

**Respite Care for Homeless Individuals:
Establishing a Medical Respite Program in Durham, NC**

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Executive Summary

Over 25% of homeless adults in Durham, NC, have been discharged from a mental or medical institution 30 days prior to becoming homeless (1). Current services available do not adequately address their complex medical needs after discharge, especially as these individuals are not ill enough for a hospital but are too ill for the streets. Respite care, or acute care in temporary housing with case management, is an evidence-based model that can help to stabilize these individuals and find them permanent housing, bridging the gap between current medical services available to homeless adults after discharge and shelters' capacity to handle complex cases.

The objectives of the analysis presented here are: 1. To identify the perceived need for respite care, any potential locations for a facility, and any potential funding sources; and 2. To research the respite models that other communities are using and to learn how they "made the case" for respite and gathered funding support. In order to accomplish the first objective, we interviewed ten stakeholders selected from a list that Julia Gamble, FNP, at the Lincoln Healthcare for the Homeless Clinic, provided. The list of stakeholders included local housing advocates, hospital discharge staff, shelter administrators, clinic administrators, government social services staff, and the director of an existing respite center in the Raleigh-Durham area. In order to accomplish the second objective, we conducted a literature review on the effectiveness of respite and other communities' respite care programs.

Key findings from our interviews include:

- A high perceived need for medical respite for the homeless in Durham, including care for chronic health conditions such as hypertension, heart disease, and diabetes and acute care needs such as post-surgical care and injury and trauma recuperation
- Preferred use of a shelter-based model, but a free standing facility, motel/hotel vouchers, contracts with nursing or group homes, and a medical respite transitional housing program were also mentioned as possible respite program models
- The need to include medical services, beds, meals, security, and organizational capacity when designing the model
- Support for a respite model that works in close connection with other services, such as case management and housing
- Possible funding from local hospitals, the federal government, local/state government, and private donors and foundations

Other cities that are similar in size to Durham have implemented respite programs using a variety of models and funding mechanisms according to their communities' needs, available funding, and organizational capacity. There is not a “one size fits all” approach to respite. Instead, these cities often combine models and funding sources to create programs that can both meet the needs of their homeless populations and build on existing resources.

Making the case for a medical respite program in Durham may be most successful if it begins on a small scale, with a few beds. This initial phase can be used to gain experience, build community support for respite, and collect data on positive outcomes associated with respite. By first building a solid base, the program can then illustrate to funders that medical respite care in

this community is necessary, that it is the right thing to do, that it is efficient and cost-effective, and that it is sustainable.

A planning group focused exclusively on the development of medical respite program should be created, to collect more data on the needs of Durham's homeless, design a respite program, and seek out funding. This planning group should be composed of key stakeholders and should make use of existing resources and collaborations. While it may be a frustrating experience to plan a respite program in the current economic climate, the needs of Durham's homeless population are too great to delay action. Through creativity and collaboration, establishing a program in Durham is feasible and crucial to improving quality of services for the homeless population in Durham.

Problem Statement

Over 25% of homeless adults in Durham, NC, have been discharged from a mental or medical institution 30 days prior to becoming homeless (1). Current services available do not adequately address their complex medical needs after discharge, especially as these individuals are not ill enough for a hospital but are too ill for the streets. Respite care, or acute care in temporary housing with case management, can help to stabilize these individuals and find them permanent housing, bridging the gap between current medical services available to homeless adults after discharge and shelters' capacity to handle complex cases.

Introduction

Homeless individuals on average have eight to nine concurrent medical illnesses, usually involving multiple organs (2). Common conditions include cardiovascular diseases, liver disease, alcohol or substance abuse, chronic airflow obstruction, HIV, malnutrition, dental caries and periodontal disease, skin cancer, and violence-related injuries, including sexual assault. It is estimated that 20-25% of the homeless population has some form of a mental illness (3). These physical and mental illnesses result in substantial wear-and-tear on the body. As Levy & O'Connell comment, "Together, street violence and these acute and chronic medical conditions contribute to markedly increased mortality among the homeless, resulting in an average life span of less than 45 years" (2, p. 2331).

The number of chronically homeless in Durham has been steadily increasing, from 95 in 2007 to 140 in 2009 (1). Urban Ministries has run a "white flag" status since May due to the economic decline and increased number of individuals seeking shelter; this status is usually reserved for

when the temperature reaches 32° Fahrenheit or below. The latest point-in-time estimate shows that the homeless population in Durham is a vulnerable population with serious physical and mental health issues, including substance use disorders, HIV/AIDS, and domestic violence. In addition, 22% of homeless adults were seriously mentally ill (104/473) and 75% had a substance use disorder (353/473) (1). Out of 473 homeless adults, 94 had been discharged from the behavioral health system (mental health hospital or substance abuse treatment) and 34 had been discharged from the medical health system (medical hospitals) within 30 days prior to becoming homeless (1). That is, roughly 27% of adults who were homeless may have a need for respite (i.e., homeless individuals who were discharged from a behavioral health institution or hospital within 30 days of becoming homeless). While current supportive services focus on case management, medical care, substance abuse and mental health treatment, and transitional and permanent housing, these services do not have a respite component nor do they address the complex medical needs of newly discharged homeless individuals (4). When homeless individuals are hospitalized for physical or mental illness, they often do not have the support of friends and family needed to recuperate (5). Without these supports, homeless individuals often cannot comply with discharge instructions, including adherence to medication or changing dressings, nor do they have adequate resources necessary for recuperation, including adequate rest, nutrition, and hygiene (5). Several scholars, health providers, and community organizations suggest respite care as one solution to this need.

Respite care is acute and post-acute care for homeless individuals who are too ill, injured or frail to recover from a physical or mental health problem on the streets, but who are not too ill, injured or frail to be hospitalized (6,7). Respite care allows homeless individuals to rest and recover in a safe environment while also receiving medical care and other supportive services

(6,7). The Health Resources and Services Administration (HRSA) has documented the benefits of respite. These benefits include a reduction in the severity of illness or medical condition; an increase in having a primary source of care after discharge; an increase in access to financial resources including food stamps; a reduction of homeless persons listing the hospital as their primary source of housing; a reduction of hospitals discharging homeless patients to the streets; an increase in patients learning to manage their condition, entering into a longer term program, and improving from social interaction; and a reduction in hospital utilization (7).

Respite models in Chicago and Boston have been cited as particularly effective in reducing future hospitalizations and number of hospital days when hospitalized. A cohort study of homeless individuals in Chicago found that during 12 months of follow-up, the respite care group required fewer hospital days than the usual care group (3.7 vs 8.3 days; $p=.002$), with no differences in emergency department or outpatient clinic visits. Individuals with HIV/AIDS experienced the greatest reduction in hospital days (8). A randomized trial conducted in Chicago found that after adjustment, offering housing and case management to a population of homeless adults with chronic medical illnesses resulted in fewer hospital days and emergency department visits, compared with usual care (9). A study in Boston also examined the effectiveness of respite. It found that after adjusting for imbalances in patient characteristics, respite patients were significantly less likely to be readmitted within 90 days compared to those released to their own care (10).

Respite may also reduce homelessness. There are several factors that some respite providers indicate are instrumental in reducing homelessness. These elements are: critical time intervention, case management, discharge planning, and housing options. Critical time

intervention is the provision of housing at critical times in a homeless person's life, such as when seeking treatment for medical problems, discharge from mental institutions, jails, and prisons (11). Case management is the provision of individualized treatment plans and long-term follow-up (11). Discharge planning and housing options need to be tailored to the individual's circumstances and medical, mental, and social needs (11). In order to reduce homelessness, these factors are also vital to respite care. As Brooks Ann McKinney at the Raleigh Rescue Mission described, respite care is a "shelter plus care model" that helps prevent individuals from returning to the streets after their illness. Through case management, individuals in respite care are able to find housing, jobs or other financial assistance, and other supportive services so that they can become self-sufficient after they recover from their physical or mental health problem. The combination of medical care and case management is part of the continuum of care for homeless individuals, bridging the gap between shelters' inability to care for complex cases, hospitals' current medical services, and the individuals' need for supportive and permanent housing (5). Given the benefits of respite care to not only the patient, medical system, and larger community, we conducted interviews in order to identify ways in which respite care could be established in Durham, North Carolina.

Methodology

Julia Gamble, FNP, at Lincoln Healthcare for Homeless Clinic, approached our health policy class (HPM 465: Underserved Populations, Safety-Net Programs and Market Based Changes) at the University of North Carolina's Gillings School of Public Health to research possibilities for respite in Durham, North Carolina. She provided background information and guidance in developing research objectives. The objectives of the analysis presented here are: 1. To identify

the perceived need for respite care, any potential locations for a facility, and any potential funding sources; and 2. To research the respite models that other communities are using and to learn how they "made the case" for respite and gathered funding support. In order to accomplish the first objective, we interviewed ten stakeholders selected from a list that Ms. Gamble provided. The list of stakeholders included local housing advocates, hospital discharge staff, shelter administrators, clinic administrators, government social services staff, and the director of an existing respite center in the Raleigh-Durham area. In order to accomplish the second objective, we conducted a literature review on the effectiveness of respite and other communities' respite care programs.

Durham Context

Our interviews and Durham's 10-Year Plan to End Homelessness (10-Year Plan) show a local commitment to end homelessness and to improve the quality of services for homeless individuals. The 10-Year Plan includes support from the city, county, and United Way (4). Respite care can serve as a strategy to eliminate homelessness, as it assists individuals recovering from illness or injury to find permanent housing. Respite fits especially well with the plan's Results-Based Accountability Initiative, Tactic 1G to provide case management to individuals with health issues (4, p. 20). Similarly, respite fits into the plan's goal to establish a community standard for discharge from healthcare institutions, with permanent housing as a goal (4). Respite could help bridge the time between discharge and finding permanent housing, especially as the individual may need medical assistance before s/he could live self-sufficiently.

Interview Findings

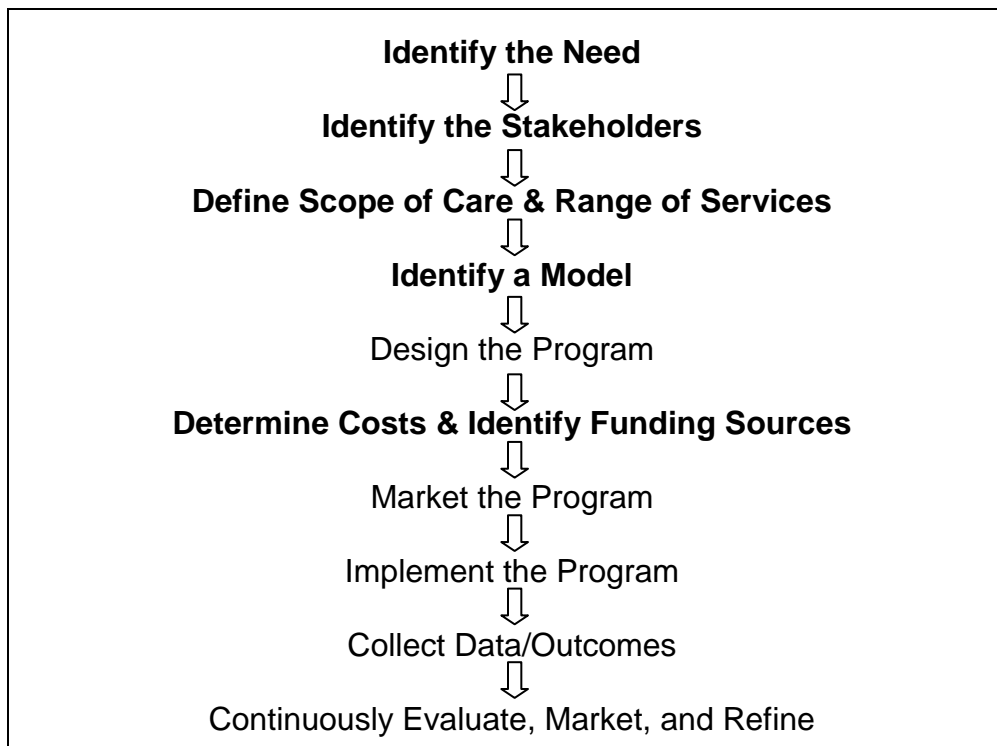
Ten stakeholders were interviewed to identify the perceived need for a medical respite program in Durham, and to obtain their perspectives on potential locations for a facility and funding sources. The stakeholders interviewed for this project are front-line providers of services to the homeless population in Durham, including local housing advocates, hospital discharge staff, shelter administrators, clinic administrators, government social services staff, and the director of an existing respite center. None of those interviewed are quoted directly, in order to preserve the confidentiality of their responses. The stakeholders interviewed were:

- Terry Allebaugh, Executive Director, Housing for New Hope
- Gay Bonds, Complex Cases Discharge Planner, Duke University Medical Center
- Peter Donlan, Program Director, Urban Ministries of Durham
- Chris Garret, Executive Director, Samaritan Health Center
- Fred Johnson, Deputy Director of the Division of Community Health, Duke University Medical Center
- Brooks Ann McKinney, Medical Respite Coordinator, Raleigh Rescue Mission
- Patrice Nelson, Executive Director, Urban Ministries of Durham
- Lloyd Schmeidler, Community Education Specialist, Ten Year Plan to End Homelessness, Durham Affordable Housing Coalition
- Bob Wallace, Program Manager, Adult and Crisis Services at Durham County Department of Social Services
- Linda White, Staff Counselor, Durham Rescue Mission

Interview questions (Appendix A) were developed based on the framework for planning a medical respite program that the National Health Care for the Homeless Council (NHCHC) published, *Medical Respite Services for Homeless People: Practical Planning*. This framework provides a useful context for understanding all of the components that must be considered in the development of a medical respite program. For the purposes of our exploratory report on the potential for respite in Durham, we focused on the following steps in planning a respite program:

1. Identifying the need, 2. Identifying the stakeholders, 3. Defining the scope of care and range of services, 4. Identifying a model, and 5. Exploring options for funding sources. Our interview findings will be discussed accordingly within the context of the NHCHC framework, outlined below (Figure 1) (7, p. 4).

Figure 1. Framework for Planning a Medical Respite Program (7, p.4)



Note: The bolded steps are the ones we attempted to complete or address in this paper.

Identify the need

The first step in determining whether a medical respite option for the homeless should be created in Durham is to conduct a needs assessment. This report presents the results of an informal needs assessment conducted to meet the objectives of this project, through interviews with key players and preliminary research into hospitalization trends of Durham's homeless. A more

formal needs assessment may be useful in the future to evaluate in more detail the needs of this population.

Our interviewees expressed a high perceived need for medical respite for the homeless in Durham. There are few medical care options for the homeless, who are predominantly uninsured. The emergency departments of local hospitals and Lincoln Community Health Center were cited as the primary resources currently utilized by Durham's homeless, in addition to the clinics operated by two shelters, Urban Ministries and Durham Rescue Mission. Those interviewed indicated that neither the shelters nor the clinics have the capacity to meet the needs of many individuals who appear at their door. The shelters and clinics have limited hours of operation, limited space, and limited resources, including personnel capable of managing complex medical or mental health cases. Local hospitals are also challenged to find locations to which they can discharge uninsured but medically needy homeless patients. There is no uniform approach to discharge, with some individuals being sent to shelters, some receiving financial assistance from the hospital to go to assisted living facilities, and others simply returning to the streets. One interviewee pointed out that medically needy individuals with insurance can be discharged to assisted care or nursing facilities, and that the uninsured should receive the same quality of care as insured patients.

Many of Durham's homeless have serious medical needs. Medical needs identified by the interviewees included chronic health conditions such as hypertension, heart disease, and diabetes, as well as acute care needs such as post-surgical care, injury and trauma recuperation. Substance users, those with mental health issues, veterans, and victims of domestic violence are

large sub-groups of Durham's homeless who were mentioned specifically during interviews, since these sub-groups often require specialized medical attention.

While none of the Durham hospitals are currently collecting or tracking hospitalizations (length of stays, services, and utilization) specific to homeless individuals, there is limited information on individuals who are on Medicaid *and* enrolled in primary care case management through Carolina Access. In fiscal year 2009, ninety-one enrollees who listed their residence as a homeless shelter accounted for 6,318 encounters at Durham Regional or Duke University. These encounters resulted in over \$815,000 in inpatient and outpatient services paid by the program. Almost 40% of these costs (approximately \$326,000) were due to inpatient services. Over 13% of the encounters were due to (in order of frequency) shortness of breath, unspecified chest pain, headache, chest tightness, backache, and major depressive affective disorder (moderate recurrent episode). Of the 117 people who identified their homes as 507 East Knox St. (Durham Rescue Mission) or 410 Liberty St. (Urban Ministries), 87 had emergency department claims totalling \$31,826 paid by the program; the remaining 20 claims are unknown (12). This cost and diagnosis information is limited as it only includes the amounts that the program paid, and it only provides utilization information for individuals enrolled in Medicaid *and* CCNC/CA (Community Care of North Carolina/Carolina Access). Cost information for homeless individuals who are uninsured, have private insurance, or are on Medicaid but not enrolled in CCNC/CA (i.e., dually eligible for Medicaid and Medicare) was unavailable at the time of this analysis. Thus, it is important to note that in all likelihood, the cost data presented here may actually be an underrepresentation of the costs that homeless individuals incur.

In order to appropriately address the plight of the homeless in Durham and their need for medical respite, it may be of use to track not only the homeless population as a whole, but to also consider other important factors as part of this tracking, such as asking individuals to report the length of time they have been homeless, so that an accurate cost analysis can be performed based on services and costs they incurred within those specified time frames.

Identify the stakeholders

The stakeholders interviewed for this project identified collaboration among themselves and others providing services to the homeless as key to the development of a medical respite program in Durham. Working together, stakeholders can more easily raise funds, maximize resources, and streamline services provided. Interviewees identified several key players that should be involved in discussions about respite in Durham. The list includes administrators, medical staff, and social workers from the following organizations: medical institutions, such as free clinics, Lincoln Community Health clinics, the public health department, and local hospitals; all nine shelters in Durham, including Urban Ministries and Durham Rescue Mission; housing advocates and service providers, such as the Council to End Homelessness, Parker's House, and Housing for New Hope; government officials, such as city and county commissioners; mental health and substance use service providers, such as Triangle Residential Options for Substance Abusers (TROSA), Freedom House, and Durham Center; programs targeting the Latino population, such as El Centro Hispano and Local Access to Coordinated Healthcare (LATCH); local faith communities; the Triangle United Way; and the Triangle Area Red Cross.

The NHCHC's planning document also suggests that establishing a planning group made up of key stakeholders, such as those mentioned above, can be advantageous to the development of a

medical respite program (7, p.7). Durham already has many existing community collaborations that could potentially be used to plan for respite care for the homeless. For example, the Durham Center has monthly Homeless Steering Committee meetings that may serve as a starting point for the creation of a respite-specific planning group for Durham.

Define the scope of care and range of services

The scope of care and range of services provided by medical respite can vary from community to community, based on the needs of patients and resources available (7, p.8). The stakeholders interviewed for this project discussed the elements that they thought would be essential for a respite program. Answers varied, but all respondents agreed that a respite program should have a medical provider (such as a nurse or doctor) and a link to support services (such as a social worker) that provide a coordination of care. Several respondents also mentioned that meals, a safe space, medication management, and transportation should also be provided to respite patients. The following table (Figure 2) from the NHCHC delineates the services typically offered by medical respite facilities (7, p. 9).

Figure 2. Classical Medical Respite Services (7, p. 9)

CLASSIC MEDICAL RESPITE SERVICES
▪ Acute medical care (by a nurse, physician, physician assistant, and/or nurse practitioner)
▪ Medication (storage, dispensing, sometimes pharmacy)
▪ Case Management (benefits acquisition, housing placement, health education, etc.)
▪ Onsite or referral for mental health/substance use treatment
▪ Transportation
▪ Food
▪ Security
▪ In-kind (pastoral care, activities, haircuts, clothing)

Having a clear definition of the scope and duration of care provided by respite was an important issue for several of the stakeholders interviewed. Many homeless individuals in Durham have chronic health conditions, and some of those interviewed were concerned that a respite program could become overwhelmed with patients with long-term needs. Respite is intended to be a transitional step, however, where individuals can become healthy and stable enough to make the transition from hospitalization to a sustainable living situation. It is important that any respite center set clear policies about the scope of care and services provided, admissions criteria, and discharge criteria. Another way to ensure that respite is implemented as a temporary measure is to link patients to outside resources. Many of those interviewed suggested that one of the essential functions a respite program could fulfill is to connect Durham's homeless to resources such as housing, social support, mental health services, long-term care, and income opportunities.

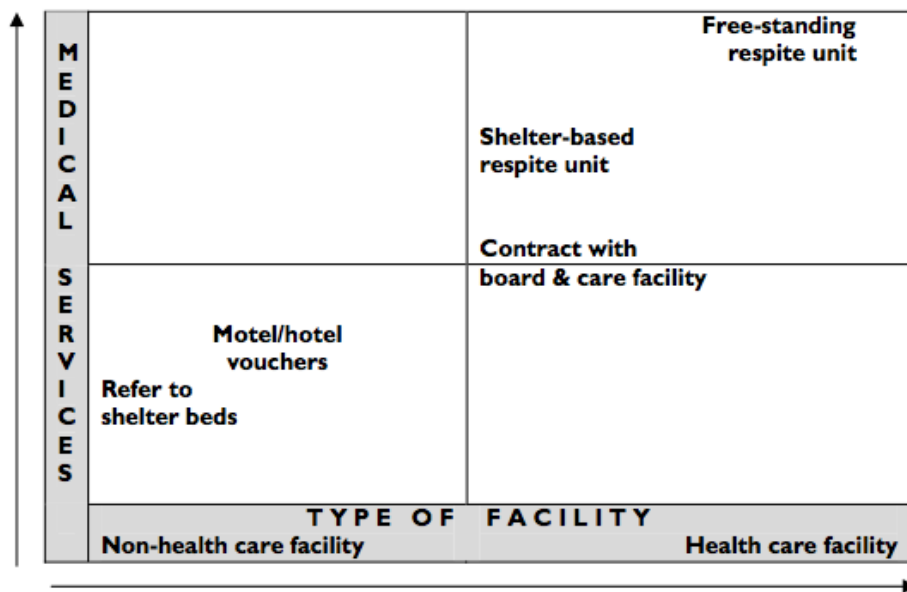
Many medical respite models function as more than just a place for recovery. Programs in Boston, Chicago, Los Angeles, and Washington, DC, have become part of an integrated continuum of care for the homeless in these cities (7, p. 8). The interviews conducted for this project show support for a respite model in Durham that works in close connection with other services.

Identify a model

Once the scope of care and range of services have been decided upon, the next step is to choose the respite model that can best provide those services. Respite programs can take a number of forms. The two primary models are: 1) a free standing respite facility and 2) shelter-based respite. These two models can be considered two extremes, with level of medical care on one

axis and type of facility on the other axis. As one moves along the continuum in either direction, different factors must be considered in evaluating cost, control over admissions, and control over the environment. Each model has advantages and challenges. Also, respite programs often start as small operations, such as beds in a shelter, then build on available resources to leverage funding and support and grow slowly into more robust models, such as a stand-alone facility. Other respite programs operate as hybrids, incorporating many different models to meet the needs of its population. The following chart (Figure 3) developed by the NHCHC can help to conceptualize a few respite models (7, p.11).

Figure 3. Respite Model Conceptual Chart (7, p.11)



Several factors will need to be taken into consideration when deciding upon which model is best suited for a respite program in Durham, including accessibility, acceptability, and feasibility. Ideally, respite services should be provided in a location easily accessible by the homeless population, and near to other services and resources. A respite program also needs to be

acceptable to the patients it plans to serve. A program that will be serving families, for example, should have the capacity for families to stay together. Finally, the model chosen for respite must be feasible. Zoning and licensing regulations, size of the program envisioned, and cost considerations often influence the respite model chosen (7, p. 9-10).

Interviews with stakeholders revealed support for an array of medical respite models in Durham. A shelter-based model was mentioned most frequently, but other ideas included a free standing facility, motel/hotel vouchers, contracts with nursing or group homes, and a medical respite transitional housing program. Some of the potential challenges and advantages of each of these models discussed by those interviewed will be discussed briefly in this report, but further research on the accessibility, acceptability, and feasibility of each of these models will be necessary to determine which is would work best in Durham. Areas for additional research are included in the descriptions of the models below.

Free-Standing Facility

Those interviewed acknowledged that, in many ways, a free-standing respite center is the ideal. Comprehensive services can be offered, and policies and procedures are within the control of program administrators. The main challenges to a free-standing facility, however, are adequate funding and finding an appropriate facility (7, p.11-12).

The potential for a free-standing respite facility in Durham exists. There appear to be several potential funding streams, as will be discussed later in this report, and interviews revealed broad support for medical respite for the homeless. The need for medical respite for the homeless in

Durham is immediate, however, and other models or an approach combining several models may be more feasible at this time.

Shelter-Based Model

Most free-standing respite programs began with a shelter-based model, utilizing existing resources and expertise to keep cost down while building the case for a more robust respite model in their community. This phased-in approach encourages coordination and collaboration among organizations that provide resources to the homeless. Shelters may have limited space and medical resources, however. Due to these limited resources, shelters may need to seek additional community partners, and this collaborative process can lead to conflict between stakeholders with different philosophies and policy preferences (7, 12-13). These philosophies and policy preferences sometimes revolve around who should be served by the program, such as those who have addiction or substance use disorders.

Additional important factors when considering a shelter-based model are the availability of medical services, beds, meals, and organizational capacity. The two main shelters in Durham are the Urban Ministries and the Durham Rescue Mission. Both shelters have clinics on-site. The on-site clinic at Urban Ministries is an independent, federally designated healthcare for the homeless clinic, operated through the Lincoln Community Health Center. The on-site clinic at the Durham Rescue Mission, the Samaritan Health Center, is an independent 501(c)3 that currently only offers medical services to individuals who are staying at the Durham Rescue Mission and enrolled in its program. Both clinics offer clinical services that would be useful to respite patients, although hours of operation are limited. The on-site clinics at both shelters operate separately from their respective shelters.

A shelter-based model may not be a feasible option for Durham at this time, however. Shelter administrators at Urban Ministries indicate willingness to support the development of respite, although its limited capacity influences the organization's ability to provide respite on site. Urban Ministries currently has few to no empty beds, offers limited day-time services, does not have the capacity to offer specialized meals or meals in patients' rooms, and does not have the staff with the necessary medical knowledge. Shelter administrators at Durham Rescue Mission indicate that they are not interested or equipped to provide respite services. Durham Rescue Mission has available beds and offers 24-hour housing and meals, but its strict screening process and highly structured, faith-based approach to homeless rehabilitation currently prevent it from accommodating individuals with serious medical or mental health needs. Interest in exploring a respite option does exist at the Samaritan Health Center, however. The Samaritan Health Center currently rents space from the Durham Rescue Mission for clinical services only, but it operates separately from the shelter and is interested in options for expansion. Further discussions with the shelters and their associated clinics, together with additional resources, may make a shelter-based model more realistic in the future.

Nursing/Assisted Living Center Contracts

In this model, respite patients are placed in a nursing or assisted living facility. Patients placed in a nursing home can obtain around the clock medical care, meals, and supportive human contact, which can be especially helpful to those with complex medical needs. Patients placed in an assisted living facility can obtain access to meals and assistance with daily living activities, but may not have access to medical care. Both of these models are limited by the program's inability to control the appropriateness and quality of care, and minimal opportunities to connect patients

with other needed services (7, p.16). Additionally, nursing facilities are federally prohibited from accepting patients with a primary diagnosis of a mental health disorder.

One stakeholder interviewed described that there have been attempts to contract with assisted living facilities in Durham in order to provide care for medically needy homeless individuals. These effort never succeeded, however, due to insufficient funding to pay for beds at the facilities and the lack of a case manager dedicated to help homeless patients apply for public assistance programs. The interviewee suggested that a respite program with adequate funding could consider attempting this model again, perhaps with additional case management support from the Department of Social Services budget for adult crisis care.

Motel/Hotel Vouchers

This model emulates a “home health model” by placing respite patients in rented motels or hotels. Medical and social services staff make “home” visits to the patients in their rooms, and transportation is provided for visits to the hospital. Meals can be provided in a variety of ways, such as through collaborations with programs like Meals on Wheels or ensuring that cooking facilities are available on-site. This model can have several benefits, such as low cost, ease of start-up, and family-friendly nature. It may not work well for individuals with high medical needs, however, and it may be logistically difficult to coordinate medical staff visits and the provision of meals (7, p.15).

This model could potentially work to provide respite services to some individuals in Durham. One stakeholder interviewed gave the example of a local hotel that provides reduced rates to women escaping domestic violence, and suggested that perhaps the same could be done for

medical respite care. Another stakeholder, however, reflected that the attitudes of motel staff toward the homeless could make this model not feasible. Detailed information on rates charged by local hotels and motels, hotel and motel attitudes and policies, the medical needs of Durham's homeless, and the feasibility of providing care, meals, and transportation to a motel/hotel-based population would need to be examined to determine whether a motel/hotel-based model could be effective at meeting the needs of the community.

Transitional Housing-Based Model

This innovative approach to respite care is relatively new, but was mentioned by several of stakeholders interviewed for this report. Transitional housing-based respite programs give the housing needs of patients as much priority as their medical needs. These programs are generally located in transitional housing facilities or residential treatment centers. They often allow patients to stay at the facility until permanent housing becomes available (7, p. 16).

Many programs addressing homelessness in Durham place the bulk of their efforts on housing, so adding a complementary respite component to that approach may be a practical option for this community. The feasibility of incorporating respite into existing housing programs, such as Housing for New Hope or Department of Social Services housing initiatives, should be examined further. A few challenges with this model that may be encountered include ensuring that the medical needs of respite clients are adequately addressed, and that beds and permanent housing options are available. An advantage to a transitional housing model, however, is that it is eligible for housing and supportive funding, such as grants from the Department of Housing and Urban Development, that traditional medical respite programs are not eligible to receive.

Combined Approaches

The above mentioned models should all be considered. Interviews revealed support for starting with just a few beds or a combined approach, utilizing existing resources to their fullest potential to meet the pressing need for medical respite care while building support and obtaining additional funding. Combined approaches may increase the accessibility, feasibility and acceptability of the respite program, given funding, capacity limits and community preferences. A combined approach may also increase the capacity to serve clients in need of respite care in a more timely manner (e.g. within the next six months rather than a year or more from now) (7, p. 14-15).

Identify funding sources

The search for funding sources for a medical respite program should be informed by careful calculations of the costs that the program is expected to incur. The scope of care and range of services provided, the model chosen, and rates paid for staffing, supplies, and medication will all affect the overall cost of the program (7, p. 24). It may be helpful to look at costs incurred by similar respite programs or other local programs providing similar services to estimate how much money will be needed to operate the respite program envisioned.

Many potential funding options for a medical respite program for the homeless in Durham exist. The options for financial support discussed by stakeholders during the interviews were local hospitals, the federal government, local/state government, and private donors and foundations. There are several ways to make the case for funding medical respite services for the homeless, and different arguments can be made to appeal to each of these different audiences. The

NHCHC document on medical respite program planning stresses that any funding appeal should first establish that “it’s the right thing to do” (7, p. 30) and then show the potential funder that medical respite is efficient, cost-effective, and sustainable.

Hospitals

The stakeholders interviewed suggested that local hospitals could be important funders of a medical respite program in Durham. Durham County has three large medical hospitals, Durham VA Medical Center, Duke University Medical Center, and Durham Regional Hospital, and a large psychiatric hospital, Central Regional Hospital, that currently treat the homeless population. Hospitals often provide support to medical respite programs through annual grants, as well as in-kind contributions such as medications, supplies, primary medical care from doctors and nurses, specialty care, and access to laboratory services (7, p. 25-26). Interviewees suggested appealing to local hospitals with evidence that a medical respite program for the homeless could save them money through diversion from the emergency department, reduced hospital admissions and readmissions, and decreased length of hospital stay.

Federal government

The federal government can provide funding to a medical respite program through a variety of routes. Interviewees mentioned that funding could be obtained through grants provided by U.S. Department of Housing and Urban Development (HUD) programs, such as the Homeless Prevention and Rapid Re-Housing Program (HPRP). Interviewees also mentioned that the Medicaid expansion in the healthcare reform bills currently under consideration could provide support, either by including respite as a Medicaid reimbursable service or eliminating categorical

eligibility requirements. Another option not mentioned in interviews but often used to fund respite programs are U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) 330(h) grants for Health Care for the Homeless (HCH) projects. HCH projects, such as the Lincoln Community Health Center's clinic at Urban Ministries, can obtain additional funding for medical respite care through their HRSA 330(h) grants, as well as HCH expansion grants. Funding from HRSA grants can only cover the costs of health services and other enabling services, however, and cannot cover facility costs. Finally, respite programs with 330(h) funding are eligible for the federal drug discount program, Section 340B of the Public Health Service Act (7, p. 26-30). Providing evidence of successful medical respite program outcomes, such as reduced numbers of homeless individuals and visits to the emergency departments, could be a useful way to make the case for respite to these government agencies.

Local/state governments

Several local and state government departments have an interest in the health and well-being of the homeless population. Interviewees often mentioned the Durham County Department of Social Services as a resource that could providing temporary funding for housing, case management, and other support. They also mentioned the county commissioners as stakeholders who could allocate funds toward a medical respite program. One stakeholder interviewed referred to the Chicago model, in which hospital money is matched by community dollars. Finally, the Durham County Public Health department may also be able to provide support to a medical respite program. The NHCHC document proposed that the case for respite can be made from a public health perspective, by arguing that caring for homeless with communicable

illnesses in medical respite programs can prevent the spread of those diseases. In addition to strategies mentioned above, the NHCHC document suggests that state agencies can be convinced to support respite since connecting uninsured homeless individuals to entitlements such as Medicaid or Medicare can shift financial pressure from states to the federal level (7, p. 31). The county department or social services special assistance can also help pay for assisted living for people who are disabled or elderly (over 65) (13).

Private donors and foundations

Interviewees mentioned several private donors that could provide funding for a medical respite care program in Durham. Suggestions included insurance companies, local churches, and grants from private foundations such as the United Way of the Greater Triangle, the Kate B. Reynolds Charitable Trust, the Blue Cross and Blue Shield of North Carolina Foundation, and the Duke Endowment. Local universities such as Duke University and the University of North Carolina at Chapel Hill were mentioned as valuable partners who could be interested in the development of a medical respite program. Other private corporations who could provide supplies to the respite program on a short-term basis were also suggested, such as Kight's Medical Supplies. Although not mentioned by interviewees, Triangle Community Foundation may also be a funding source. Appeals to private donors can be tailored to their respective organizational missions, but may include the ethical importance of medical respite, as well as evidence that medical respite can lead to reduced numbers of homeless individuals and a reduction in healthcare costs.

Other Respite Care Programs

The Respite Care Providers' Network, part of the National Health Care for the Homeless Council, conducted a survey in 2006 of all 32 known homeless respite centers. Participating respite programs were geographically dispersed across 24 cities in 21 states, primarily in large urban centers. A key feature of these programs was their innovation in finding existing beds and resources within their communities: they are providing medical services in beds located in (in order of frequency) homeless shelters, stand-alone facilities, transitional housing, nursing homes/assisted living facilities, hotels/motels, treatment programs, apartments, health centers, and hospice units. On average, these programs were small, with a median of 13 beds. In most cases (20 of 25 respondents), the clients served are male; just two programs had the capacity to serve women, children and/or families. The programs surveyed are designed to provide acute medical care, so the median length of stay for clients is just over two weeks (17.5 days). All of the programs surveyed provide comprehensive clinical and social support services to their clients, either directly or by referral, during the respite stay. Comprehensive services include case management, transportation, and meals. These programs were able to serve approximately six out of every ten patients referred to them. Over half of the referrals came from hospitals. The most common diagnoses included (in order of frequency) fractures/injuries, diabetes, cellulitis/infections, respiratory problems, heart disease, hypertension, surgical recovery, and cancer. The survey results indicate that respite programs across the country are a critical component of the continuum of homeless health care. The respite programs remain under-resourced, however, and must obtain more adequate and sustainable funding if they are to continue to meet the growing need for them (14).

Salt Lake City (population 184,881 (15)) is an example of a city roughly the size of Durham (population 223,284 (15)) that has used a multi-level approach to providing respite care. Patients are referred to the Fourth Street Clinic Respite Program from local hospitals and other service providers. Based on the acuity of illness and need for nursing care, patients are admitted to one of four programs: 1. Shelter-based Day Bed Program, 2. Temporary Emergency Housing (Motel) Program, 3. Tuberculosis Housing Program, or 4. Nursing Home Program. Respite patients receive medical, social, and behavioral health services and are discharged to local shelters when stable. The respite program provides a safe refuge for recovery from acute illnesses for those experiencing homelessness (16). This multi-faceted approach may be one way that Durham can address the multiple conditions and needs of its homeless population as well as to build on existing resources and infrastructure. The different elements of the program could be developed simultaneously or as funding becomes available.

Examples of other medical respite programs for the homeless implemented in other U.S. cities similar in size to Durham are presented in table form in Appendix B, and summarized below.

Medical respite programs in each of these cities have used a variety of models and funding mechanisms according to their communities' needs, available funding, and organizational capacity. The diversity in programs and funding sources underscores that there is not a "one size fits all" approach to developing and implementing a respite program.

The respite care models include using apartment units, assisted living facilities, stand-alone facilities, and existing shelter space. Single or multiple agencies, including non-profit organizations, hospitals, and Health Care for the Homeless (HCH) health centers, operate these models. Funding mechanisms include hospitals, federal health centers [HRSA 330(h) and HCH

expansion grants], Medicaid, Medicare, local governments, foundations, United Way, and private donations. The number of respite beds ranges from three to thirty-two, with one site having beds on an as-needed basis only (7).

Admission criteria varies, but common criteria includes homeless individuals who have an acute medical need and are medically stable and not contagious. They must be able to perform activities of daily living and able to live in a group setting, including not having a behavioral problem or being a danger to themselves or others. The average length of clients' stay ranges from fourteen to thirty days. A variety of clinical and support services are provided during their stay with each site providing services according to their clients' needs, funding amounts, and organizational ability. Clinical services provided include access to a physician or physician extender care, nursing care, dental care, counseling and assistance by social workers or qualified mental health providers, medication dispensation and storage, and patient education. Support services provided include meals, transportation, case management, housing referrals, and job training and/or placement. All of the sites accept clients with mental illness or substance abuse or addictive disorders; however, none of the sites accept clients with active addiction or with *primary* diagnoses of substance abuse or mental illness (7).

It should also be noted that cities much smaller than Durham have set up respite care in their community (e.g. Bangor, ME, population 31,609 or Fairfax, VA, population 23,281 (15)); these smaller communities use a model that is amenable to their available resources and center need (7).

Recommendations and Next Steps

The interviews and research conducted for this report revealed that there is a high perceived need for medical respite care for the homeless in Durham, and that there are many options for potential program models, locations, and funding sources. The findings also revealed that medical respite programs in cities similar in size to Durham are using a variety of approaches, often combining models and funding sources, to create programs that can both meet the needs of their homeless populations and build on existing resources.

In order to make the case for a medical respite program in Durham, it may be most effective to start with a small program. Our research has shown that successful respite programs often start as small operations by building on available resources, such as a few beds in a shelter or housing facility. This initial phase of the respite program can be used to build experience with medical respite, and acceptability of medical respite in the community. It can also be an important period to collect data on the positive outcomes associated with respite care. By first building a solid base, the program can then illustrate to funders that a medical respite program in this community is necessary, that it is the right thing to do, that it is efficient and cost-effective, and that it is sustainable.

We recommend that the establishment of a planning committee focused exclusively on medical respite be next step toward the creation of a medical respite care program in Durham. The planning group should be composed of key stakeholders, such as those interviewed for this project and other administrators, medical staff, social workers, and government officials invested in Durham's homeless population. The Durham Center has monthly Homeless Steering

Committee meetings that may serve as a starting point for the creation of a respite-specific planning group for Durham.

The first priority of the medical respite planning group should be to assess the needs of the homeless community in Durham. This report can provide a starting point for that needs assessment, but more detailed data on medical needs, hospital discharges, and re-hospitalization rates would be useful in identifying the need, planning the program's scope and range of services, and making the case for funding. The second priority for the planning group should be to create a vision and philosophy for Durham's medical respite program. Guided by the needs assessment and their vision of the program, the planning group can then design the respite model most appropriate to meet the needs of its population. Designing the program includes determining the scope of medical care, range of services, staffing, facility location, and other elements of the medical respite program. Finally, the planning group should develop a formal program plan, generate a budget, and seek out funding for its proposed program.

During the program planning, the planning committee should make use of existing resources and collaborations in the development of Durham's medical respite program. The nearby medical respite program in Raleigh, the Raleigh Rescue Mission, may be able to offer counsel on best practices and other considerations. The NCHC document can also provide a useful blueprint for designing the program.

There is neither a “one size fits all” program model nor a “one size fits all” funding source; each respite program’s design is based on community need, capacity, and resources. Programs also

use a patchwork of funding sources to finance the program. Establishing respite does not require a large community; communities much smaller than Durham have set up a medical respite program. While it may be a frustrating experience to plan a respite program in the current economic climate, the needs of Durham's homeless population are too great to delay action. Through creativity and collaboration, establishing a program in Durham is feasible and crucial to improving quality of services for the homeless population in Durham.

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Appendix A. Stakeholder Interview Questions

Key interview topics: 1. Need for a respite facility, 2. Potential location for a facility, and 3. Potential funding sources for the facility.

Introduction, if needed: Many homeless individuals have complex medical needs that require a level of care that is beyond the level of most shelters, but below the level of care provided in a hospital setting. Due to being uninsured or having fragmented family relationships, they are not eligible for hospital discharge to a caregiver at home or nursing home. Respite care can address the complex medical needs of homeless individuals.

Questions:

1. Do you see a need for a respite care facility for the homeless in Durham? What are your reasons for thinking there is/is not a need?
2. *If there is a perceived need for respite:* Can you elaborate on the types of *medical needs* faced by the homeless here in Durham (e.g. types of illness, mental health, substance use, etc.)?
3. What resources are currently available for the homeless (i.e. what is filling the gap since there is no respite)?
4. What are your thoughts about where a respite services might be started in Durham?
5. Do you have any ideas about potential funding sources?
6. Do you have any suggestions for potential partners in establishing a respite facility?
7. What are some *non-medical needs* of the homeless population in Durham?
8. What things do you think should be included in respite care to make it successful?
9. Are there any other considerations we need to take into account (i.e., relationships with other facilities, "political" considerations)?

Appendix B. Respite Care Models in Other Cities Similar in Size to Durham

According to the 2006-08 American Community Survey that the U.S. Census conducts, the household population of Durham is 212,789 (15)

Sources: Programs (17), Populations (15)

City	Model	Operating Agency(s)	Funding Source	Staffing	Number of Respite Beds	Average Length of Stay	Admission Criteria	Clinical Services Provided	Support Services Provided	Additional Comments
Dayton, OH (population 144,008)	Apartment units within an independent living program in a nursing home	HCH Health Center Hospital	Funding is not separate from clinic funding (clinic funded through hospital grant, HRSA 330(h), HUD, Medicaid, Medicare, private donations, local government, religious groups, United Way, foundations)	FT Licensed Social Worker (coordinator who collaborates daily with a multi-disciplinary team of doctors, nurses, licensed social workers, dental staff, mental health counselor, chemical dependency counselor, psychiatrist, and nurse manager)	3	20-21 days	Are immune-compromised; Need recuperative care following medical or surgical procedures; Have contracted a contagious disease and need to be isolated from others; Need pre-operative or -procedure care; Are able to perform activities of daily living	Physician Nurse Practitioner/Physician Assistant Nurse Dental Eye Care Medication dispensing Medication storage Substance abuse/mental health	Meals Transportation Case management	Substance abusers cannot be in active addiction when admitted Mental illness cannot be the primary diagnosis

City	Model	Operating Agency(s)	Funding Source	Staffing	Number of Respite Beds	Average Length of Stay	Admission Criteria	Clinical Services Provided	Support Services Provided	Additional Comments
Fort Lauderdale, FL (population 164,833)	Assisted Living Facility (ALF)	HCH Health Center Hospitals Non-Profit Organization	Hospital HRSA 330(h) Health Care System	FT coordinator 24-hour staff at ALF	As needed by referrals and as available at the ALF	14-21 days	County resident; Age 21 or older; Scheduled for discharge from a local hospital; Requires short-term acute care post-hospitalization; Homeless prior to hospitalization; Does not have a primary diagnosis of alcoholism, substance abuse, or psychiatric disorder; Not a present danger to self or others; Is free of communicable diseases as certified by a licensed physician or nurse practitioner; Does not require 24-hour skilled nursing care	Physician Nurse Practitioner/Physician Assistant Nurse Dental Medication dispensing Medication storage Substance abuse/mental health	Meals Transportation Case management Housing referrals	The primary diagnosis must be a short-term medical need

City	Model	Operating Agency(s)	Funding Source	Staffing	Number of Respite Beds	Average Length of Stay	Admission Criteria	Clinical Services Provided	Support Services Provided	Additional Comments
Savannah, GA (population 127,840)	Stand-alone Facility	HCH Health Center Non-Profit Organization	Hospital Medicaid Medicare Private donations Local government United Way	Not included in the directory	32	18 days	A physician or nurse at the health center must refer client from any of the area hospitals	Physician Nurse Practitioner/Physician Assistant Nurse Dental Medication dispensing Medication storage Substance abuse/mental health	Meals Transportation Case management Housing referrals Job training or placement	Clients with substance abuse or addictive disorders or with mental illness are accepted by the program
Augusta, GA (population 191,829)	Shelter	Non-Profit Organization	Hospital (per diem amount for each admission) Private donations Local government Foundations	Not included in the directory	16	21 days	Homeless (HUD definition); Able to perform own activities of daily living; Able to tolerate a group living situation; Acute medical diagnosis is the primary diagnosis; By referral from participating hospitals	Nurse Practitioner/Physician Assistant Nurse Medication dispensing Medication storage	Meals Transportation Case management Housing referrals	Clients with substance abuse or addictive disorders or with mental illness are accepted by the program

City	Model	Operating Agency(s)	Funding Source	Staffing	Number of Respite Beds	Average Length of Stay	Admission Criteria	Clinical Services Provided	Support Services Provided	Additional Comments
Grand Rapids, MI (population 187,695)	Assisted Living Facility	Not included in the directory	Not included in the directory	Not included in the directory	25	N/A (program is in the process of starting up)	Not included in the directory	Not included in the directory	Not included in the directory	Not included in the directory
Richmond, VA (population 200,158)	Stand-alone Facility	HCH Health Center	Hospital (grants) Local government United Way	Not included in the directory (although a nurse screens for eligibility)	20	30 days	Homeless; Not in contagious phase of infectious disease; Medically stable; Able to perform own activities of daily living & medication administration; Independently mobile & able to exit the building unassisted in case of emergency; Continent; Willing to see a nurse everyday & comply with recommendations; Able to arrive during set admission hours; Does not require medications that interfere with daily living activities, IV lines or non-portable oxygen tanks; Is not a behavioral problem in a group setting; Does not have active domestic violence issues	Physician Nurse Dental Eye care Medication storage Substance abuse/mental health Patient education	Meals Transportation Case management Housing referrals Job training or placement	Clients with substance abuse or addictive disorders are accepted by the program; Clients with mental illness are accepted if mental illness is not their primary diagnosis, are mentally stable at the time of admission, & they bring a 30 day supply of their prescribed psychotropic medications

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