



# No Place To Go: Addressing the Challenge of Homeless Patients in Sacramento

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## Introduction

With hospitals reducing lengths of stay over the last few decades, the importance of continued recovery and recuperation at home has increased. This presents a difficult challenge in the case of homeless patients, as a return to the streets may hinder a medical recovery.

Hospitals face the difficult choice of either keeping a non-acute patient in an expensive acute care bed or discharging a patient while realizing that recuperation will be tough. The former decision risks financial losses for the hospital, while the latter risks poor patient outcomes and high re-admissions.

Recently in Los Angeles, multiple hospitals have been criticized for discharging and transporting homeless patients to the city's skid row, where many homeless shelters and services are located. In response, the Los Angeles County Board of Supervisors has approved a \$100 million plan to provide five homeless centers across the county for individuals in need of temporary shelter.<sup>1</sup>

In addition, the California legislature is considering a bill (AB 2745) that would require hospitals to develop discharge-planning protocols for homeless patients.

A handful of respite care programs exist in California. These range from a small number of beds designated for respite care in a homeless health care clinic to a 40-bed unit with 24-hour nursing support as provided at the Recuperative Care Program in Los Angeles. Most of these

programs are funded by government and foundation grants.

In Sacramento, however, a collaborative of community organizations, hospital systems, and the county government have come together to develop, fund, and oversee a respite care shelter for homeless patients discharged from hospitals located in Sacramento County. All of the major hospital systems in the county provide equal funding despite the fact that they treat unequal volumes of homeless patients. The unifying goals are to improve the quality of care and to enhance the probability of recovery for the county's homeless patients, not to reduce any one individual hospital's costs of providing care to the homeless. The willingness of competing hospital systems to work together and help fund a respite care program is unique to the Sacramento program. It provides an important model for other communities to consider when investigating the development of their own respite care programs.

## The Respite Care Model

In response to the challenges presented by homeless patients admitted to the hospital, some communities have started respite care programs to provide a safe, clean shelter for homeless patients to recover from their hospitalizations. Across the nation, respite care programs provide a wide range of services to homeless patients discharged from hospitals. A program can be as simple as a free hotel voucher or as elaborate as a dedicated facility that provides onsite nurse

practitioners, physicians, and 24-hour nursing services. What unites the respite care programs is the motivation to provide a better alternative for homeless patients than being discharged to the streets.

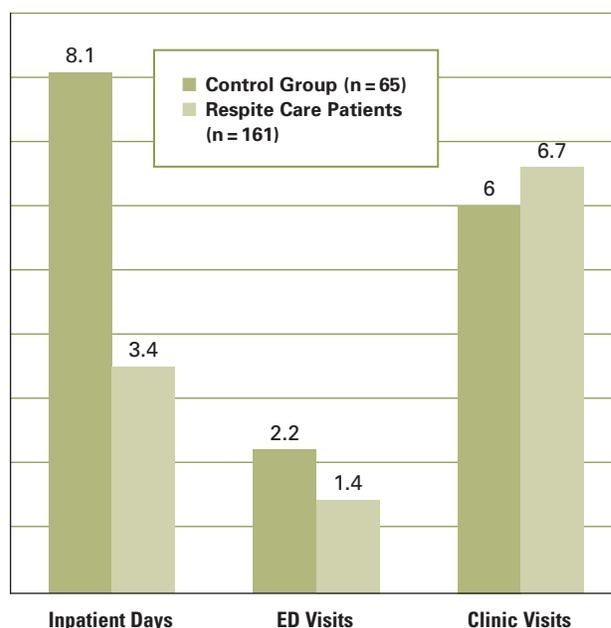
Respite care programs allow hospitals to discharge homeless patients after an appropriate length of time, freeing up beds for those in need of acute care. In addition, such programs offer the hope of reducing re-admissions and follow-up emergency room visits from homeless patients who do not adequately recover from their hospitalization.

While proving the benefits of respite care programs is challenging, researchers in Chicago and Boston have studied the impact of such programs on homeless patients' use of health care services. Researchers in Chicago studied the use of health care services by homeless patients referred from Chicago's largest public hospital to a respite care program that provides food, shelter, and access to social services for up to 64 individuals. Patients who were not placed in the respite care program due to unavailable beds served as a control group to patients who entered the respite care program. While the respite care group showed slightly higher use of emergency department and inpatient services than the control group in the 6 months prior to referral to the respite care program, the respite group used significantly fewer hospital services in the 12 months following referral.<sup>2</sup> (See Figure 1.)

Based on this data, Dr. David Buchanan of Stroger Hospital in Illinois estimated that this represents a significant savings to the health care system.

In Boston, researchers evaluated the effect of discharge to a medical respite program on re-admissions and death for homeless patients. Boston's Barbara McInnis House is the largest respite care program in the country and provides 24-hour nursing care, onsite physicians and nurse practitioners, and in-house dental and psychiatric care. Researchers found that within 90

**Figure 1. Use of County Health Services in the 12 Months after Discharge**



Source: Buchanan, David, MD et al. "Respite Care for Homeless People Reduces Future Hospitalizations." *Journal of General Internal Medicine*, April 2003, Vol 18 (S1), p 203.

days of hospital discharge, fewer respite care patients (15 percent) experienced re-admission or death (R/D) compared to patients discharged to their own care (19 percent), patients who left against medical advice (20 percent), and patients discharged to other care settings (22 percent). After adjusting for risk differences in the population, researchers found that "compared to Own Care, Respite patients had 50 percent lower odds of early R/D, 1 less inpatient day, and \$1,740 less inpatient charges."<sup>3</sup>

While existing data are certainly not definitive, the Chicago and Boston research suggest that medical respite programs can provide an effective place for homeless patients to recover from hospitalizations and surgeries, while also helping to reduce hospital re-admissions and inpatient stays resulting from insufficient recovery. A desire to achieve similar outcomes has prompted other communities to investigate options for respite care programs.

## Profile: The Interim Care Program in Sacramento

In 2003, MAAP, Inc. a local community organization in Sacramento formerly known as the Mexican American Alcoholism Program, convened representatives from the local hospital systems, the County of Sacramento, and local homeless shelters to discuss the problem of homeless hospital patients lacking an appropriate discharge location for their recovery. Following the initial meeting, interested parties formed the Interim Care Council to evaluate options for providing short-term respite care for homeless patients recovering from a hospital stay. The Interim Care Council included representatives from the hospital systems, the Salvation Army, the county, and MAAP.

### A Community Solution to a Community Problem

The Interim Care Council considered various options for the physical respite shelter. What they wanted in a shelter was a separate space for respite care patients, handicap-accessible beds and bathrooms, three meals a day, the ability to store medications and wound care materials, and a 24-hour shelter. Based on these requirements, the Salvation Army was chosen as the best location to house the Interim Care Shelter.

The Interim Care Council developed a project agreement, signed by each partner, that details each partner's role and responsibility.

- Each hospital system, UC Davis Medical Center, Sutter Medical Center, and Catholic HealthCare West, contributed \$50,000. (Kaiser Permanente joined later, in December 2005, and contributed the same amount.)
- The County of Sacramento contributed \$118,000 for the first year; some of that funding came from federal funds the county had received to care for the homeless. In addition, the Department of Human Assistance (DHA) and the Department of Health

and Human Services (DHHS) agreed to play an ongoing role in monitoring the Interim Care Program.

- MAAP agreed to serve as the administrator of the program (including budget management) and to provide part-time case management and nursing services to the shelter.
- The Salvation Army provided the physical space for the shelter, which opened March 1, 2005.

The Interim Care Council established an oversight board to provide management assistance to the program. Each partner—the four hospital systems, the County of Sacramento, and the Salvation Army—has a voting member on the oversight board. A representative from one of the voting partners serves as chair of the board for one year. Representatives from MAAP attend board meetings.

The board meets monthly and reviews protocols for use of the shelter, approves or modifies the budget, and troubleshoots any problems. A unanimous vote is required for any significant changes to the program, including changes to the budget, staffing ratios, or client approval process.

### A Shelter within a Shelter

The Salvation Army's Interim Care Shelter is a separate shelter within its larger overnight homeless shelter. The Interim Care Shelter provides 18 respite-care beds in six rooms, rather than dormitory style as many homeless shelters provide. Each room holds 3 hospital beds, plus a sink and toilet area. Initially, some of the rooms housed bunk beds, but they were replaced because some residents had difficulty using the bunk beds, which led to underutilization. There is one room for females and five for males. The rooms and hallways of the Interim Care Shelter are wheelchair accessible and residents have a place to store their medications and wound care supplies.

The Interim Care Shelter is open throughout the day to give residents time to recuperate. (In contrast, the regular shelter closes from 8 a.m. to 4 p.m.) Respite care residents receive three meals a day. From a cost perspective, the Interim Care Shelter is only slightly more costly per person than the traditional shelter because of the provision of lunch every day and the slightly higher janitorial and maintenance costs resulting from the extra wear-and-tear of 24-hour residents (wheelchairs, spills, etc.).

The Salvation Army encourages its interim care residents to take advantage of the social services provided by the regular homeless shelter. Such services include:

- Housing workshops;
- Alcohol and drug abuse support group meetings;
- Clinic hours provided by UC Davis medical students; and
- Medi-Cal eligibility screening by Sacramento County Department of Human Assistance workers.

In addition, the Salvation Army offers many respite care patients the option of moving to the overnight shelter once their medical recuperation is complete. The director of the shelter estimates that three-quarters of respite care patients transition to the overnight shelter, where they can continue to access the variety of social services intended to help get them off the streets.

### **A Shelter, Not a Medical Center**

The Salvation Army does not provide medical care to residents of the Interim Care Shelter. Individuals need to be able to independently change the dressing on a wound, take medications, or receive home health care providers. To help with their recovery, MAAP provides a caseworker who helps connect the ICP residents to medical services, such as finding a primary care physician and obtaining medications.

The referring hospital is responsible for sending the patient to the Interim Care Shelter with any medical supplies they need or with an arrangement to obtain medical supplies. The county Medically Indigent Services Program (MISP) may absorb the cost of medical supplies, durable medical equipment, and home health services needed by respite care patients. Otherwise, the referring hospital will pay for necessary supplies and services.

### **Ensuring Appropriate Referrals**

The respite care program at the Salvation Army is not appropriate for all homeless patients ready to be discharged from the hospital. As mentioned previously, the Salvation Army does not provide medical care. In addition, the Salvation Army has specific requirements for its regular shelter residents that also apply to the Interim Care residents.

To ensure that only appropriate individuals are referred to the Interim Care Shelter, the Interim Care Council established these criteria:

- **Medical need.** The patient must demonstrate a medical reason for respite care. Medical need can range from requiring a physical address to receive home health services to requiring a safe, clean place for cleaning wounds.
- **Independent.** The patient needs to be able to provide his or her own care including wound care, medication administration, and glucose monitoring.
- **Ambulatory.** The patient must be able to get to the bathroom and dining room without assistance.
- **Bladder and bowel continent.** This requirement is strictly enforced and essential to maintaining a clean shelter for the residents.
- **Psychologically stable.** Patients must be alert and oriented. Patients with psychiatric conditions must be stable on their medications.

- **Clean and sober.** The Salvation Army has a zero-tolerance policy for alcohol and drug use and any resident found using will be evicted from the shelter.

These criteria are clearly outlined on a checklist that is provided to each discharge planner. The checklist also notes the discharge planner(s) at each hospital who is responsible for approving referrals prior to contacting the Salvation Army.

To help ensure appropriate referrals, MAAP provides a part-time nurse to serve as liaison between the hospitals and the Interim Care Shelter. Once the patient has been admitted to the shelter, the Interim Stay Nurse evaluates each patient to make sure they are medically appropriate for the shelter. To encourage hospital accountability, any patient who is inappropriately referred to the shelter will be returned to the referring hospital. This has only occurred four times in the shelter's first year of operation.

The Interim Stay Nurse does not provide any medical care, but serves as an important resource for the Salvation Army. The nurse meets with each patient to discuss their medical care, review necessary appointments and medications, and check effectiveness of self-care. In addition, the nurse can reassure Salvation Army staff that individuals who may appear quite sick are indeed appropriate for the shelter.

In addition, a clinical review committee, comprised of representatives from each hospital (such as discharge planners and case managers) and the Interim Stay Nurse, meets monthly to review the appropriateness of patients referred to the Interim Care Shelter. The clinical reviews were critical for the first few months the shelter was open to ensure that hospitals were referring appropriate patients and that the shelter was not keeping residents in Interim Care beds beyond their need for medical respite. Such reviews provide an important opportunity to refine hospital discharge criteria and to discuss challenging cases.

## Standardized Referral Process

While most Interim Care referrals are patients discharged from a hospital, the emergency and outpatient surgery departments also can refer appropriate individuals. For each potential referral, the hospital discharge planner or case manager must verify that the patient meets the shelter criteria. In addition, the discharge planner completes a standard referral form. The form was developed by the Interim Stay Nurse and gathers the following information about the patient's condition and recovery needs.

### Patient's Current Condition

- Mental status
- Mobility
- Presence of infections
- Evidence of tuberculosis test

### Patient's Recovery Needs

- Medical needs
- Equipment needs
- IV medications
- Wound care
- Outside services needed (for example, home health or home infusion)
- Homeless resources needed (for example, transitional housing or counseling)

Based on the patient's condition and recovery needs, the discharge planner estimates the patient's length of stay at the Interim Care Shelter. Before contacting the Interim Stay Nurse, the discharge planner must receive approval from the case manager at the hospital. Then the discharge planner faxes the standard referral form, a chest x-ray, and an in-house medication sheet to the Interim Stay Nurse. Based on this information and a follow-up phone call with the discharge planner, the Interim Stay Nurse decides whether the patient is appropriate for the shelter and, if so, when the patient

can be admitted. At this point, the patient’s physician is notified; the physician writes discharge orders and faxes them to the Interim Stay Nurse.

The referring hospital provides transport to the Interim Care Shelter, typically with a taxi voucher. The hospital also provides additional vouchers, if necessary, for the patient to pick up prescriptions.

### Graduating from the Interim Care Shelter

Individuals remain in the Interim Care Shelter for stays ranging from two days to over ten weeks. The average length of stay is four weeks.

**Table 1. Expected Length of Stay for Respite Care Patients**

|   |                         |
|---|-------------------------|
| Diabetic event                                | 1 week                  |
| Simple wound closure (e.g., sutures, staples) | 1 – 2 weeks             |
| Laparoscopic surgeries                        | 2 weeks                 |
| Respiratory event                             | 2 – 4 weeks             |
| Burns or deep wounds                          | 2 – 6 weeks             |
| IV medications                                | As ordered by physician |
| Cardiac events                                | 4 weeks                 |
| Open surgeries                                | 4 weeks                 |
| Fractures                                     | 4 – 6 weeks             |
| Amputation                                    | 4 – 6 weeks             |
| Dialysis                                      | Up to 6 weeks           |
| Cancer treatment                              | 6 weeks                 |

The Interim Stay Nurse is responsible for deciding when a patient is ready to be discharged. The nurse receives regular updates from shelter residents about their follow-up visits with medical providers. In addition, the nurse will physically check the progress of the resident’s medical recovery. The nurse looks for wounds to be covered with skin and for surgical sites

to be dry and well healed. With fractures, the individual cannot stay in the Interim Care Shelter until full recovery, but four to six weeks of elevation can provide a helpful start to stability.

Once the nurse is convinced that the shelter resident is ready to be discharged from the Interim Care Shelter, the nurse notifies the shelter staff. Most residents will move to the regular shelter dorms for an additional stay of 30 to 60 days. In the best cases, the stay in the Interim Care Shelter and the regular Salvation Army shelter helps individuals to not only recover from their hospitalization but also quit drugs, find employment, and move into transitional housing.

### Lessons from Sacramento’s Program

In its first year of operation, the Sacramento Interim Care Program served 121 individuals and filled an important gap in the health care system. After a slow start, the shelter has run at an average daily census of 13 residents for the last eight months. While data on the costs have not been analyzed, program sponsors are confident that the Interim Care Program has paid for itself by reducing hospital stays, subsequent emergency department visits, and re-admissions. In addition, all of the partners believe that the Interim Care Program has provided an important service to the community and they are committed to its continuation.

The two years of development and the first year of operation offer lessons for other communities considering organizing a respite care program.

- 1. Involve the community.** Seek out community organizations that already serve the homeless. A respite care program will work best if the program can link discharged patients to other homeless services. When choosing an administrator for the respite care program, look first to groups that support the homeless.

**2. Limit the program.** It would be ideal if a respite care program could accept and help all homeless patients discharged from the hospital. As a practical matter, however, the most effective programs will be those that define a population to serve and limit their efforts to helping that population. Care providers, homeless organizations, and the shelter will need to collaborate to determine the appropriate population and ensure that they are holding to that population.

It is also important to recognize that there will be individuals who refuse the services being offered. The director of case management for one of the participating hospitals estimated that the Interim Care Program was appropriate for one-third of their homeless patients. The remaining patients were inappropriate because they were unwilling to forego drugs and/or alcohol, or they preferred to return to the streets.

**3. Track data from the start.** Hospitals and communities that develop respite care programs should identify important data to track and begin doing so from the inception of the program. At a minimum, respite care programs should consider tracking:

- Number of referrals
- Medical reason for referral (selection from a standard list of reasons)
- Referring hospital
- Number of denied referrals and reason for denial (selection from a standard list of reasons)
- Number of individuals re-admitted to hospital from respite care
- Length of stay in respite care
- Daily interim care shelter occupancy
- Discharge destination (selection from a standard list of destinations)

In addition, respite care programs may want to track use of medical care while in shelter (such as home health visits or emergency department visits), identify patients with mental health and substance abuse problems, and monitor connection with insurance. Responsibility for data tracking should be clearly assigned and data reports should be distributed to all partners monthly.

Many communities struggle with the problem of providing adequate and effective health care to the homeless. In particular, inner-city hospitals struggle to ensure that uninsured and indigent patients receive appropriate follow-up care upon discharge. The Interim Care Program is an innovative, collaborative model that should be considered as other communities address the needs of their homeless members.

## Other Resources

Boston Health Care for the Homeless Program:  
[www.bhchp.org](http://www.bhchp.org)

Interfaith House, Chicago's program, which has been in operation for ten years: [www.interfaithhouse.org](http://www.interfaithhouse.org)

*Medical Respite Services for Homeless People: Practical Models.* National Health Care for the Homeless Council, December 1999: (Launches PDF)  
<http://www.nhchc.org/Publications/MedicalRespiteServices.pdf>

*An Evaluation of the Respite Pilot Initiative,* March 2006. The National Health Care for the Homeless Council assisted the Bureau of Primary Health Care in evaluating their ten respite pilot projects, funded in May 2000 by the Health Resources and Services Administration (HRSA) to enhance their medical respite services for homeless people: <http://www.nhchc.org/respitepilotproject.html>

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## ENDNOTES

1. DiMassa, Cara Mia. "L.A. County OKs 'Historic' Homeless Plan." *Los Angeles Times*. April 5, 2006.
2. Buchanan, David, MD et al. "Respite Care for Homeless People Reduces Future Hospitalizations." *Journal of General Internal Medicine*, April 2003, Vol 18 (S1), p 203.
3. Kertesz, S.G., S. Swain, M. Posner, J. O'Connell, M. Shwartz, A. Ash. "Hospital Discharge to a Homeless Medical Respite Program Prevents Early Readmission."

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