Medical Respite Services for Homeless People

Sally Willmott – Churchill Fellow 2012

I understand the Churchill Trust may publish this report, either in hard copy or on the internet or both and consent to such publication. I indemnify the Churchill Trust against any loss, costs or damages it may suffer arising out of any claim or proceedings made against the Trust in respect of or arising out of the publication of any report submitted to the Trust and which the Trust places on its website for access over the internet. I also warrant that my final report is original and does not infringe on the copyright of any person, or contain anything which is, or the incorporation of which into the final report is, actionable for defamation, a breach of any privacy law or obligation, breach of confidence, contempt of court, passing off or contravention of any other private right or of any law.

Signed: Sally Willmott Dated: 14 July 2013
Medical Respite Services for Homeless People

Executive Summary

On any given night in Australia there are an estimated 105,237 homeless people (Homelessness Australia, 2012). This means that nearly 1 in every 200 Australians was experiencing homelessness on census night in 2011 (Homelessness Australia, 2012). For those without family and a supportive home, recovering from an illness or injury can be challenging. I visited 3 states in USA that have developed innovative programs to address health outcomes of homeless people and which have embarked on developing a long term coordinated approach to breaking the cycle of chronic homelessness. Key to my investigation was the medical respite service model. Medical Respite provides recuperative care for people who are too sick to get well living on the street or in crowded unsanitary homes but not sick enough to be hospitalised.

Medical Respite services have been demonstrated to be a cost effective alternative by providing recuperative care to those without a clean and supportive home. An emerging trend is that eligibility for programs for homeless people are being broadened to include people living in poverty, vulnerable to poor health outcomes and becoming homeless as a result of ill health.

The medical respite service which is developed in partnership with a shelter makes use of existing resources, however tensions between the different missions of the services has seen the emerging trend of motel rooms being used for medical respite services. More established services have developed stand-alone facilities which are staffed 24 hours a day and can provide intensive and complex care.

Partnership and data sharing between agencies and organisations such as shared electronic health and social records, data on service usage sharing has enabled continuity of care for a transient population, analysis of what is and is not working and shared problem solving.

The provision of physical care is only part of the healing that occurs in a respite service. Linkage to mental health and substance abuse treatment, assistance with completing application forms and linkages with housing, welfare benefits, support with writing resumes, computer skills, job interview training, job readiness training all reconnected consumers with the possibility that their life could be different and most importantly gave consumers hope. However consumers and former consumers frequently said it was the compassion of the staff that was the most powerful experience that stimulated thoughts of lifestyle change.

The medical respite services aim to discharge the client to housing or a shelter but some discharges back to the street are inevitable. Thus partnerships with accommodation providers are essential to making a real impact on the health and wellbeing of homeless people.

Without exception consumers identified that becoming housed was the beginning of a long and difficult journey to reintegrate into the community, change their mindset, behaviour patterns, overcome intense loneliness and address the factors which led to their homelessness. To assist the transition several respites run consumer groups for discharged clients to provide peer support and feedback on program development.

Sally Willmott; Manager Primary Care Services, Perth Central and East Metro Medicare Local
Ph: (08) 9376 9200 Email: Sally.willmott@pcemml.org.au
# Medical Respite Services for Homeless People

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Introduction and Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>Programme</td>
<td>5</td>
</tr>
<tr>
<td>What is a Medical Respite service?</td>
<td>7</td>
</tr>
<tr>
<td>Cost Effectiveness of the Medical Respite for Homeless People Model</td>
<td>10</td>
</tr>
<tr>
<td>Funding</td>
<td>11</td>
</tr>
<tr>
<td>Developing a Medical Respite Business Case</td>
<td>12</td>
</tr>
<tr>
<td>Models of Medical Respite Services</td>
<td>13</td>
</tr>
<tr>
<td>Stand-alone Facility</td>
<td>14</td>
</tr>
<tr>
<td>Shelter based respite</td>
<td>15</td>
</tr>
<tr>
<td>Motel based Medical Respite facilities</td>
<td>16</td>
</tr>
<tr>
<td>Board and Care</td>
<td>17</td>
</tr>
<tr>
<td>Sobering Centre</td>
<td>17</td>
</tr>
<tr>
<td>Harm Minimisation</td>
<td>18</td>
</tr>
<tr>
<td>Referral and Admission</td>
<td>18</td>
</tr>
<tr>
<td>Length of stay</td>
<td>21</td>
</tr>
<tr>
<td>Discharge</td>
<td>21</td>
</tr>
<tr>
<td>Service Collaboration and Integration</td>
<td>22</td>
</tr>
<tr>
<td>Boston</td>
<td>22</td>
</tr>
<tr>
<td>San Francisco</td>
<td>23</td>
</tr>
<tr>
<td>California</td>
<td>23</td>
</tr>
<tr>
<td>Consumers</td>
<td>24</td>
</tr>
<tr>
<td>CAB Composition:</td>
<td>25</td>
</tr>
<tr>
<td>Support</td>
<td>25</td>
</tr>
<tr>
<td>Training</td>
<td>25</td>
</tr>
<tr>
<td>The meeting</td>
<td>26</td>
</tr>
<tr>
<td>Other duties of a CAB Member</td>
<td>26</td>
</tr>
<tr>
<td>Learnings and recommendations</td>
<td>27</td>
</tr>
<tr>
<td>References</td>
<td>29</td>
</tr>
<tr>
<td>APPENDIX 1: Willie’s Medical Respite Story</td>
<td>30</td>
</tr>
</tbody>
</table>
Medical Respite Services for Homeless People

Introduction and Acknowledgements

I have worked with the homeless and substance use community for the last decade and during this time I met people who purposely ensured they were sentenced to a prison term because it was the only way they knew to access the healthcare they needed or they needed a break from homelessness. Others were living rough in mid winter, with health conditions such as pneumonia, emergency accommodation services were already at capacity and were concerned about their duty of care if they admitted someone who is ill, another person with end stage liver disease dying in a squat after being ejected from healthcare facilities because he continued to drink alcohol. These are just a few life stories that led me to search for a more compassionate solution. I found the medical respite model on the National health Care for the Homeless website and immediately had a sense that this is what is needed in Australia to fill the gap in the continuum of care for homeless people.

In early May 2013 I returned from 2 months in USA on a Churchill Fellowship to investigate models of medical respite services for homeless people in USA. I found that medical respite services in USA are providing a compassionate system of care that assists people fulfill their potential in a healthy way and helping them to become a contributing and productive members of society.

Homelessness is a significant Australian public health and social concern given that the Census identified that the number of homeless people increased by 17% from 89,728 people in 2006 to 105,237 people in 2011. Medical Respite provides recuperative care for people who are too sick or injured to get well living on the street or in overcrowded, unsanitary and unstable accommodation but not unwell enough to be hospitalised.

I have been greatly inspired by all whom I met; hearing from clinicians, administrators and advocates the great and compassionate work they do every single day and hearing from consumers what they have survived, overcome and achieved. A list of those who I formally met with and am indebted to is provided in the program. However there are many nameless others with whom I had a brief contact and conversation and who contributed to my learning. I very much appreciate the overwhelming warmth and support from all those I met on my journey to USA.

I would like to sincerely thank the team at Perth Central and East Metro Medicare Local (formerly Perth Primary Care Network) that supported my application and enabled me to take extended leave to undertake the Churchill Fellowship. In particular I would like to thank Christopher Carter, Jonine Collins, Michael Keeble, Learne Durrington, John Palmer, Sharon Hillman and Sharon Foster for their support.

I thank Mick, Cameron and Toby Williams for their support and in particular, I thank Mick who arranged to stay in Perth and support our children while I was away. I am deeply grateful to have been known the home front was stable, functioning and in good humour while I was in USA. Mick, Cameron and Toby, your warm tolerance and support has enabled me to follow my dreams and make the most of my time in USA. Thank you.

Finally, I will be forever grateful to the Winston Churchill Memorial Trust for the opportunity to travel to the USA to immerse myself in homeless healthcare and medical respite services. I am very
appreciative of having the opportunity to learn from others working and living in the homeless healthcare arena; an area I am deeply passionate about. It has been a life changing and enriching experience and one I will ensure is a good investment for the community.

The following report aims to provide some insight into Medical Respite services and the lessons learnt by administrators, clinicians and consumers who have paved the way. I hope it will assist homeless health care service providers to better understand the steps necessary to operate a successful Medical Respite program. The voice of the consumer provides important insights on the impact a medical respite service has on them, what has worked and what doesn’t work for the homeless community. Except for the testimonial on the impact of the medical respite service from Willie J Mackey, consumer and advocate and which he wrote for this report, I have highlighted verbatim quotes from consumers and former consumers but have not used their real names to protect their privacy.

This report focuses on five key areas. The first covers what a Medical respite service is, and what the benefits are, the next looks at funding models and factors to include when building a business case, the third covers different models of Medical Respite services, the fourth looks at examples of service collaboration including the role of the consumer and finally lessons learnt and recommendations going forward.

I spent the first twenty years of my life drinkin’, druggin’ and ranchin’ until the druggin’ took over. Then I ended up in the medical respite and one day a nurse said to me “Joe, is this all you want from life, don’t you want more from life?” and I said “you mean I got options?” She said “there are a lot of things you could do” and sat down and talked it over with me. I’ll never forget her, she had such a kind face and it came out in her voice. Then she organised for a social worker to come and go through different things I could do. When it was time to leave I said “I want something different for my life but I don’t know what” and they said “well why don’t you volunteer here for a few weeks while you think about it.” So I did, and then I got a job with the respite and then at age 41 I went back to school and after a lot of years and a lot of hard work I ended up with a MBA. I’ve been there for 20 years now and worked in nearly every damn non clinical job there is. I love those guys more than myself. I’ll fight with everything I’ve got for them; but I wont fight alone. They’ve got to fight for themselves. But you gotta keep an eye on those clinicians. They want to do everything for their patients and that’s not good for them. They (patients) have to learn that they’ve got responsibilities to improve their life too and if they participate, we’ll work to help them. But they’ve gotta want to help themselves to – it’s got to be a partnership or it doesn’t work. Joe, Chief Operating Officer of a large medical respite service.
Medical Respite Services for Homeless People

Programme

WASHINGTON DC, USA

- Barbara di Pietro, National Policy Director Homelessness, National Health Care for Homelessness Council
- Sabrina Edgington, Policy and Program Specialist, National Health Care for Homelessness Council
- Zachary Santoni-Sanchez, Data Specialist, National Health Care for Homelessness Council
- Barbara Meyers, Medical Director Cincinnati Medical Respite, Cincinnati.
- Monte Hanks, Director Operations, Fourth St Clinic Medical Respite, Salt Lake City, Utah.
- consumers

BOSTON, Massachusetts, USA

- Sarah Ciambrone; Director, Barbara McInnes House (BMH), Boston Health Care for Homeless Program (BHCHP)
- Cheryl Kane, Director of Nursing, BMH
- Barbara Donahue, Director Facilities and Consumer Advisory Board Liaison, BMH
- Kathleen Saunders, Director Case Management, BHCHP
- Desiree Otenti, Case Manager Supervisor, BHCHP
- Melinda Thomas, Associate Medical Director, BMH
- Dr David Munsen, Medical Director, BHCHP
- Billie, Director Suboxone Program, BHCHP
- Matt Mitchell, Manager High ED Users Program, BHCHP
- Cathy, Admissions Nurse, BMH
- Romy Lee, Case Manager, StreetClinic at Boston General Hospital, BHCHP
- Joanne Guarino, BHCHP Board of Directors; Consumer Representative, Consumer Advisory Board and National Consumer Advisory Board member, BHCHP
- Consumers, BHCHP

CHICAGO, Illinois, USA

- Jennifer Nelson-Seal, Executive Director, Interfaith House
- CarieBires, Service Integration Manager, Heartland Alliance
- Randi Tolliver, Heartland Health Outreach, heartland Alliance
- John Fallon, Program Manager – Re-entry, Corporation of Supportive Housing
- Juanona Brewster, Director of Early Childhood Development, Illinois Chapter, American Academy of Pediatrics
Medical Respite Services for Homeless People

SAN JOSE, California, USA

- Linda Stone, Executive Director, Santa Clara Valley Homeless Healthcare Medical Respite and Boccardo Reception Centre.
- Lorna Lindo, Medical Social Worker, Santa Clara Valley Homeless Healthcare Medical Respite
- Amber Frymer, Registered Nurse, Santa Clara Valley Homeless Healthcare Medical Respite
- Willie Joe Mackey, member Consumer Advisory Board and the National Consumer Advisory Board
- Eileen Richardson, Executive director, Downtown Streets Team
- Anne Marie Meacham, Senior Director Development and Communications, Downtown Streets Team
- Jen Padgett, Executive Director, Community Technology Alliance
- Allan Baez, Community Technology Alliance
- Cornelius Solomon, founder and Chief Executive Officer, Hope for Outdoors People
- Consumers

SAN FRANCISCO, California, USA

- Dr Joshua Bamberger, Medical Director, Housing and Urban Health, Department of Public Health and Housing.
- Tae-Wol Stanley, Program Director, San Francisco Medical Respite and Sobering Centre.
- Michelle Nance, Nurse Practitioner, San Francisco Medical Respite and Sobering Centre
- Sal Salas, member Consumer Advisory Board and National Consumer Advisory Board
- Consumers
- Bonnie Schwartz, Program Director Cross Current Team and City Wide Focus
Medical Respite Services for Homeless People

What is a Medical Respite service?
Medical Respite services provides short term, residential, recuperative care for people who are too sick to get well living on the street or in crowded unsanitary homes but their condition does not warrant hospitalisation.

Homeless people have much higher rates of mortality and morbidity than the general population. Many homeless people are living with a set of social, mental and physical health conditions that are interrelated and that work together to significantly increase the burden of disease in the population. Violence, poor nutrition, substance use, mental health disorders, illness and injuries and exposure are some examples of these mutually enhancing problems. Furthermore, there is no health condition that is not exacerbated by, or as easily or easier to treat while a person is homeless.

There are multiple barriers to health care access for homeless people:

- They tend to have significant and complex needs that cross systems.
- They lack knowledge of services and how to navigate them.
- They lack comfort with using services- concerned about ramifications such as discrimination and punitive measures in response to substance use, their children being apprehended.
- Providers don’t have the background, skills or resources and are constrained by rigid program rules resulting in services not being able to be responsive to consumer needs.

Despite the well-developed public healthcare system in Australia, people experiencing homelessness continue to have longer inpatient stays and accrue significantly more hospitalisation costs than their housed counterparts Zaretzky, K., et al. (2013). Furthermore, once hospitalised the lack of housing complicates discharge planning and subsequent recovery is compromised due to unstable living conditions which in turn leads to worsening health status and high rates of emergency department presentations and readmission to hospitals.

Medical Respite for homeless people was developed in 1993 by the Boston Homeless Healthcare Program team to reduce healthcare costs, avoid hospitalisations and readmissions of people who were experiencing homelessness. Though models of Medical Respite services vary they all provide post-acute or sub-acute medical care for homeless people who are too ill or frail to recover from physical illness or injury while living rough, or in overcrowded and unstable housing but who are not ill enough to warrant hospitalisation. The availability of respite care facilitates the discharge of consumers from hospital when medically indicated and reduces hospital bed demand as suitable discharge options are sought. While there is a wide range of services provided within Medical Respite facilities, they all provide a level of medical support and linkage to housing and other social services that address the social determinants of disease. There are now 57 medical respite facilities operating in 29 states within USA and another 2 in Canada.

For those who are housed but financially and socially disadvantaged poor health can contribute to loss of employment and housing. An emerging trend in homeless healthcare services appears to be
Medical Respite Services for Homeless People

to allow access to homeless healthcare services for housed people who are economically and/or socially vulnerable with the aim of preventing homelessness. In Massachusetts, the Boston Health Care for Homeless Program (BHCHP) inclusion criteria for homeless healthcare programs has been defined as everyone who is living at + 110% above the poverty line. In Georgia vulnerability to homelessness is defined as all those earning 80% below the median wage. Most other services I visited have defining the parameters of socioeconomically vulnerable populations on their agenda. In Australia, a Study into the cost of homelessness found that persons at risk of homelessness are heavier users of non-homelessness services than the population in general. Zaretzky, K., et al. (2013) The Affordable Care Act which is currently progressing through Congress will ensure that, from 2014, all those living 133% of the Federal Poverty Level (FPL) will have access to subsidised medical insurance and therefore improved access to healthcare. Lack of health insurance has been a significant factor responsible for a worsening homelessness rate in USA. As a result of not being medically insured many homeless people are have been discharged to the streets, known colloquially in some USA Emergency Departments as “treat em and street em”. However, in common with Australian homeless population, they are living in an exposed environment, vulnerable to violence, with instructions to rest, complete a course of medication, follow up with a doctor or nurse for wound care and return for outpatient appointments. However with the need to find shelter and food taking priority over appointments, lack of access to transport, unsanitary living conditions, being exposed to communicable diseases in overcrowded living arrangements, needing to sell medication to meet other needs which have a higher priority or being stood over to hand over medication results in the person not able to engage in treatment and developing complications and worsening of medical conditions. The end result is preventable presentations to Emergency Departments, avoidable hospitalisations and increased mortality - the average lifespan of a homeless person in San Francisco is 42.3 years. Bermúdez, R. (1999).

There has been a shift in philosophy over the previous few years so that instead of trying to deliver services to as many people as possible the focus is on delivering high quality services to fewer to focus on quality outcomes rather than outputs and ending the cycle of homelessness.

Medical respite services fill a gap in the continuum of care for people who are homeless and lack a safe, supportive environment to recuperate. Ideally the scope of care is directly linked to consumer needs. However, of necessity, a number of different models of medical respite services have developed depending on local need and resources.

Services commonly offered by a Medical Respite are listed below:

- Provision of a clean, safe place for recuperation with good nutrition and adequate rest;
- Preventative interventions such as immunisations, screening for BBV and STI, TB;
- Receive regular medication regimes and wound care;
- Pre procedure preparation, e.g. prior to colonoscopy, day surgery procedures;
- Care during prolonged treatment such as chemotherapy and radiotherapy, hospice care;
- Psychological counselling as an inpatient and outpatient;

The community has to heal along with consumers; they’re dealing with negative perceptions of homeless people and people who are poor. That’s why I facilitate poverty awareness groups. Mark, Consumer Peer Support and Advocate, medical
Medical Respite Services for Homeless People

- Treatment for psychiatric diagnosis and referrals for ongoing psychiatric care when needed;
- Provision of treatment for substance use;
- Some facilities off domestic violence groups for men and women;
- Some larger facilities offer dental care;
- Completed applications for entitled benefits when the consumer doesn’t already receive them;
- Completed applications for permanent housing;
- Completed applications for Medicaid health insurance;
- Discharge to temporary housing when the permanent housing application is still in progress;
- Provision of intensive case management services for ongoing support when appropriate;
- Linkages to specialist homeless primary care providers and facilitation of ongoing care, including specialist and allied health providers, to provide continuity in management of acute and chronic conditions;
- Inpatient peers support, post discharge support groups and Consumer Advisory Boards.

“I’ve been on the streets for 15 years and when Darren (partner) was diagnosed with diabetes 4 years ago, we came up here to Boston from New Orleans because we knew we could get good healthcare here. I was in the medical respite 4 months ago. While I was in there they were making an ad for the centre and one of the guys said “you ought to get Julie to sing on it” and I didn’t want to because I hadn’t sung in 6 years and I’m a professional; if I can’t do a proper job I don’t want to do it. Anyway a couple of the guys and one of the nurses got together and wrote a song: Just Give Me a Shot of Anything. I couldn’t believe a nurse would write anything like that! But I could sing it because it was real. Next thing I know some production team came in and they were real professionals and they wanted to record me. I didn’t like it because I didn’t have enough time to do the musical arrangement properly. I wanted to do a professional job, and I could have done better but they couldn’t wait. It really bought me back to myself. I’ve even started thinking about a detox. I’ve talked to Darren about it but he doesn’t want to do it and I won’t do it without him, I’m just not ready, you know.

Then one of the nurses found an old lady with a piano she didn’t want any more so they put it in a church hall and I can use it whenever I like. I’ve been in there nearly every day since I got out; composing. Everybody says you need a detox and housing, but the important thing to me is that I’m composing again.” Julie, currently homeless, Homeless healthcare consumer
Medical Respite Services for Homeless People

Cost Effectiveness of the Medical Respite for Homeless People Model
Considerable research into the cost effectiveness of medical respite care has demonstrated they are able to decrease hospital utilisation and provide cost effective alternative health care.

| Demonstrated Cost avoidance for hospitals partnering with medical respite programs |
|---------------------------------|---------------------------------|
| Los Angeles, CA                 | $3 Million total annual cost avoidance for hospitals |
| Portland, OR                    | $3.5 Million total cost avoidance over 3 years for 1 hospital |
| Cincinnati, OH                  | $6.2 million total cost avoidance for 3 hospitals and the community |
| San Deigo, CA                   | $800 000 total annual cost avoidance for 20 consumers studied over the course of a year |
| Atlanta, GA                     | $185 000 total cost avoidance based on length of stay reductions for 154 consumers |
| Sacramento, CA                  | $1.07 million total cost avoidance for 119 consumers |
| Richmond, VA                    | $11.2 million total cost avoidance over 2 years for 3 health systems |
| Salt lake City, UT              | $5.5 million total annual cost avoidance |

Medical Respite Care: Reducing Costs and Improving Care April 2011 [www.nhchc.org](http://www.nhchc.org)

A study, published in 2009, looked at the whether a post hospital discharge to a medical respite was associated with a reduced readmission rate within a 90 day period compared to other discharge destinations in Boston. The study found there was a 50% reduction in the rates of readmission at 90 days post discharge compared to discharge to the streets or shelters. Medical Respite Care: Reducing Costs and Improving Care April 2011 [www.nhchc.org](http://www.nhchc.org)

In another study Interfaith House in Chicago conducted a 2 year retrospective data review for consumers 12 months after discharge from medical respite services. The control group consisted of those referred to Interfaith House for respite care but were not accepted as there were no beds available. The study showed respite consumers had 60% fewer hospital stays and cost savings of $5439 - $13 680 per consumer. [www.interfaithhouse.org](http://www.interfaithhouse.org)

Total costs for medical respite services vary depending on the facility type, level of services, staffing and partnerships.
Medical Respite Services for Homeless People

Average adjusted costs per inpatient stay in hospital compared to the daily cost in a medical respite program reinforces the cost benefits of medical respite services.

<table>
<thead>
<tr>
<th>Location</th>
<th>Average cost per inpatient in a Hospital</th>
<th>Average cost per inpatient in a Medical Respite facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond</td>
<td>$1698</td>
<td>$68</td>
</tr>
<tr>
<td>Chicago</td>
<td>$1856</td>
<td>$90</td>
</tr>
<tr>
<td>Salt Lake City</td>
<td>$1359</td>
<td>$135</td>
</tr>
<tr>
<td>San Francisco</td>
<td>$2279</td>
<td>$180</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>$2279</td>
<td>$175 - $200</td>
</tr>
<tr>
<td>Houston</td>
<td>$1859</td>
<td>$125</td>
</tr>
</tbody>
</table>

Hospital utilisation based on participation in medical respite during the 12 month follow-up period following hospital discharge:

![Bar chart]


Funding

Medical respite facilities have few opportunities for independent funding because there isn’t a formal classification niche for recuperative health care facilities. There is significant advocacy within the medical respite networks for a specific classification as a healthcare provider so they can become eligible as a designated reimbursable service through medical insurance and to be able to
Medical Respite Services for Homeless People

attract funding. However current medical respite services are mostly classified as an emergency accommodation service with health staff, primarily nurses and case managers which are funded through collaboration between hospitals and community partners who purchase services. Faith based organisations are a significant source of medical respite funding.

There has been a recent breakthrough in medical respite status as a health institution. After Sr Dr Adele O’Sullivan, a doctor in Arizona lobbied the state legislature for 5 years a new classification: “Unclassified Health Institution” was included in the list of registered health institution classifications. As a result of Arizona becoming the first state to register Medical Respite as a health institution the Catholic church is funding Arizona’s first Medical Respite facility; a state of the art standalone facility.

Nurse Practitioners, Physician Assistants and Medical Directors are able to bill for Home Visits and hospitals are billed per bed night or lump sums are negotiated. Some Medicaid (State Medical insurance) funding can sometimes be negotiated and federal grants. Therefore the funding model in USA is mostly through hospitals which pay for beds as utilised. Pressure on beds in hospitals is high and one outcome of the health reform strategies in USA is that hospitals will, within 3 years, be penalised through funding (lack of Medicaid reimbursement) if a consumer is readmitted to a hospital within 30 days of discharge. Therefore medical respites are finding that there is growing interest from hospitals to develop partnerships and provide funding.

Medical respite service administrators have learnt that it is essential clinical staff understand the funding model the respite operates under to ensure their fulfilment offunder’s requirements and willingness to link funders requirements to the model of care. Some issues medical respite administrators have experienced is that when there is a lack of awareness of the funding model staff will accept unfunded consumers, allow consumers to remain an inconsumoer longer than funder is willing to pay for or don’t provide timely feedback to referrers which ultimately results in reduced referral rates and therefore bed usage. Staff not understanding the funding structure has directly led to at least one medical respite service alienating their hospital partners, becoming unviable and closing. Post closure analysis revealed the hospitals funders became concerned they were paying for consumers in beds after the need for medical oversight has passed and were paying for case management or for the time the consumer was waiting for social and housing services and therefore stopped referring into the program. Word of mouth suggests this hard lesson has been experienced by a number of facilities. Administrators have found that an agreed length of stay provides the funder with a sense of control and confidence in the program.

Developing a Medical Respite Business Case

In Australia funding from hospitals is less likely but issues that result from providing care to homeless people and those without support systems in place are the same. To assist build a case for Medical Respite services Sarah Ciambrone, Director of Barbara McInnes House, Boston, Massachusetts, and Leslie Enzian, MD advises to gather local homeless hospital utilisation data and get to know local hospital priorities and use this to inform the development of the medical respite service. The respite can then develop expertise around local priorities and garner funding support.
Medical Respite Services for Homeless People

Useful data includes:

- bed capacity/census;
- Emergency Department capacity;
- appropriate lengths of stay;
- cost of high utilisers of Emergency rooms and hospital beds;
- the hospitals ability to place homeless consumers in alternative facilities such as mental health institutions;
- lengthy hospital stays of homeless people due to conditions and treatment which would be suitable for a Medical Respite facility such as intravenous therapy, wound care;
- behavioural management issues of challenging consumers.

Medical Respite services can offer:

- decrease length of stay thereby opening up more hospital beds
- a safe discharge option thereby decrease readmission rate
- avoid emergency room visits
- optimise health outcomes due to respite care and followup
- offer expertise in behavioural management
- Integrated team based care to address the patterns of high utilisers of emergency rooms and hospital beds by assisting the consumer to engage with primary care, chronic disease treatment and access mental health and alcohol and other drug services.

All respite facilities are developed through collaborative partnerships and open communication and flexibility are critical to the success. Developing a trusting relationship takes time and experienced service providers stress that the relationship needs to be established in the early planning stages rather than after funding has been granted.

Models of Medical Respite Services

Medical respite services have taken on a number of different models depending on local needs, who drives the development and what community resources engage and are available. The primary models are:

- Free Standing dedicated Medical Respite facility
- Shelter based beds
- Motel rooms with medical monitoring

I was assaulted with a baseball bat and every bone in my face was broken. I went to the medical respite and the pain was terrible. I went out one night and bought a bottle of vodka to help deal with the pain. When I got back the nurse said: “The doctor has said that we cannot tolerate you going out and getting drunk, if this happens again we will have to discharge you”. It was the compassion in the nurse’s voice; it was real compassion - for me, that made me think I should change my life. I knew that with my injuries I couldn’t survive on the street and would have to stop drinking while I was in the medical respite but it was her compassion that changed me.

Aaron, previously homeless for 25 years, medical respite graduate
Medical Respite Services for Homeless People

- Family respite in a motel, family shelter when a member of a homeless family is ill.
- Board and Care

Many are developed in partnership with short term emergency accommodation shelters with a more recent trend to new start-ups in motels. There are medical respites which occupy a floor of a hospital, motel units, standalone facilities, an extension of a medical centre for homeless people or a few beds set aside in shelter.

Medical respite capacity ranges from standalone facilities that can provide acute, intensive and complex medical services which require sophisticated medical equipment and advanced nursing skills to care for to those who can only admit a consumer who is stable medically, fully self-caring, including being able to cook their meals, for the person who just needs a place to rest for a few days. Some are staffed 24 hours a day with nurse’s, physicians, psychiatrists, social workers, housing workers etc. on site to those with just a daily visit from a nurse to provide medical monitoring and treatment.

One common experience has been that the location of the facility is important to its acceptance by the target population. Some respite centres have been located on beautiful but isolated ranches or in outlying urban light industrial areas and which consumers refused to go to resulting in closure of the facility. The accepted wisdom is that the respite is best situated near the areas the population frequent as this is where they like to be and consumers are most likely to complete their stay in respite.

All respite services aim to discharge the consumer to housing or a shelter but some discharges to the street are inevitable. Partnerships with shelters provide the medical respite discharged consumer with priority to a bed for a set number of days after their medical discharge.

It will be no surprise that it is so much harder to be healthy and stay healthy when homeless. Dr Josh Bamberger has been collecting data on the association with health outcomes of homeless people who are housed and the quality of housing. His data to date indicates housing reduces mortality for homeless people with AIDS and that the more beautiful the housing the better the health outcome for all homeless people. Given these results it is imperative that Medical Respite services develop strong partnerships with housing providers if a sustainable impact on the health and wellbeing of consumers is to be achieved. However housing is not a panacea with ongoing support required while the person transitions from homeless lifestyle to a productive, contributing community member.

Stand-alone Facility

The stand-alone facility is most desirable as the health care service has control over the design and facility rules as well as the medical care. There can be a designated variety of rooms and facilities.
Medical Respite Services for Homeless People

that are not usually available in motel or shelter based respites. These rooms include dedicated lounges and dining rooms, a private room for counselling and purpose built treatment rooms. They are usually able to offer some single rooms suitable for those with infectious diseases or who are vulnerable to infection. In addition some well-established services such as Boston Homeless Health Care Program and Barbara McInnes House have substance use, dental and primary care clinics within the facility. Some stand-alone facilities also have barbers, chapels, exercise rooms, libraries and computer rooms, an exercise room.

This model is the most costly to establish and operate. If the facility is a new building finding a suitable location can be challenging, given many homeless people prefer to congregate in inner urban areas. In addition, as it is a new facility all staff must be funded throughout the 24 hour period. The kitchen, laundry and housekeeping and security infrastructure also need to be established.

Shelter based respite

Medical respite services are rarely able to attract independent funding as they have not, to date, been able to convince government authorities to develop a classification which fits the Medical Respite model. Therefore most new and developing programs are based in shelters. Some well-established programs that operate in stand-alone facilities also run concurrent beds in shelters to supplement bed capacity. I visited Santa Clara Valley Medical Respite Service which is situated within the homeless shelter run by EHC Lifebuilders in San Jose, California. The Medical Respite service has 15 beds set aside. There is an outreach medical service funded by Santa Clara Valley Healthcare Program which has 5 beds allocated for their use and the remainder 10 beds are for consumers transferred through private hospitals and the Santa Clara Valley Medical Centre.

The key advantages to establishing a partnership with a shelter is that existing infrastructure is utilised:

- Beds are in place with administration, kitchen, laundry and security arrangements established. At Santa Clara Valley Medical Respite Program (SCVMR) which has been established since 2008, the 15 beds are in separate rooms from the general shelter population.
- With 24 hour staffing in place, the addition of health care providers is required at the respite during business hours only which keeps establishment costs down. Generally there is a health provider on call at night. A small staff of 1.0 FTE Registered Nurse, 1.0 FTE Social Worker, and 0.5 FTE Nurse Coordinator and 0.4FTE doctor provide all medical monitoring, treatment and case management services.
- Shelters often have a number of programs running and an existing network and referral pathways to education and employment services which the respite consumer can be linked to. For example in the SCVMR is located within a shelter that has a number of programs running including a large veterans support service and links to housing, Downtown Streets and other work networks, food stamps etc. The staff work closely together and link consumers to programs which will meet their identified needs.
Medical Respite Services for Homeless People

There are also disadvantages and compromises required:

- Many shelters are highly structured and with strict rules. The respite doesn’t have control over the facility rules, with consumers having to conform to the rules of the shelter first, then the rules of the medical respite. This has resulted in tension between a medical respite’s harm reduction approach to healthcare and a shelter’s philosophy of abstinence. Many respites that have shelter beds have reported that consumers are sometimes discharged due to alcohol or other drug use before they are medically stable.
- Not all respite beds will be in a separate room to the general shelter dormitory which can make provision of treatment difficult.
- There is little control over diet and some with dietary requirements such as a soft diet are not well met.
- Some consumers have burnt their bridges with shelters and shelters have refused to allow their admission into the medical respite.
- There are other consumers who have had previous altercations with shelter staff and refuse to come to the medical respite facility once they learn it is situated within a shelter.
- Hygiene standards are not to medical standards which can lead to tension between shelter staff and respite staff.
- Nursing and, to a lesser degree social work staff often get called to assess a shelter consumer. This means they are called away from their work with their own consumers and can sometimes also feel they are placed in a medico legally vulnerable position.

Despite the disadvantages an established shelter requires only the addition of minimal equipment and staff and a medical respite service with basic services can become a reality.

Motelbased Medical Respite facilities

A fairly recent development is the use of motels for medical respite services. A number of medical respites consist of wholly of motel beds or have motel beds for overflow levels of consumers. Some respite services consist of long term booking of a number of beds while others have a master lease of the motel. Of those who have a master lease some retain the current reception staff, manager, kitchen and housekeeping services. Others, such as in San Francisco the Department of Public Health has master leases of motels and put in their own staff to run the service. Leases are often easy to negotiate as the motel owner is generally very pleased to have 100% bed occupancy rate.

The advantages address the disadvantages of shelter based respites.

- The infrastructure required is in place, such as reception area, a dining room, kitchen, laundry and housekeeping services. These services usually continue in collaboration with the health care providers.
- The medical staff has more control over the environment so that facility rules, hygiene and a harm minimisation approach can be established.
- Consumers have greater level of privacy.
- A motel is usually acceptable to the consumer.
- There are fewer conflicting priorities such as providing services to Medical Respite consumers and shelter consumers.
Medical Respite Services for Homeless People

The main disadvantages of the motel model are:

- It is suitable for low acuity level consumers who primarily require rest. Generally a Nurse will check on the consumer once or twice daily, with a case manager visiting as required;
- Referral pathways to supportive programs need to be established.

Board and Care
Board and Care facilities are frequently known referred to as “Mom and Pop” care, where spare bedrooms can be used to provide accommodation in a family setting. Individuals receive basic training such as nutrition, crisis intervention, conflict resolution and diversity sensitivity. A carer must always be available and residents maybe long term. The carers ensure that the resident is fed, has access to a laundry, their hygiene needs are met, medication is given regularly. A maximum of 6 residents is allowed in a house. The owners of the house are paid through the residents social security payments with a few having contracts with state or county agencies. Board and Care is for those who are frail, require assistance to meet their medical and living needs and occasionally used for homeless people. However the complex needs and behavioural challenges frequently encountered in the homeless population mean this is not a usually the best option for this population.

Sobering Centre
The San Francisco Medical Respite service has an 11 bed sobering centre which provides a safe place for acutely intoxicated homeless consumers to sober up. Some consumers arrive in a police vehicle or ambulance having been observed to be acutely intoxicated while others are referred in by a community outreach team. The service liaises closely with a second sobering centre operated by police for intoxicated individuals with challenging behaviours. The aim of the sobering centre is to address public intoxication, improve health outcomes of chronically intoxicated people and reduce the use of emergency room resources. At the sobering centre the primary issue is alcohol abuse though many consumers will have co-occurring issues with other substances, mental illness and other medical disorders.

Admission is following a clinical assessment that must find vital signs within acceptable limits and that the consumer does not need any medical intervention including for withdrawal symptoms. Medical monitoring is offered 24 hours a day, throughout the year. Meals are provided and encouraged. Many consumers are regulars and staff build rapport and engages the consumer in harm minimisation strategies and other health behaviours. Case management services are available to link the consumer with services if the consumer indicates they are interested in lifestyle changes.

Clinicians talk to us about our addictions but they don’t say anything about their addiction – to caring. Some clinicians are addicted to caring. They want to do everything for you. It’s a disaster when someone like that gets to be in charge of an organisation. I’ve seen it happen, their numbers go way up and they think they’re doing real good, but no-one changes. Their addiction to caring keeps everyone down”.

Nick, homeless 6 years
Medical Respite Services for Homeless People

Harm Minimisation
Medical respite services vary in their tolerance of alcohol and substance abuse. Some have mandatory discharge if a consumer uses alcohol or other mind altering substances, while others operate on a harm minimisation philosophy.

As many consumers are dependent on alcohol or substances so the medical respite needs to be clear on whether if they are able:

- to offer a medical detoxification or;
- if the consumer needs to be detoxed before admission or;
- ongoing alcohol and other substance use will be tolerated to keep the consumer stable.

Many homeless people with alcohol and substance abuse and dependence issues are not ready to embrace abstinence. Therefore if a respite has a requirement that consumers remain abstinent rather than a harm reduction philosophy significant numbers of consumers won’t be eligible for treatment. Many of the respite I visited tolerate the use of alcohol and other substances providing it is off premises. Some medical respite services are “wet” which means consumers can drink alcohol on the premises.

Retention and completion of medical treatment has been demonstrated to be improved when the medical respite is able to implement harm reduction model of care. Therefore, if the medical respite is to work within a harm minimisation philosophy, it is important to employ staff who agree with the harm minimisation approach. Support for staff, open discussion, opportunities for debriefing, training on harm minimisation and clear consumer goals are helpful strategies to retain staff needed as it can be difficult to witness self-destructive behaviour.

Alcohol and substance use policies need to be balance needs of those trying to give up and whose cravings are triggered by those using around them. Key to successful harm reduction practice is that staff are well versed in motivational interviewing and referral pathways for those who are contemplating reducing or stopping their alcohol or substance use.

In addition, respite staff need to be prepared for potential overdoses and if 24 hour supervision is not available then the respite needs to ensure that non-medical shelter staff are trained to assess sedation.

Referral and Admission
An emerging trend is that homeless services are gradually being opened up to those who are assessed as socially and economically vulnerable and therefore at an increased risk of poor health outcomes. In Boston this has been identified as those living to 110% above the poverty level while the state of Georgia has identified all those earning 80% less than the median wage. In all other states I visited services are actively considering establishing a defined vulnerability level which will be used to prioritise access to services. Allowing housed but vulnerable people access to services such as Medical Respite aims to improve the health outcomes of populations traditionally experience poorer health outcomes and prevent homelessness.

Priority in respite is generally given to the most vulnerable and to those with an acuity level most appropriate to the level of care available at the respite facility. Primarily admissions were referrals...
Medical Respite Services for Homeless People

from hospitals though referrals from homeless healthcare services such as outreach services and primary care providers also occurred according to available funding guidelines and agreements. Some respites accept self-referrals but this is uncommon due to funding requirements. All facilities I visited prioritised high utilisers of emergency rooms in an attempt to link the consumers to other services and break the cycle of emergency room use as default primary care provider by teaching the consumer them alternative ways they can get their health needs met.

More generally referral and admission criteria includes that the person is homeless or has been homeless in the past and is:

- medically and psychiatrically stable enough to be managed in the facility;
- have an acute or post-acute illness or injury;
- be too ill to be admitted to a shelter;
- is not homicidal or suicidal;
- on the emergency room high user list;
- agreeable to entering the respite;
- is independent in activities of daily living (such as showering, dressing, eating, ambulating).

Some respites include pre-procedure workup in their admission criteria such as before colonoscopy and hospice services for terminally ill consumers.

Creating a communication pathway with one point of contact for all communication between referrers and the respite service is a necessity to avoid confusion between the services.

A number of staff from Medical respites advised to keep referral forms to one(1) page. Many had started with much lengthier referral forms, some up to 12 pages long, in response to concerns about accepting consumers requiring care beyond the capacity of the respite service. The lengthy forms were found to be a barrier for time poor health staff. Shortening the forms to one (1) pageresulted in the medical respite being seen in a more positive light and more referrals being generated. If more information is required to assess suitability then a phone call can usually get the necessary additional information.

Strong clinical assessment skills are required to assess the consumer’s medical stability and appropriateness for transfer to the medical respite facility. Some respites services employ doctors to triage referrals while others employ nurse practitioners or registered nurses. Respite staff are encouraged to decline inappropriate referrals, usually meaning consumers with higher needs than their scope was able to care for adequately. However all respite staff admitted that they sometimes accepted a person who was more acutely ill than they were resourced to deal with, because the person would otherwise be discharged to the street.

Policies regarding what constituted a timely response to referrals varied between four (4) hours to a same day response. A referral response time policy is a result of lessons learnt whereby delayed referral response impacts hospital planning and strains the partnership relationship. Delayed response can result in consumers who would have been accepted being discharged and lost to follow up. However a timely response to referrals can be challenging to achieve. For example the day I visited the Admissions department of Barbara McInnes House, by 2pm 120 referrals had been
Medical Respite Services for Homeless People

received for 3 available beds. Referrals were processed and feedback provided such as; the consumer is too acute for now but will be a strong candidate in a few days’ time.

BHCHP developed the Vulnerability Index to assist prioritisation of consumers. The vulnerability index is used to determine who is most at risk of dying on the street and therefore will be prioritised for medical respite and housing. The vulnerability Index, which includes frostbite as a significant indicator or risk has had a mixed reception outside of Boston, particularly in warmer climates. Fort Worth is developing an adapted version while San Francisco homeless healthcare services have developed their own Clinical Assessment Tool to assess vulnerability to mortality and morbidity to assist prioritisation of homeless people to health and housing services.

When setting up a medical respite service, regular meetings with discharge planning supervisors of affiliated hospitals is essential to build and maintain mutual understanding and respect. Due to overwhelming demand on medical respite services, the person who triages referrals needs to be diplomatic, flexible and able to maintain a professional even tempered discussion with hospital discharge staff.

In addition, building in the flexibility of providing late admissions is a way to demonstrate cooperation and willingness to assist the hospital meet their needs and the needs of their consumers and keeping the partnership relationship smooth.

For continuity of care and to support the partnership relationship, consumers which have been transferred back to the hospital because their condition deteriorated or they required further hospital based interventions are usually prioritised. In addition consumers who have been admitted in the past are also prioritised so the respite service can continue to build on the relationship and linking the consumer to services to help and reinforce lifestyle change.

Many homeless people have challenging behaviours and maladapted coping mechanisms. Therefore, all medical respite services visited have behavioural contracts that are discussed and signed on admission and consumer stays are dependent on appropriate behaviour.

As many consumers return to medical respite at some point in the future, clear documentation of past experience helps to provide information about how future admissions need to be managed. Consumers with known difficult behaviours have behaviour management agreements incorporated

“African Americans grow up believing violence is normal. There needs to be more discussion on what success is. People think success is making a lot of money and they can do it selling drugs. People think they’re doing good. But we need people to realise success is living a life where you support each other, where you work and maybe not make much money but you’re there for kids. My nephew is just getting out of prison after 27 years in there for murder. I’ve decided I’m going to be there to give him hope that he can still live a good life. We’ve been talking about him doing some study at university so he can teach people to learn from his life. He needs someone to help him with his moral development because his family hasn’t got time for him – they’ve got their own problems. So I have to be there – who else is going to give him hope his life can be different? It’s going to be really hard for him because he went to prison when he was 21 and no one had showed him hope before then but he sees how I turned my life around and that gives him hope.” Colin, formerly homeless for 18 years, now working full time as a waiter. He is also provides consumer peer support medical respite graduates group.
into treatment agreements and which may include visitors and external appointments being limited, random urine screening, no drop offs or gifts from others allowed.

Health professionals tend to be highly mobile so ongoing education sessions to hospital staff on the medical respite service is important to ensure the Medical Respite service is maintained as a discharge referral option. To maintain a profile within the hospital staff some strategies that are employed include emailing newsletters to hospital staff, being integrated into staff induction programs and organising annual seminars in hospitals for staff. In addition, brochures outlining the service and which include photos of the facility are provided to hospital wards to prompt staff to consider respite as an option and to inform potential consumers.

Length of stay
The average length of stay in a medical respite is a highly variable factor which is influenced by the model of care, demand for service and available community resources. In Barbara McInnes House for example, the average stay is 13 days, while for the Santa Clara Valley Medical Respite the average consumer stays for 42 days and for Interfaith House in Chicago it is 60 days.

It is a combination of consumer health status and the funding model that determines the length of stay. Negotiating with funders the length of stay prior to admission is essential to maintaining a good relationship with the funder. Most negotiate the expected length of stay for each consumer individually prior to admission while one respite has contracted that all consumers may stay up to 12 days, renegotiating only if the stay is expected, or turns out to require additional days. When renegotiating a length of stay respite staff have found that providing access to the medical records progress notes as well as a summary and including a discharge plan is helpful to reassuring funders that the additional time is medically indicated is not for case management or waiting for accommodation purposes.

Discharge
Medical Respite services aim to discharge their consumers to a form of housing or shelter. Interfaith House will not discharge consumers to the streets so the longest consumer stay is currently 2 years. Housing is particularly difficult to access as the individual concerned has been blacklisted from all accommodation options due to behavioural challenges.

Some hospitals have had adverse media attention for “patient dumping”, which is discharging unwell homeless patients to the streets. Therefore some respites which don’t have shared electronic medical records provide feedback on the consumers’ progress and final discharge destination. Regular feedback assists hospitals and other referrers with their records and reduces their sense of vulnerability to assaults on their reputation upon consumer discharge from care.

While all services I visited assist the consumer to apply for permanent housing the long waitlist means that most respite services usual discharge destination is to a shelter. San Francisco which where there is significant commitment to providing public housing most are discharged to some form of permanent accommodation or, they may be admitted to transitional housing, until permanent housing becomes available.

Dr Josh Bamberger developed the San Francisco model of care after consulting with established Medical Respite services. He found that when homeless health care and medical respite
Medical Respite Services for Homeless People

programs operate successfully, engaging homeless consumers in healthcare thus reducing hospital utilisation, there was less incentive for the state to provide public housing. To have maximum impact on the health outcomes of homeless people and ending the cycle of homelessness he recommends ensuring accessible primary care services and links to permanent housing programs are in place before opening a medical respite service. If housing options are not available the consumer ends up cycling in and out of homeless healthcare services with no real change in homelessness.

Service Collaboration and Integration

As is common throughout the world, many healthcare systems and services are fragmented and operate in silos. Many homeless health care organisations have embraced collaborative partnerships and service integration to provide comprehensive community based care aiming to ending the cycle of homelessness. Most medical respite services were linked to housing, education and employment programs. Two outstanding examples of collaborative and integrated practices included shared electronic health and social records in Boston and collaborative partnerships to facilitate joint problem solving and better address the needs of high users of multiple services in San Francisco. In addition, a technology organisation in San Jose has developed a central database to collect and analyse data on homeless people with the aim of ending homelessness.

Boston

Shared electronic health and social records considerably improve the standard of coordinated and integrated care. There were two services that are more advanced than others. BHHCP used an electronic health and social record system that was shared by 75 health and accommodation organisations, at over 80 sites through the greater Boston area. The health organisations included primary care, medical respite, outreach services and 3 major hospitals, inpatient and outpatient clinics. To ensure consumer privacy, each organisation’s employees were granted different levels of access to records which is appropriate to their role. Housing, shelter staff and case managers had access to the social justice pages where applications for housing and benefits were recorded as well as stays in shelters and transitional housing etc. The behavioural health team of psychologists and counsellors had access to the social justice pages and their counselling records, while Registered Nurses, Nurse Practitioners, Physician Assistants and Medical Directors and Psychiatrist had complete access.

An example of the value of shared electronic health records was demonstrated when sitting in on a medical clinic. The doctor noted he had pathology results for a consumer who would need treatment. When he didn’t present to the clinic that day he was able to see that the consumer had spent the night in a shelter across town. A note was posted requesting staff of the next facility he accessed to assist him to the nearest clinic for results and treatment. There are regularly Nurse Practitioner clinics in the shelters so treatment is accessible.

It is the aftercare that is important because you are in a house, you feel so lonely, you have forgotten how to cook or don’t know how to cook, do laundry; even hygiene such as taking a daily shower has been forgotten.

Chris, formerly homeless for 6 years, in accommodation for 3 years and says he is still adjusting to the lifestyle change, medical respite graduate
San Francisco
In most major hospitals and communities in USA and Australia there are meetings to address the needs of high users of Emergency Departments. In San Francisco the concept has been further developed with systems in place to address the needs of High Users of Multiple Services (HUMS). Though not a homeless health care specific program, homeless people regularly feature in the top 10 frequent users list.

The Department of Public Health and Housing developed a database in which daily attendance/admission records are entered by a wide range of public, private and Not For Profit organisations and agencies. The range of services that contribute to the database includes hospitals, substance use, mental health, primary care organisations and agencies. The names, location and contact details of case managers are also entered. The top 100 highest users of services are identified as are any case managers. In this way those people who have multiple case managers and treatment plans can be identified and the case managers are able to contact each other to ensure the consumer has coordinated care and shared treatment plans. The list also identifies those who are presenting at different services multiple times but not being picked up or “slipping through the cracks”. Monthly meetings are held with senior clinical representatives from each organisation to develop strategies to better meet the needs of the high users of multiple services.

The HUMS meeting also provides an opportunity for services to increase their awareness of programs that are available and to present consumers who are high users of their own service resources but whose needs are not being met. Advice and referral pathways can be identified through the meeting participants. For example, at one HUMS meeting I attended, an agency presented a consumer with Borderline Personality Disorder (BPD) that the agency was expending considerable time and resources on but not apparently achieving positive outcomes for the consumer. The agency staff were at a point of not knowing what to do next. A participant from another organisation stated they had a program providing intensive treatment and case management for people with BPD and would be happy to accept a referral and contact details of relevant program personnel provided.

California
In San Jose, California I met with Jen Padget, Executive Director of a small technology Not For Profit organisation: Community Technology Alliance (CTA).

CTA provides the database management for organisations that have received funding from a Federal grant in California. The 16 grant recipients are mandated to share their information. In addition to the 16 organisations they have recruited over 100 organisations that provide services to homeless people throughout California to share information. They developed a swipe card which is issued to all homeless people who access services. The swipe card uploads the consumers data to the organisations database which is also accessed by CTA for analysis. The data is individualised for each organisations program and funding requirements so that individuals are identified if they meet program inclusion or exclusion criteria. For example if a program can only issue 2 food boxes per month to an individual the swipe card will register their use and identify how many food boxes they have received that month. In addition the agencies are able to extract their own data to for reporting purposes.
Medical Respite Services for Homeless People

CTA use the data to examine the flow of people through the system, are able to provide reporting data for organisations and get a true picture of homelessness and issues faced by people on a very low income. After 10 years of collecting data they are ready to look at analysing the journey of a homeless person and see if there are factors that predict who will do well, those most likely be reintegrated into the community.

CTA are active advocates for homeless people’s access to technology. They conducted a study of the local San Jose homeless population which found 70% homeless people had a mobile phone and 50% of homeless people had access to a laptop computer. They successfully lobbied the city council to provide free wifi throughout the downtown area so people would not be obliged to frequent fast food outlets to connect to the internet for social media, job applications etc.

CTA have in the past developed the community voice mail program so that a homeless person can provide a phone number and access a voice mail system without having to use an agency’s phone as a contact and being identified as homeless by potential employers or, in more recent times, be concerned about frequently changing mobile phone numbers. etc. One of their current projects is developing amore cost efficient voice mail system. Other projects CTA are involved are the development of an app that can provide targeted health and other information to people, such as where the nearest homeless healthcare service, shelter or nearest soup kitchen is to their location.

The day I met with Jen Padgett she had received a letter from the World Health Organisation identifying her as a leading innovator in health technology and inviting her to meet and discussing technology to improve health service delivery in developing countries.

Consumers

At each location I was provided with opportunities to meet with consumers individually and in groups. Without exception consumers admitted that being admitted into a medical respite facility was credited by the consumer with helping them to develop a sense of hope that their life could be different. Current and former consumers stated that that being cared for with compassion and being treated with respect started their own journey to recovering a sense of self-respect and hope, encouraged their engagement into lifestyle changes and in some cases, resulting in their reintegrating into the community. Those who have completed treatment are referred to as medical respite graduates and medical respite alumnus. It is a title many graduates wore with pride.

There is a strong movement nationally to involve consumers in the development of homeless healthcare programs and organisations. The consumers’ voice has been recognised as vital to connecting the service with the homeless community. Those respites that receive federal funding are mandated to have consumer involvement and must:

- have 51% Board of Director members are consumers or former consumers,
- Meet at least once a month,
- Consumers approve all program developments

Medical respite graduates group is good for peer support as you adjust to your new life, also those that graduated a while ago can provide peer support to newer graduates. Providing peer support is an important part in the healing process for both the parties. Jo, medical respite graduate
Medical Respite Services for Homeless People

- Consumers approve the selection of CEO (sometimes called Program Director)

I found that most medical respite facilities, whether mandated or not, supported a Consumer Advisory Board (CAB). Some also ran support groups for those who had decided to engage in lifestyle changes.

Returning to a medical respite for the support group or CAB meeting provided an opportunity to access peer support and to build a sense of meaning and purpose in providing other community members with support. It also provided an opportunity to connect with the professional health care staff that community members knew and trusted and could discuss ongoing issues and options. One respite offered follow up medical appointments clinic to coincide with the timing of the evening support group.

However, the degree of consumer engagement, role and effectiveness varied greatly. Some organisations had several unsuccessful attempts to develop a CAB which was usually identified as a lack of staff resources to support the group. Many people will volunteer to participate but due to their unstable lifestyle frequently drop out. The consensus is that, with organisational support, it will take at least 2 years to develop a strong and consistent consumer board membership.

Some common themes of successful Consumer Advisory Boards (CAB) include:

**CAB Composition:** There is a focus to recruit people on the CAB who represent different aspects of the community; e.g. Hispanic, transgendered, marginally housed, rough sleeper, formerly homeless, family members, engaged with different programs within the homeless services. However members of the CAB need to be either current consumers or former consumers of the service and at least 51% of consumers should be current consumers of the service.

A community advocate on the CAB can be helpful to provide consumers with support and a perspective that comes from outside the organisation.

**Support:** Some organisations pay their consumer representatives $20 to attend a meeting and provide transport and a meal. In addition, the use of a computer is advised for consumers so they can attend to minute writing. The allocation of an email address linked to the organisation when liaising with other organisations as a CAB member is also useful.

The organisation nominates a Liaison person to be the primary contact and provide support to the consumer members, particularly with the development of an agenda and minute writing. New representatives benefit from a meeting before they attend their first CAB to have some basic meeting training on meeting etiquette.

**Training:** provided to new CAB members includes:

- They are encouraged to sit back and listen initially as experience has found many are keen to become involved, and are vocal without understanding what is going on or has gone before. Explain they need to understanding context.
- An information sheet of common courtesies is provided and a discussion on how to handle yourself in a meeting such as raise hand to speak, don’t interrupt and limit the length of time you speak.
Medical Respite Services for Homeless People

- Ensure an understanding that everything that is said in the meeting stays in the meeting room.
- Ensure understanding that the purpose of the CAB is to provide advice and feedback. It is not a management role though they can provide feedback and recommendations on the management of the service.
- Ensure understanding of the mission of the service so the consumer doesn’t get distracted with other issues such as housing etc.

The meeting

- The initial meetings are facilitated by a service manager but aim for the CAB to be led by consumers as soon as possible. The meetings are attended by a senior manager and the liaison officer. The attendance of a senior manager demonstrates to the consumers that their input is valued by the organisation and, in addition, they can give the organisation’s perspective on issues. The liaison officer assists the CAB’s secretary with the development of an agenda for every meeting and writes and distributes the minutes until a consumer is happy to take over.
- Some CAB’s have two (2) Chairs: a chair and co-chair to provide assistance and support. The service manager liaises with new chairs to ask that if a meeting is going badly does she have permission to intervene. Sometimes this is needed to control personality issues. Other successful CABs have 1 chairman and up to 3 deputy chairs to provide support.
- The service manager does a presentation on what is going on with the service including if there are any new initiatives or problems and gets consumer feedback.
- CAB members who are participants of programs give their report on the program.
- It is an opportunity to recognise and thank different people and programs.
- Voting rights are limited to consumers and advocates. If a consumer becomes a paid employee of the organisation they forfeit voting rights.

Other duties of a CAB Member

- A CAB member does a presentation at the orientation of new staff to the service.
- CAB members attend functions where funders are present;
- CAB members speak to the media.
- CAB members liaise with the homeless community and help link potential consumers with health services.
- When a service representative is doing a presentation a CAB member goes along and shares their story.
- 1 CAB member is sometimes funded to attend the National Health Homeless Healthcare conference.
- Organise events such as for Homeless Persons Memorial Day, Nurse Appreciation Day.
- A CAB member sits on Board of Directors in most organisations of 14 BHCHP Board of Directors members, 5 are consumer representatives. Each consumer representative is mentored by another Board Member.
Medical Respite Services for Homeless People

Some examples of CAB recommendations which have been incorporated into the Boston Health Care for the Homeless Program:

- All indications that referrals to other services came from a homeless health care service was removed as consumers felt they were discriminated against;
- Medical respite residents who have an alcohol or other drug abuse must attend support groups while they are an inpatient in Barbara McInnes House. CAB has recommended those who are housed can continue to attend the groups while they transition into their new lifestyle rather than have to immediately find a new group.
- When the new premises for BHCHP were being designed the CAB recommended that the room capacity were increased from 2 beds per room to 4 beds per room to maintain a sense of community.

Learnings and recommendations
My journey to USA to investigate models of medical respite care confirmed the value of the service the potential it has to contribute to improving the health and well-being of homeless people in Australia. Medical respite does not compete with existing services but fills a gap in existing services in the continuum of care. It is clear that admission to a medical respite service provides the consumer with respite from daily fight to survive and allows time to reflect on other possibilities. Without exception, the consumers who had made lifestyle changes acknowledged the practical assistance and connections to community resources they had gained through the medical respite service and all credited the compassion of staff with enabling them to regain hope, their self-respect and make lifestyle changes.

The evidence demonstrates that medical respite programs offer a cost efficient approach to improving care, reducing emergency room presentations and hospitalisations for people who are experiencing homelessness in USA. Similar outcomes can be expected in Australia and data needs to be collated and analysed to inform program development. Data including: emergency department presentations by homeless people, hospital bed capacity/demand, cost of high utilisers of Emergency rooms and hospital beds, number of prolonged hospital stays due to lack of discharge options, lengthy hospital stays of homeless people due to conditions and treatment which would be suitable for a Medical Respite facility such as intravenous therapy, wound care; behavioural management issues of challenging consumers.

With the widely acknowledged increase in housing stress in the general population, the development of a definition which identify and provide support to those vulnerable to homelessness due to poor health would be an important tool for Medical Respite and other program development.

Consumers need to be consulted regarding program development to truly engage the homeless community and develop a program that best meets their needs. Successful consumer involvement requires commitment of resources from the organisation to support the group.

A harm minimisation approach to alcohol and substance use will enable consumer engagement in with a medical respite service.
Medical Respite Services for Homeless People

A stay in the respite facility appears to offer an opportunity to reflect and consider the possibility of change. The sense of acceptance they experience enables them to engage with healthcare, become connected to other community organisations and consider the possibility of another life. Ongoing outreach support services are essential if consumers are to maintain momentum for lifestyle changes and improved health outcomes.

Emergency accommodation and Motel based medical respites utilise existing community resources and are a much less costly alternative to a stand-alone facility. Partnering with an Emergency accommodation provider or funding motel rooms is a good start up strategy even though they only serve those who are self-caring and only require daily visits from health personnel.

If the cycle of homelessness is to be broken supported housing needs to be in place before the medical respite service is developed to avoid discharges back to the street and continuing the cycle of homelessness. Ensuring Primary care services and supportive, permanent accommodation options are available post discharge from Medical Respite services will be important to have in place if a real impact on homelessness is to be achieved.

There are two primary care providers that specialise in homeless and hard to reach populations in Perth, including StreetDoctor which is operated by Perth Central and East Metro Medicare Local. Existing networks and new connections between services need to be strengthened and the Medicare Local, community mental health organisations, drug and alcohol sector, emergency accommodation, education, employment providers engaged with view to developing a pilot medical respite service with measurable goals and real time feedback for process and outcome evaluations. If partnerships are in place funding opportunities can more easily be taken advantage of or an unsolicited funding proposal submitted.

---

I became homeless 28 September 2011 and that was the last time I used drugs. I had been injecting drugs for many, many years even though I damaged my leg and couldn’t walk as a result of injecting into it, I still did it. I was thrown out of my accommodation at midnight on 28 September with no money and one phone call left on my phone. I was really scared and didn’t know what to do. While I was wandering the streets I made a promise to myself to seek help. I really didn’t know what to do and I was really scared I would get attacked. Eventually I called 911. The police came and took me to a shelter for the night. The shelter took me to a hospital the next day and I was in hospital for 4 weeks. I had surgery to my leg, eye surgery and then when I was stabilised I went to the medical respite centre. I stayed there for 2 months. There they gave me physiotherapy and now I can use my leg, medications, nursing care, counselling, caseworker, mental health care. Then they helped me get transition housing and then 4 months ago I got a permanent home. To all the nurses and doctors – tell them that the healing power of being cared for cannot be overestimated.

I’m still clean – I always say to other homeless people that you have to sacrifice some stuff to get some stuff. Simon, Consumer Peer Support, medical respite graduate
Medical Respite Services for Homeless People

References


Hospital Council of Northern and Central California, “Medical Respite-Santa Clara” www.hospitalcouncil.net/post/medical-respite-santa-clara accessed May 2013

National Health Care for Homeless Council, “Medical Respite Care: Reducing Costs and Improving Care”, April 2011 www.nhchc.org accessed June 2013


Homelessness Australia, Sector briefing: 2011 Census night homelessness estimates; 13 November 2012

APPENDIX 1: Willie’s Medical Respite Story

Willie is a medical respite graduate and consumer advocate. He gave me this account of the effect of medical respite service on his life so others can better understand the impact a medical respite facility has on a homeless person.

Long before I had a physical home, and after being on the streets for more than six years, medical respite offered me a MEDICAL HOME, and it started a process that would transform my life from being "Willie the Homeless Guy" to "Citizen Willie!"

It is truly an honour to have this opportunity to share about my personal journey and how a Medical Respite Program has impacted my life.

There is so much information to share and I hope that this is just the beginning of a dialogue that we all will engage in. Each of us - project staff, consumers, subject matter experts and other stakeholders - has an opportunity to take ownership of and responsibility for creating change in the lives of those of us that have experienced poverty and homelessness. Together, we can truly change the game.

My journey started in 1994, when I was diagnosed with diabetes and high blood pressure. My job of 15 years had been eliminated, and it took me 2 years to secure another full-time job that unfortunately included a 50% cut in pay. That position lasted for 5 years, but I could not afford to live in an apartment any more. I started living in motel rooms, when I could afford it, in a car, or on the street. Eventually, I started hanging out at a Kinko's that was open 24 hours, and spent Thanksgiving Day, 2005 there, because it was one of the few businesses open.

Now it was June 29th, 2006, my 54th birthday, and I was still trying to survive around Kinko's … only now without a car or any place to lay my head down. I would end up going 10 consecutive days without food, riding busses all night or at Kinko's, or just trying to survive on the street while carrying my life around in a red shopping cart.

With no job, home or medical insurance, and very poor eating habits, my health kept getting worse, and in March of 2008, my foot developed a wound that would not heal. After sleeping for several months on a slab of rock at a commuter train station in the San Francisco Bay Area, part of my left foot had to be amputated.

I was facing the horror of returning to that slab of rock, not being able to walk, and possibly dying on the street, when I heard about the Santa Clara Valley Homeless Healthcare Program and its Medical Respite Center.

I will often show a gruesome picture of my foot wound, explaining that it also represents the wound of poverty and homelessness. We are a wounded community - physically, socioeconomically, and spiritually!
Medical Respite Services for Homeless People

My first foot surgery occurred on October 27th, 2008, the day that our Medical Respite Program officially opened its doors.

Our program is a community partnership between several hospitals and other service providers in Santa Clara County, California that enables our Respite team to provide people need with medical, mental health, and social services, regular meals, and a safe, dry place to sleep.

A weekly support group meeting with current and former Respite clients offers us positive reinforcement in a very safe and supportive environment, and I like the way that Respite staff will never give up on a client even when we sometimes want to give up on ourselves!

This is a very important piece of the healing process because it can be so very easy to get caught up in an immediate crisis and lose focus of how to constructively deal with life’s challenges.

Living on the street, we can often feel isolated and question our self-worth, but my continued participation in Respite helps me stay focused, allows me to give back in some way, and to be part of the team!

It is well-documented that in 2008, 55 homeless people died on the streets of Santa Clara County. When I entered the Medical Respite Program in October of 2008, I was on a path to become victim number 56!

But I quickly learned from my Respite experience that there are a lot of people in my corner who want to see people in need rebuild our lives.

With the support of all stakeholders involved, my foot wound has healed, I now have permanent housing, continue to participate in weekly and monthly respite support group meetings, and have set long-term goals.

… when I told Janet Kohl, our Respite Coordinator, that one of my goals was to walk for my first time in an American Diabetes Association Walk to Fight Diabetes, she immediately responded:

“Willie, I want to walk with you!” … and in October of 2010, Janet and I completed 5 miles together!

No matter where the journey takes Respite clients, my Respite team will always walk with us, and for me, that walk has lasted more than five years!

The Medical Respite Program and its partners helped save my life, has allowed me to transition from being “Willie the Homeless Guy” to “Citizen Willie”… and thank each one of you for also walking with me!

My writing here is also a very important piece of the healing process.

I often tell people that just placing a roof over someone’s head does not end homelessness, as homelessness is as much a mindset as it is lack of a physical structure.
Medical Respite Services for Homeless People

Respite should not be just another "band aid" or temporary stop along the circuit of many revolving hot meals, temporary shelter beds, and emergency room visits. The wound of poverty and homelessness does not fully heal during a brief stay in a respite program. It is an ongoing process of healing and transformation. I like a "one stop" approach of service delivery, and respite should be that "one stop" for rebuilding lives.

I am not just a client or consumer in my medical respite project. I am a partner, as I have had many opportunities to take ownership of and responsibility for our program and its participants.

☐ Thirty days after entering my respite program, I wrote a thank you letter and hobbled to the hospital administration building, shook the hand of the Chief Medical Officer, and presented him with that letter.

☐ I continue to attend weekly support group meetings as well as a monthly graduate alumni meeting.

☐ Several respite clients entered our program that could not speak English, so I created a little flyer in their native language that simply said: "Welcome! We are your new family"

☐ When our respite coordinator was asked to present information about the "Culture of Homelessness" for nursing grand rounds, I was her "subject matter expert" and helped her research the topic.

☐ There have been many opportunities to share about my experience including at the Stanford Hospital & Clinics monthly management meeting, a Kaiser Permanente annual community partnership event, and our medical respite anniversary celebration.

☐ My respite team presented a workshop at the National Council conference in San Francisco two years ago, and invited me to talk about my journey. It was called: "From Sleeping on a Rock … to Respite … to Rebuilding My Life."

A lot of my time is now spent advocating in the areas of poverty, homelessness and health care.

That involvement in the San Francisco Bay Area includes several organizations and initiatives:

☐ African American Community Health Advisory Committee

☐ Bay Area Association of Kidney Patients

☐ Hearts for Homeless Mission Team at Menlo Park Presbyterian Church

☐ Homeless Healthcare Advisory Board in Santa Clara County

☐ Hope for Outdoor People, an outdoor citizens coalition and think tank

☐ Peninsula Healthcare Connection, the organization that operates a community clinic in the building where I live, and

☐ Step-up Silicon Valley: the Campaign to Cut Poverty in Half by 2020

☐ National Health Care for the Homeless Council

When Sabrina interviewed me for a Respite News article, she inquired about my community involvement, and I responded, "The only way to affect change in policy is to be part of the conversation … and that's what I really want to do."

Whether it is a homelessness forum at a local college during National Social Work Month in March, a college or community symposium on poverty and homelessness, a conference on health disparities or minorities in health, activities during National Homeless Awareness Week in November.
Medical Respite Services for Homeless People

or Homeless Person’s Memorial Day in December, I strive to represent the National Health Care for the Homeless Council, our National Consumer Advisory Board, my HCH project’s medical respite program, and the homeless / consumer / outdoor citizens community as a “favorable return” on society’s investment in ending poverty and homelessness.

I am proud and honored to wear a jacket which represents Santa Clara Valley Health & Hospital System’s Valley Homeless Healthcare Program.

I don’t know of any other national organization like our National Council, no government or service delivery agency that is so committed to including consumers in every aspect of its operation.

At church, a faith leader talked about “Game Changers,” and that "every person on the field has the power to change the game!"

I am proud and honoured to be a part of the National Health Care for the Homeless Council, know that they will continue to walk with consumers, and view us as partners and team members.

We too are game changers, and together, we ALL have the power to change the game of poverty and homelessness!

A lot of my thoughts here were shared at church recently, and the Hearts for Homeless Mission Team is so excited about medical respite that they want to start a respite program in its area, which is San Mateo County.

The journey of my medical respite experience has led to a remarkable transformation in my life!

I can never say thank you enough for the role that the Valley Homeless Healthcare Program, our Medical Respite team and the National Health Care for the Homeless Council continues to play in helping those of us in need, and for always treating consumers with COMPASSION, DIGNITY and RESPECT!!!

Let’s continue this conversation, and thank you again for allowing me to be part of it.