth Shelter (Non-profit)
Site of respite beds: Homeless shelter
Number of respite beds: 6 to 12 (men), 4 to 6 (women)
Hours of operation: 24 hours a day; 365 days a year
Average length of stay: 60 days

Admission Criteria
Referred from Hospital or HCH and a doctor’s statement required

Clinical Services Provided
Medical oversight and care provided onsite by HCH (hours vary depending on need)
Nurse
Therapist
Social Worker

Support Services Provided
Meals
Case Management

Funding Sources
Hospital - Annual grant of $40,000 from indigent fund
Private donations
Local government
Religious organizations
NEW YORK

Bowery Residents’ Committee Medical Respite Program

Agency: Bowery Residents’ Committee
Address: 127 West 25th Street, Third Floor, New York, NY 10001
Contact: Karin Roach, Program Director
Phone: (212) 533-3281
Fax: (323) 343-8856
Email: kroach@brc.org
Web: www.BRC.org

Description
BRC’s Medical Respite program was born in 2001 from a challenge to provide medical services for homeless people who need a place to recuperate from a physical injury or illness. Today, the BRC Medical Respite offers a safe and appropriate initial primary care environment for homeless people who have severe chronic health problems, yet do not require an inpatient hospitalization stay. The Medical Respite program provides primary care services including health screening, assessment, and treatment; medication management; 24-hour/7-day nursing care; and linkages to long-term primary care, chemical dependency and psychiatric treatment services. Co-located within BRC’s Chemical Dependency Crisis Center (CDCC), participants in the Medical Respite program also benefit from the full range of behavioral health services available from CDCC, including comprehensive inpatient substance abuse and mental health treatment services. Referrals to the BRC Medical Respite program are made through the CDCC intake nurse or Respite Nurse Practitioner.

Profile
Operating agency
- Bowery Residents’ Committee, Inc. (HCH)
Year program was established: 2001
Site of respite beds: Inpatient behavioral health crisis center
Number of respite beds: 24
Hours of operation: 24-hours a day, 7 days a week
Average length of stay: 6-7 days

Admission Criteria
- Must have a medical need for respite, as evidenced by an acute condition that can be resolved in a short time, or a chronic condition for which a short-term intensive intervention is needed
- Must meet criteria for admission to the CDCC (active substance abuse or at-risk for relapse)
- There is a 2 to 3 week limit to respite care.

Clinical Services Provided
Nurse Practitioner/Physicians’ Assistant
Nurse
Medication dispensing & storage
Substance abuse/mental health
Screening for/ connection to primary care provider

Support Services Provided
Meals
Case Management

Funding Sources
HRSA 330(h) funds
Private donations
Local government
North Carolina

Samaritan House, Inc.

Agency: The Samaritan House, Inc.
Address: 611 Fortune Street, Charlotte, NC 28205
Contact: Brad Goforth, Executive Director
Phone: (704) 333-0110
Email: bgoforth@thesamaritanhouse.org
Web: www.thesamaritanhouse.org

Description
Samaritan House provides short term recuperative care for homeless men and women in a home like setting. We provide our guests clean bedrooms, bath facilities, nutritious meals and transportation to follow-up medical appointments. We help guests obtain additional assistance through local social service agencies as well as rehabilitation and training programs.

Profile
Operating agency
- The Samaritan House (Non-profit)
Year program was established: 2005
Site of respite beds: Stand-alone facility
Number of respite beds: 12
Hours of operation: 24 hours
Average length of stay: 10-20 days

Admission Criteria
- Referral by competent medical authority
- Must not be on oxygen or use colostomy bag
- May not be on the sex offender list

Clinical Services Provided
Home health services may be ordered by referring physician

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Private donations
Foundations
Religious organizations
OHIO

Center for Respite Care, Inc.

Agency: Center for Respite Care, Inc.
Address: 3550 Washington Ave., Cincinnati, OH 45229
Contact: Mary Beth Meyer, Executive Director
Phone: (513) 621-1868
Fax: (513) 621-1872
Email: MaryBethMeyer@CenterForRespiteCare.org
Web: www.homelessrespite.org

Description
The Center for Respite Care is a freestanding 24-hour medical recovery care facility serving homeless patients since 2003. Patients receive basic short-term medical and nursing care as well as social services while they recover from illnesses. The Center for Respite Care is licensed as a Residential Care Facility, and staffed with a physician, nurses and nursing assistants. Clients receive diagnostic medical evaluations, lab testing, prescription and OTC medications, nursing care, health education, treatment of acute and chronic illnesses, coordination of follow-up care and surgeries with hospital medical staff, and transportation to follow-up medical appointments. The Center also provides a bed, three healthy meals each day, showers, laundry facilities and clothing as needed. Social services provided during a client’s stay include a social service assessment and development of a social service plan with clients. About 75% of clients who complete the medical recovery program are placed in permanent or transitional housing, treatment programs or other special needs programs.

Profile
Operating agency
- Center for Respite Care, Inc. (Non-profit)
Year program was established: 2004
Site of respite beds: Stand-alone facility
Number of respite beds: 14
Hours of operation: 24/7
Average length of stay: 3–4 weeks

Admission Criteria
- Homeless
- Adult
- Acute medical illness or injury as primary diagnosis
- Expected recovery period of 24 hours to 30 days
- Mentally stable
- Able to perform ADLS, ambulatory, continent
- Able to self-medicate

Clinical Services Provided
Physician
Nurse
Medication storage
Connection to a primary care provider
Support Services Provided
Meals
Transportation
Case Management
Job Training or Placement
Life skills training

Funding sources
Hospital annual grants
HRSA 330(h) funds
HUD Permanent housing program – pays rent for 4–12 months while applying for entitlements
Private donations
Local government
Religious organizations
Foundations
State government
OHIO

Joseph’s Home

Agency: Joseph’s Home
Address: 2412 Community College Avenue, Cleveland, OH 44115
Contact: Rodney Dial
Phone: (216) 685-1551
Email: Rodney.dial@josephshome.com
Web: www.josephshome.com

Description
This program, established in 2000, provides residential space for 11 homeless men recovering from temporary or chronic illnesses. They are referred from area agencies, shelters or health care facilities. Residents participate in activities of daily living and literacy, sobriety and other self-improvement programs. It is the only facility of its kind in Northeast Ohio.

Local hospitals, emergency shelters, clinics, meal sites and other social service agencies often refer residents at Joseph’s Home. Men entering Joseph’s Home have an acute or temporary medical issue that can be stabilized within three to six months after their arrival. A resident’s average length of stay is 4.8 months, and Joseph’s Home is typically at full occupancy, with 11 men sharing the home-like facility.

Joseph’s Home accepts referrals for homeless men who are confronting a range of acute or temporary medical needs, such as:

- Stabilization of acute onset conditions such as diabetes, high blood pressure or asthma
- Recuperation from the effects of chemotherapy or radiation treatments
- Recuperation from stroke, colostomy, renal dialysis and those in need of home health care
- Recovery following surgery, fractures

Profile
Operating agency
- Joseph’s Home (Non-profit)
Year program was established: 2000
Site of respite beds: Transitional Housing
Number of respite beds: 11
Average length of stay: 4.8 months

Admission Criteria
- Individual must be homeless, male and over 18 years of age
- Individual must be able to care for himself and be continent
- Individual must have a medical problem that is acute/semi-acute and can be stabilized in three to six months
- Individual must be capable of working with programs that lead to stable, permanent housing and living within the community
- Individual must be ambulatory with or without assistive devices
- Individual must be able to get along in a group living situation
- Individual must be willing to accept all rules of Joseph’s Home

Clinical Services Provided
Unavailable

Support Services Provided
Unavailable

Funding Sources
Unavailable
OHIO

Care Alliance Recuperative Care Program

Agency: Care Alliance
Address: 1530 St. Clair Avenue, Cleveland, OH 44114
Contact: Donna Kelly, RN, Outreach Program Manager
Phone: (216) 924-0275
Fax: (216) 781-6723
Email: dkelly@carealliance.org
Web: www.carealliance.org

Description
Located within the Lutheran Metropolitan Ministries 2100 Lakeside Men’s Shelter, Care Alliance has nine recuperative care beds in the Central Intake (CI) community and four in the Emergency (E) community. The Recuperative Care Program is a post-hospitalization program (from in-patient and emergency room settings), which cares for individuals who are too sick to manage within the shelter environment but do not meet criteria for in-patient hospitalization.

The overall goal of the program is to provide a service systems approach to facilitate the reduction of preventable and costly hospital and emergency medical services used by homeless men residing in this shelter. This program offers a safe and therapeutic environment for acute medical stabilization and recuperative care.

Services provided by Care Alliance medical outreach staff include:
• Creating and documenting a care plan and communicating this plan to relevant shelter staff
• Providing daily nurse visits and weekly physician visits
• Providing transportation for medical appointments
• Managing the distribution and oversight of medications
• Evaluating patients for discharge and developing a discharge plan

Profile
Operating agency
• Care Alliance (HCH)
Year program was established: 2008
Site of respite beds: shelter
Number of respite beds: 13
Hours of operation: 24 hours
Average length of stay: 2 weeks

Admission Criteria
• Current resident of LMM 2100 Lakeside Shelter
• Has acute medical problem of physical disability that requires management assistance
• Independent in activities of daily living
• Independent in mobility (able to access living areas at 2100)
• Willing to comply with treatment plan
• No suicide or assault risk
• No intravascular lines
• Able to take own medications
Clinical Services Provided
Physician
Nurse Practitioner/Physicians’ Assistant
Nurse
Screening for/ connection to primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
HRSA 330(h) funds
Private Donations
Foundations
OHIO

Samaritan Homeless Clinic

Agency: Good Samaritan Hospital
Address: 921 S. Edwin C Moses Blvd., Dayton, OH 45417
Contact: Diane Cummins, Executive Director
Phone: (937) 461-1376
Fax: (937) 461-9280
Email: dmcummins@PremierHealth.com

Description
The goal of recuperative care is to provide sick patients with a healthy respite from the streets. To that end, we lease three off-site apartments where homeless patients who are too ill to live in the shelter system or on the streets can recover. This temporary housing comes with three meals a day and medical supervision. Patients also get help with transportation and have access to all other services offered by the Samaritan Homeless Clinic.

Profile
Operating agencies:
- Samaritan Homeless Clinic (HCH)
- Good Samaritan Hospital (Hospital)
Year program was established: 2010
Site of respite beds: Apartments units
Number of respite beds: 3
Hours of operation: Clinic hours 7:30-4:30 Monday & Wednesday; 7:30-6:30 Tuesday & Wednesday; 7:30-2:30 Friday. Respite unit 24/7 for patients in program, much of which is unsupervised
Average length of stay: 8 weeks

Admission Criteria
Must be eligible for homeless services and be in need of short term acute recuperative care. Units are unsupervised so must be able to provide self-care. Transportation, grocery shopping, laundry and other services are assisted.

Clinical Services Provided
Physician (offsite)
Nurse Practitioner (offsite)
Nurse (offsite)
Social Worker (onsite)

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital
HRSA 330(h) funds, Private donations
OREGON

Central City Concern – Recuperative Care Program

Agency: Central City Concern  
Address: Administration: 727 W. Burnside, Portland, OR 97209  
Contact: Jordan Wilhelms  
Phone: (503) 517 0321  
Fax: (503) 243 2044  
Email: rcp@ccconcern.org  
Web: www.ccconcern.org

Description
Hospitals and major medical providers are faced with serving patients who are ready for discharge, but are held unnecessarily or return immediately to the Emergency Room because of social barriers, lack of primary care/insurance and homelessness. By providing immediate housing, intensive case management and a primary care home with immediate post-hospital follow up, Central City Concern’s Recuperative Care Program removes these barriers for hospitals, HMO’s and other agencies. Patients are picked up from the hospital, given their own room, and are immediately established with a primary care doctor and a multi-disciplinary case management team, transforming the patients experience of their health care, lowering the costs for the population and most importantly, improving clinical outcomes.

Profile
Operating agency  
- Central City Concern (HCH)  
Year program was established: 2005  
Site of respite beds: Apartment units  
Number of respite beds: 35  
Hours of operation: on call 24/7  
Average length of stay: 2-6 weeks

Admission Criteria
- Single adult, 18 or older  
- Lack medically stable housing at discharge  
- Meet InterQual discharge criteria  
- Have daily medical needs post discharge (e.g., infusion, PT/OT, wound care) or non-weight bearing status  
- Must be able to keep and administer own medication  
- Approved and funded by referring hospital or managed care plan (currently only CareOregon and Providence Health Plan)

Clinical Services Provided
Physician (onsite & offsite)  
Social Worker (onsite & offsite)  
Community Health Worker (onsite & offsite)  
Nurse Practitioner (onsite & offsite)  
Physicians’ Asst (onsite & offsite)  
Nurse (onsite & offsite)  
Connection to Primary Care Provider  
Substance abuse and mental health services

Support Services Provided
Meals  
Transportation  
Case Management  
Job Training or Placement  
Crisis Management (on-call 24-hours)
**Funding Sources**
Hospital (payment per patient referred/ annual grants)
Private donations (durable medical equipment, clothing, etc.)
Local government (Grant funding from City)
Other: contract with Managed Care Organizations
Foundations
TENNESSEE

Guest House Medical Respite Program

Agency: Room in the Inn
Address: 705 Drexel Street, Nashville, TN 37203
Contact: Myranda C. Wright
Phone: 615.251-9791 x235
Email: myranda.wright@roomintheinn.org

Description
Room in the Inn’s Campus for Human Development is a non-profit organization that provides comprehensive services in one location to the homeless of Middle Tennessee. The mission of the Room in the Inn’s Campus is to provide programs that emphasize human development and recovery through education, self-help, and work, centered in community and long-term support for those who call the streets of Nashville home. The Campus provides a targeted array of short and long term programs, including emergency shelter, support services and case management, education and workforce development, medical respite care, and transitional and permanent housing. Medical respite is offered through the onsite, Guest House Medical Respite Program, which is the only recuperative care program for the homeless in Middle Tennessee. The Guest House offers an integrated model of care to serve individuals recovering from illness or injury, managing chronic conditions that have become acute, undergoing social detox, or stabilizing on mental health medications.

Profile
Operating agency
- Room in the Inn (Non-profit)
Site of respite beds: Stand-alone facility (part of a comprehensive center for homeless services)
Number of respite beds: 21
Hours of operation: Monday–Sunday, 24/7
Average length of stay: 2 weeks

Admission Criteria
Patient must be:
- Ambulatory
- Independent in all activities of daily living
- Patient cannot be:
  - Oxygen dependent
  - Wheelchair dependent
  - Require constant nursing care
  - Suspended from the Campus (shelter). Patient may be suspended if verbally or physically abusive, uses drugs or alcohol on premises, or is unable or unwilling to follow Campus rules.

Clinical Services Provided
Access to follow-up appointments and medications
Screening and connection to a primary care provider
Substance abuse and mental health screenings
Substance abuse and mental health referrals

Support Services Provided
24/7 supervision
Case Management
Meals
Transportation
Laundry

Funding Sources
Private donations
Local government
Central Texas Recuperative Care Program

Agency: Front Steps  
Address: P.O box 684519 Austin, TX 78768  
Contact: Kameron Fowler, LMSW, Program Director  
Phone: (512) 305-4108  
Fax: (512) 519-8166  
Email: kfowler@frontsteps.org  
Web: http://www.frontsteps.org/what-we-do/recuperative-care

Description
The Front Steps Recuperative Care Program offers four-six funded beds in an area nursing home, serving homeless patients about to be discharged from area hospitals but who are too frail or fragile to return to life on the streets or in a shelter. The program opened as a pilot project on April 10, 2008. While in the nursing home clients receive intensive case management as well as substance abuse counseling. Front Steps provides transitional housing and permanent supportive housing to clients when they are discharged from the nursing home.

Profile
Operating agency
- Front Steps (Non-profit)
Year program was established: 2008
Site of respite beds: Nursing Home
Number of respite beds: 4-6
Hours of operation: M–F, 8:00 a.m.–5:30 p.m.; Program Manager on call after hours and weekends; nursing home staff on duty 24/7
Average length of stay: 35 days

Admission Criteria
Applicants must be homeless, must not need continued inpatient care in a hospital setting, must not be in acute alcohol or drug withdrawal and still receiving associated medication, must not require a sitter or restraints, must have no acute psychiatric issues, and must not need placement in a skilled nursing facility. Clients must be willing to enter the Recuperative Care Program, and must sign a client contract agreeing to follow the rules of the nursing home, to participate in their medical treatment plan, and to work with the Recuperative Care Case Manager.

Clinical Services Provided
Physician
Physicians’ Assistant
Nurse
Social Worker
Medication dispensing & storage
Substance abuse/mental health

Support Services Provided
Meals
Transportation
Case Management
Job Training or Placement
SOAR applications

Funding Sources
Central Health (County Hospital District), Medicaid, Private donations, Religious organizations
TEXAS

Harmony House Respite Center

Agency: Harmony House, Inc.
Address: 602 Girard, Houston, TX 77002
Contact: Timothy L. Johnson
Phone: (713) 236-0119
Fax: (713) 236-0120
Email: tim_johnson@harmonyhouse.org
Web: www.harmonyhouse.org

Description
The Respite Center is a 35 bed, self-contained facility that provides a clean, dignified and nurturing environment for healing. This program intervenes at the time of hospital discharge for homeless men who are too sick to be on the streets, but not sick enough to be in the hospital. Patients receive intensive case management and referral to community supportive services. In-house services include a physician supervised nurse practitioner, pharmacy and substance abuse counseling.

Profile
Operating agency
- Harmony House (Non-profit)
Year program was established: 2000
Site of respite beds: Stand-alone Facility
Number of respite beds: 35
Hours of operation: 24/7
Average length of stay: 6–9 months

Admission Criteria
Recovering from physical injury or illness

Clinical Services Provided
Nurse Practitioner/Physicians’ Assistant
Medication storage
Substance abuse/mental health
Screening for/connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management
Job Training or Placement

Funding Sources
HUD (all services provided are covered)
TEXAS

Russell M. Scott Jr. Convalescent care center

Agency: Open Door Mission
Address: 5803 Harrisburg Blvd, Houston, TX 77011
Contact: Kirsten C. Besch, LMSW, MPH, Director of Social Services
Phone: (713) 921-7520 x 219
Fax: (713) 923-8743
Email: kbesch@opendoorhouston.org
Web: www.opendoorhouston.org/HealingDorm.htm

Description
The Open Door Mission’s (ODM’s) Russell M. Scott Jr., MD, Convalescent Care Center (RMSCCC) provides homeless men a safe short-term environment to continue their convalescence from surgery, injury or illness. The function of the RMSCC is to facilitate the care prescribed by the hospital, clinic, social service organization, or other entity that referred the patient. The center does not provide medical services per se to residents of the RMSCCC.

Residents are provided, at no cost, the basics of food, clothing, and shelter in a clean, supportive, and nurturing environment. We also provide a wide array of supportive social services, such as scheduling clinic visits, transportation to hospitals, clinics and physician’s offices, aiding in the resolution of legal matters, long-term housing assistance, and helping residents make plans for spiritual rehabilitation.

Profile
Operating agency
- Open Door Mission Foundation (Non-profit)
Year program was established: The Open Door Mission established the “Healing Dorm” in 1991. In 2004, it was renovated and expanded to 35 beds, and renamed the Russell M. Scott Jr. Convalescent Care Center.
Site of respite beds: Non-profit organization that houses three programs: (1) faith-based residential program for substance abuse, (2) community integration and work program for homeless men (3) respite program (RMSCCC)
Number of respite beds: 35
Hours of operation: Admissions: M–F, 8:00 a.m.–5:00 p.m.; Respite Dorms open 24-hrs a day, 365 days a year.
Average length of stay: 90 days

Admission Criteria
- Homeless males
- Actively recovering from injury, illness or surgery
- Self-care (includes ADLs, injections, & management of bodily functions)
- Independent in mobility
- Able to establish personal identification
- Medically and psychiatrically stable
- Behaviorally appropriate for community setting
- Agrees to placement in faith based respite facility

Clinical Services Provided
Medication storage
Substance abuse/mental health
Screening for/connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management
Job Training or Placement

**Funding Sources**
Private donations
Religious organizations
Hospital District
Foundations
**UTAH**

**Fourth Street Clinic Recuperative Care**

Agency: Wasatch Homeless Healthcare, Inc.  
Address: 404 South 400 West, Salt Lake City, UT 84101  
Contact: Monte J. Hanks, Client Services Director  
Phone: (801) 364-5572  
Fax: (801) 364-0161  
Email: monte@fourthstreetclinic.org  
Web: www.fourthstreetclinic.org

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**Description**

We are an independent non-profit entity that operates a comprehensive, full service primary and allied health care project. The Fourth Street Clinic Recuperative Care Program provides appropriate funding and other resources for placement and medical case management for homeless patients in need of recuperative care. Given that each patient’s continuum of recovery is different, the Recuperative Program designs a medical care plan, a unique placement and case management plan for each admission.

**Profile**

Operating agencies:
- Fourth Street Clinic (HCH)
- Wasatch Homeless Health Care, Inc. (Non-profit)

Year program was established: 1989

Site of respite beds: Homeless Shelter, Motel/Hotel, Nursing Home, Apartment units

Number of respite beds: 40

Hours of operation: The clinic is open from 8 a.m. to 7 p.m. Monday thru Thursday & Friday 8 a.m. to 5 p.m.; 24/7 Triage Phone; Phone access to Case Management after hours and on weekends.

Average length of stay: 18 days

**Admission Criteria**

- The patient must meet the federal criteria for homelessness.
- An on-site assessment at the hospital, by clinic staff prior to acceptance of the patient, is required for nursing home admit. Shelter beds and motel stays are for medical purposes and require clearance from clinic medical providers. Transitional Housing (TB Housing) requires an application process through the local housing authority.
- The patient must be seen at the clinic for a history and physical for nursing home admit unless the nursing home will accept a hospital history & physical.
- Patient must have an anticipated, short-term resolution of his/her medical issue except for TB Housing.
- Medications are provided by the referring hospital for the patient’s estimated length of stay for nursing home admit. Medications are requested from hospitals for one week for shelter beds. Otherwise, Fourth Street Clinic provides the necessary medications.
- Restrictions are addressed on a case-by-case basis with patient agreements that address substance abuse, probation, behavioral, violence and mental health issues.
- Client Services is on call to assist care center staff in the Recuperative Protocol, case management and discharge planning.
Clinical Services Provided
Physician (offsite)
Physicians’ Assistant (offsite)
Community Health Worker (offsite)
Substance abuse services

Support Services Provided
Transportation
Case Management
Interpretation Services
Health Education

Funding Sources
HRSA 330(h) funds
HUD
Medicaid
Medicare
Local Government
Religious organizations
Emergency Food & Shelter Program (FEMA)
Fairfax County Medical Respite Program

Agency: Fairfax County
Address: 11975 Bowman Towne Dr, Reston, VA 20190
Contact: Karen M Wood, ANP
Phone: (571) 323-1417
Fax: 703-707-0339
E-Mail: Karen.wood3@fairfaxcounty.gov

Description
The Medical Respite Program in Fairfax County provides 4 male beds and 1 female bed in an existing shelter. The beds are dedicated for homeless clients with an acute medical condition from which they have to recuperate.

Profile
Operating agency
- Fairfax County (Public)
Year program was established: 2006
Site of respite beds: Homeless Shelter
Number of respite beds: 5
Hours of operation: 24/7
Average length of stay: 30 days

Admission Criteria
The Client must
- Meet federal definition of homelessness
- Be a Fairfax County resident
- Have the need to recover from some type of acute medical event
- Be able to perform ADL’s without assistance and be independent in mobility (with or without devices such as wheelchair, crutches)
- Be oriented, able to make own decisions, not a danger to self or others
- Have the potential to recover and leave the MRP in 30 days.

Clinical Services Provided
Nurse Practitioner/Physicians’ Assistant
Home Health Aides
Medication storage
Substance abuse/mental health
Screening for/connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Local government
Micah Ecumenical Ministries – Residential Recovery Program

Agency: Micah Ecumenical Ministries
Address: P.O. Box 3277, Fredericksburg, VA 22401
Contact: Chuck Ellis
Phone: (540) 479-8301
E-Mail: chuckellis4@hotmail.com
Web address: www.dolovewalk.net

Description
Micah’s residential recovery program serves chronic homeless patients who do not meet hospital inpatient criteria, but are too ill to be on the streets. With the ability to house eight guests on any given day, this program provides a safe, community-based alternative to costly inpatient care. The ministry provides short-term accommodations on a first-come, first-serve basis. Guests receive a nurturing environment for physical and mental recovery and case-managed services that promote individual success. Guests also have access to all of Micah’s day services, which assist with additional case management and basic needs—showers, food, clothing, mail service, as well as transportation to and from outpatient and medical follow-up care.

Profile
Operating agency
• Mary Washington Hospital (Hospital)
Year program was established: 2008
Site of respite beds: Stand-alone facility
Number of respite beds: 8
Hours of operation: 24/7
Average length of stay: 2 weeks

Admission Criteria
• Adult experiencing homelessness.
• Uninsured or underinsured
• Mental disorder or at least suspicion of one
• Level of disability
• Level of illness
• Ability and willingness to participate in program

Clinical Services Provided
Social Worker (onsite/offsite)
Care Coordination

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital, United Way, Private donations, Religious organizations, Foundations
VIRGINIA
The Daily Planet Community Medical Respite

Agency: The Daily Planet
Address: 517 W. Grace Street, Richmond, VA 23220
Contact: Helena DeLigt, COO Programs
Phone: (804) 934-1822
Email: deligt@dailyplanetva.org
Web: www.dailyplanetva.org

Description
Free-standing facility provides short-term convalescent supervision in a shelter environment for homeless clients with primary medical diagnoses. This 20 bed program serves adults over age 18 for up to 30 days. These individuals are usually discharged from medical facilities, or are referred from the community, and are not able to stay in the emergency shelter system due to medical conditions that warrant a higher level of care. Nursing care, case management, and medical services are provided.

Profile
Operating agency
- The Daily Planet Health Care for the Homeless Center (HCH)
Year program was established: 2008
Site of respite beds: Stand-alone facility
Number of respite beds: 20 beds
Hours of operation: 24/7; admissions are Mon – Fri 8am to 4pm
Average length of stay: 30

Admission Criteria
A nurse screens referrals to determine if they are appropriate for the program. Patients must:
- Be homeless; Certification of Homelessness form must be completed
- Not be in the contagious phase of an infectious disease
- Be psychiatrically stable
- Be independent in Activities of Daily Living and medication administration
- Be willing to see a nurse or medical provider as necessary and comply with treatment recommendations
- Cannot require IV lines or require non-portable oxygen concentrators
- Cannot be a behavioral problem in a group setting

Clinical Services Provided
Physician (offsite)
Nurse Practitioner (onsite)
Nurse (onsite)
Psychiatrist (offsite)
Community Health Worker (onsite)
Social Worker (onsite)

Support Services Provided
Meals
Transportation
Case Management
Funding Sources
Hospital (grants)
HRSA 330(h)
HUD
Medicaid
Medicare
Private donations
Local government
United Way
# WASHINGTON

## Seattle-King County – The Edward Thomas House

Agency: Seattle & King County  
Address: Box 359944, 325 Ninth Ave., Seattle, WA 98104  
Program contact 1: Tammy Stone, Program Manager, (206) 744-5206, tstone@uw.edu  
Program contact 2: Leslie Enzian, Medical Director, (206) 744-1543, enzian@u.washington.edu

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## Description

The Edward Thomas House, Medical Respite Program at Jefferson Terrace, is a collaborative project among seven area hospitals and Health Care for the Homeless Network. A free standing program, the medical respite program provides nursing care 12 hours per day and non-clinical care 24 hours per day, 7 days per week. Patients share a room with one or two other patients and have a bath in each room. Nurses provide twice a day care for acute issues, as well as IV infusion and complicated wound care. Mental health clinicians complete a psychosocial screening to assess housing, mental health and funding needs; subsequent referrals to services and shelter or housing options. Medical respite staff include a medical director to oversee clinical care, ARNP’s for admission intakes, pain management and acute issue evaluation and staff psychiatrist to perform psychiatric assessments and provide treatment.

## Profile

### Operating agency
- Seattle & King County (HCH)
- Harborview Medical Center (Non-profit)

### Year program was established
1997 (program expansion in 2011)

### Site of respite beds
Free standing facility (floor of a public housing complex)

### Number of respite beds
34

### Hours of operation
24/7

### Average length of stay
3 weeks

## Admission Criteria

- Patient agrees to respite admission and to see nurse and staff daily
- Patient has an acute medical need requiring medical respite
- Homeless
- Independent in mobility and transfers
- If in alcohol withdrawal, CIWA < 10
- Behaviorally appropriate for group setting
- Continent of feces
- Not a registered sexual offender

## Clinical Services Provided

- Physician
- Nurse Practitioner
- Nurse
- Psychiatrist
- Medication storage
- Substance abuse/mental health
- Connection to primary care provider

## Support Services Provided

- Meals
- Transportation
- Case Management
- Laundry
Funding Sources
Contribution from seven area hospitals
HRSA 330(h) funds
HUD Supportive Services Only (SSO)
Local government,
MIDD (county) money
WASHINGTON

Inland Northwest Transitional Respite Program

Address: 32 West Pacific Avenue, Spokane, WA 99201
Contact: Rebecca Doughty, MN, RN
Phone: (509) 638-3728
Fax: (888) 746-5865
E-Mail: rebecca.doughty@email.wsu.edu

Description
The Inland Northwest Transitional Respite Program is a warm, safe place for homeless individuals to recover from injury and illness outside of the hospital setting. A transitional care model is used to facilitate safe discharge from the hospital and provide education and support for health self-management. In addition to respite services, clients are offered access to rapid rehousing, legal services, mental health counseling, and substance abuse interventions.

Profile
Operating agencies
• Providence Sacred Heart Medical Center (Hospital)
• Deaconess Medical Center (Hospital)
Year program was established: 2011
Site of respite beds: homeless shelter
Number of respite beds: 6 male, 2 female (expanding to 13 male beds)
Hours of operation: 24/7
Average length of stay: 15 days

Admission Criteria
Homeless, behaviorally stable, referred by a physician, and able to ambulate independently

Clinical Services Provided
Physician (onsite)
Nurse (onsite)
Medication dispensing & storage
Substance abuse/mental health services
Screening for/connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management
Transitional Care/Patient Education

Funding Sources
Private donations
Yakima Neighborhood Health Services – Neighborhood Connections

Agency: Yakima Neighborhood Health Services
Address: Yakima, WA
Contact: Rhonda Hauff, Chief Operating Officer /Deputy CEO; Annette Rodriguez, Director of Homeless and Housing Services
Phone: (509) 574-5552; (509) 454-4143
Fax: (509) 454-3651
E-Mail: rhonda.hauff@ynhs.org; annette.rodriguez@ynhs.org
Web: www.ynhs.org

Description
With support from the Homeless Network of Yakima County, Yakima Neighborhood Health Services provides respite housing and support services out of six one-bedroom apartments in Yakima. Care is available for individuals after discharge from the hospital, or for individuals identified by clinic doctors as injured or just too weak to be in shelters or living on the streets. Services include:

- Emergency shelter for up to four weeks
- Meals and laundry
- Nursing assessments and daily health education in a safe setting
- Mental health or chemical dependency assessments and counseling as needed
- Help in accessing primary care, follow-up care, and other needed services to help in their recuperative care
- Case management and nursing education
- Assistance to transitional and or permanent supportive housing placement once respite care is complete

Profile
Operating agency
- Yakima Neighborhood Health Services / Neighborhood Connections (HCH)
Year program was established: 2007
Site of respite beds: Stand-alone facility
Number of respite beds: 6
Hours of operation: Units are individual apartments. No staff is onsite after hours; however access to clinic providers for telephone consultation is available.
Average length of stay: 14-24 days, maximum length of stay is 4 weeks

Admission Criteria
To be eligible, the patient must have an acute medical problem that would benefit from short-term respite; be independent in ADL’s including medication administration, independent in mobility, continent, medically stable, behaviorally appropriate to be left alone, no IV lines, does not need SNF placement, and willing to see respite staff daily.

Clinical Services Provided
Physician (offsite)
Nurse Practitioner (offsite)
Physicians’ Assistant (offsite)
Nurse (as needed)
Dental (offsite)
Medication storage
Substance abuse/mental health
Screening for/connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management
Laundry

Funding Sources
Private, Foundations, WA State Consolidated Homeless Grant Program, Homeless Network of Yakima County
WASHINGTON, DC

Christ House

Agency: Christ House
Address: 1717 Columbia Road, Washington, D.C. 20009
Contact: David Inoue, Administrative Director
Phone: (202) 328-1100
Fax: (202) 232-4972
Email: administration@christhouse.org or dinoue@christhouse.org
Web: www.christhouse.org

Description
Christ House opened in December 1985 as one of the first residential medical facilities for the homeless in the United States. Today, this 33-bed facility is still the only such mission in Washington, D.C., providing 24-hour medical care for sick, homeless men and women. Our patients suffer from an array of illnesses and injuries including cancer, diabetes, kidney and liver diseases, HIV/AIDS, respiratory ailments, fractures, frostbite, hypertension, tuberculosis, severe lacerations and burns from sleeping on heat grates. Most patients suffer with multiple diagnoses.

Profile
Operating agency
- Christ House (Non-profit)
Year program was established: 1985
Site of respite beds: Stand-alone facility
Number of respite beds: 33
Hours of operation: 24/7 nursing care (Administration 8:30 a.m.–5:00 p.m.)
Average length of stay: 35 days

Admission Criteria
- Homeless
- Acute medical need

Clinical Services Provided
Physician
Nurse Practitioner
Physicians’ Assistant
Nurse
Medication dispensing & storage
Substance abuse/mental health
Connection to a primary care provider

Support Services Provided
Case Management
Meals
Transportation

Funding Sources Private donations, Local government, Religious organizations, Foundations, Federal (not specified)
Wisconsin

Salvation Army Emergency Lodge

Agency: Salvation Army
Address: 1730 N. 7 Street, Milwaukee, WI 53205
Contact: Teresa Siemaszko, Respite RN
Phone: (414) 265-6360 ext. 39
Fax: (414) 431-0591
Email: teresa.siemaszko@aurora.org

Description
The medical respite program is for homeless adults who have acute medical problems. People who have just had surgery and are being released from the hospital are the target population. We also accept people who have had an exacerbation of an existing medical condition, such as congestive heart failure, diabetes or hypertension. An onsite clinic (20 hr/week) is available for clients who do not have another primary care physician.

Profile
Operating agencies
- Salvation Army (Non-profit)
- Outreach Community Health Center (HCH)
- Aurora (Medical System)
Year program was established: 1997
Site of respite beds: Homeless Shelter
Number of respite beds: 20
Hours of operation: 24/7
Average length of stay: 3 months

Admission Criteria
Must be homeless with an acute medical illness or injury or in need of post-surgical recuperation.

Clinical Services Provided
Physician (onsite)
Nurse Practitioner (onsite)
Social Worker (onsite)
Nurse (onsite)
Medication dispensing & storage
Connection to a primary care provider

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Hospital
HRSA 330(h) funding
HUD
Private donations
Local government
Religious organizations
Foundations
United Way
ONTARIO (CANADA)

Booth Center Special Care Unit

Agency: Ottawa Inner City Health
Address: 5 Myrand Ave, Ottawa, ON K1N 5N7
Contact: Wendy Muckle, Executive Director
Phone: (613) 562-4500
Fax: (613) 562-4505
Email: wmuckle@ottawainnercityhealth.ca
Web: http://ottawainnercityhealth.ca

Description
Ottawa Inner City Health provides health care to people who are chronically homeless with complex health needs. We offer respite programs at two shelters for the homeless in Ottawa. The programs serve men at one location and women at the other. We accept any client with complex health needs depending on the availability of beds but give priority to persons with co-occurring mental health and overwhelming addictions.

Profile
Operating agency
- Ottawa Inner City Health (Nonprofit)
Year program was established: 2001
Site of respite beds: Homeless Shelter
Number of respite beds: 30 for men, 15 for women
Hours of operation: 24-hours per day
Average length of stay: Varies, can be up to 3 months and extended if necessary

Admission Criteria
Homeless, eligible for shelter bed, complex health needs that cannot be met in the general shelter

Clinical Services Provided
Physician
Nurse Practitioner/Physicians’ Assistant
Nurse
Medication dispensing & storage
Substance abuse/mental health
Screening for/connection to primary care provider
Other: Concurrent disorders treatment

Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Religious organizations
Ministry of Health in Ontario Canada
ONTARIO (CANADA)

Rotary Club of Toronto Infirmary - Seaton House

Address: 339 George Street, Toronto, ON M5A 2N2
Contact: Art Manuel, Infirmary Coordinator, Dan Anstett
Phone: (416) 392-5598
Fax: (416) 392-5549
Email: amanuel@toronto.ca, danstet@toronto.ca

Description
Seaton House is an 800-bed men’s shelter in downtown Toronto, one of the largest in Canada and in existence for over 80 years. The Seaton House Annex Harm Reduction program is a unique service targeting alcohol dependent men. It is a “wet” program monitoring and controlling access to alcohol, which is permitted on the premises. The 34-bed infirmary, opened in 2001, is located within the Annex program. Referrals are received from within Seaton House, from hospitals throughout the Greater Toronto Area and from community agencies. Room sizes range from 2 to 6 beds, most with shared bath down the hall. Most referrals are secondary to recent or repeated hospital admissions or emergency room visits, poorly controlled chronic conditions, infection control, trauma or palliative care.

A Seaton House team of registered nurses, registered practical nurses, social workers and non-regulated personnel provides health care. Physician care is provided through a partnership with Saint Michael’s Hospital whose Department of Community Medicine offers University of Toronto medical residents and students the opportunity to work with the homeless population. Most referrals for specialist care and diagnostics are coordinated with Saint Michael’s Hospital Outpatient Departments. Additional services, such as personal hygiene care, physiotherapy, and intravenous and wound care nursing are provided through visiting community agencies, contracted through the Toronto Community Care Access Centre (CCAC). Health services, both hospital and home-care, are covered by the publicly administered health insurance plan that is available to all Ontario residents. Seaton House’s directly administered health services are funded by the municipality’s Hostels budget.

Profile
Operating agency
• Seaton House (Non-profit)
Site of respite beds: Homeless Shelter
Number of respite beds: 34 (male only)
Hours of operation: Monday–Sunday, 24/7
Average length of stay: 4 weeks

Admission Criteria
• Eligible for Seaton House admission (i.e., homeless men)
• Health care needs requiring follow-up that cannot be met as an outpatient
• Is to be discharged from hospital and requires frequent physician/nursing care and/or rehab.
• May be admitted for one or more of the following: post-operative/wound care, multi-system medical issues, chronic alcohol or substance use, severe and persistent mental illness, uncontrolled/poorly controlled chronic illness (e.g. diabetes, cirrhosis, seizure disorder, HIV or CHF), frequent ER visits, complex plan of care to be developed, terminal illness requiring palliation

Clinical Services Provided
Physician
Nurse
Substance abuse/mental health
Screening for/connection to primary care provider
Psychiatrist
Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Local government: Physician and home care funding through Ontario Ministry of Health and Long-Term Care. Nursing, social and shelter support through City of Toronto municipal funding.
ONTARIO (CANADA)

Sherbourne Infirmary

Agency: Sherbourne Health Centre
Address: 333 Sherbourne Street, Toronto, ON M5A 2S5
Contact: Mary Grondin, Program Director, Homeless Health Services
Phone: (416) 324-4180
Fax: (416) 324-4258
Email: mgrondin@sherbourne.on.ca
Web: www.sherbourne.on.ca

Description
The Sherbourne Health Centre Infirmary is a short-term healthcare unit where people of all genders who are homeless or underhoused may stay while recovering from an acute medical condition, illness or injury. The Infirmary program provides a safe space where clients are able to rest and recover in a comfortable, supportive environment.

Health care is provided by a multi-disciplinary team including consulting physicians, nurses and a case manager for homeless and underhoused persons. It operates seven days a week, 24 hours per day, providing recuperative and holistic health care to such people who are expected to recover in a short period of time from a medical condition and do not require hospital care.

The Sherbourne Health Centre Infirmary program is intended to augment already existing health care available through hospital and community sites. Our intent is to enhance the recuperative or recovery options for people who are homeless or underhoused, with a focus on individuals with health issues requiring short-term stays. The Infirmary program is not intended to replace other needed forms of health care such as emergency or urgent assessment, crisis, mental health or addiction services.

Profile
Operating agency
  • Sherbourne Health Centre (Non-profit)
Year program was established: 2007
Site of respite beds: Stand-alone Facility; Located on the third floor of the Sherbourne Health Centre
Number of respite beds: Staffing for 10 beds; future capacity of 20
Hours of operation: 24/7, 365 days
Average length of stay: 11 to 14 days

Admission Criteria
• Must have an acute medical problem and be in need of short-term recuperative care
• Must be medically and psychiatrically stable enough to receive care in a communal setting.
• Must not require acute or hospital based care
• Must be independent in self-care and must be mobile

Clinical Services Provided
Physician
Nurse Practitioner/Physicians’ Assistant
Nurse
Medication dispensing & storage
Substance abuse/mental health
Screening for/connection to a primary care provider
Support Services Provided
Meals
Transportation
Case Management

Funding Sources
Ontario Ministry of Health and Long Term Care via the Toronto Central Local Health Integration Network