# AN EVALUATION OF THE RESPITE PILOT INITIATIVE

**FINAL REPORT**

**SUZANNE ZERGER**
**RESEARCH SPECIALIST**

**MARCH 2006**

*Production and distribution of this publication is made possible by a grant from the Health Services and Resources Administration (HRSA). The views expressed herein do not necessarily reflect the views of HRSA.*

# TABLE OF CONTENTS


| | Page Number |
|---|---|
| EXECUTIVE SUMMARY..... | 4 |
| | |
| ACKNOWLEDGEMENTS..... | 7 |
| | |
| INTRODUCTION AND METHODS..... | 8 |
| | |
| PROGRAM-LEVEL DATA..... | 11 |
| P.1 Data Sources | 11 |
| P.2 Program Model Overview | 11 |
| P.3 Admission Criteria and Policies | 17 |
| P.4 Staff | 20 |
| P.5 Services | 23 |
| P.6 Community Resources and Environment | 25 |
| P.7 Future Changes | 26 |
| P.8 Program Model Effectiveness | 26 |
| | |
| CLIENT-LEVEL DATA..... | 30 |
| C.1 Data Sources | 30 |
| C.2 Client Characteristics | 31 |
| C.3 Referral Sources and Expected Length of Stay | 34 |
| C.4 Clients' Status at Admission | 36 |
| C.5 Treatment During Respite Stay | 39 |
| C.6 Comparison of Admission and Discharge | 42 |
| C.7 Exiting the Respite Program | 45 |
| C.8 Clients Not Admitted to the Respite Program | 46 |
| | |
| APPENDICES..... | 47 |
| A.1 Respite Coordinators' Selected Comments | 47 |
| A.2 Consent Form and Procedures | 50 |
| A.3 Client Database (Paper Form) | 53 |
| A.4 Program Survey | 66 |
| A.5 User Manual for Database | 79 |

# LIST OF TABLES


PROGRAM-LEVEL DATA

1. Respite Program Overview
2. Program Facilities
3. Admission Criteria
4. Official Admission Rules
5. Assessment Decisions: Ethical Dilemmas
6. Respite Program Services
7. Community Resources Readily Accessible to Homeless Persons
8. Environmental Issues with Negative impact on Service Quality
9. Program Changes Anticipated Over Next 2-3 Years
10. Program Model Effectiveness

CLIENT-LEVEL DATA

1. Client-Level Admissions Data
2. Client Demographic Characteristics
3. Veteran Characteristics
4. Homelessness Characteristics
5. Referral Sources
6. Expected Length of Stay
7. Admitting Diagnoses
8. Admitting Diagnoses-Severity
9. Clients' Hospitalization and Treatment History
10. New Diagnoses Made During Respite Stay
11. Encounters During Respite Stay
12. Additional Treatments Provided During Respite Stay

*Comparisons: Admission and Discharge*

13. Primary Diagnosis Severity Ratings
14. Source of Health Care and Health Insurance
15. Housing Status
16. Income Source(s)

17. Reason for Exit
18. Clinician Assessment of Program's General Benefits to Client

# EXECUTIVE SUMMARY

Being homeless directly impacts an individual's ability to prevent or avoid certain health problems, and on the ability to attend to and manage one's health. It is therefore not surprising that homeless individuals tend to require high levels of health services, or that, lacking healthcare and income resources, they often obtain these services through hospital emergency departments. An increasingly managed care environment in hospitals, however, is resulting in shorter hospital stays and more procedures provided on an outpatient basis. The impact on homeless individuals is especially harsh, because they are frequently discharged from the hospital with prescriptions for medication they cannot afford to have filled, and/or with instructions for follow-up care they are unable to heed, such as a safe bed to rest in and nutritious food. One response to this gap in health care between hospitals and the streets has been the development of medical respite services for homeless persons.

In May 2000, the Health Resources and Services Administration (HRSA) funded ten Health Care for the Homeless grantees, for up to five years, to enhance their medical respite services for homeless persons. HRSA also supported a prospective evaluation to 1) document the differing models of respite care delivery being used, and 2) assess the effect of those respite services on the health of homeless persons. This report summarizes results from this multi-method evaluation.

**Effective respite care services can be provided in a wide variety of settings with diverse staffing arrangements.**

- These ten respite programs operate in various settings in their communities, including homeless shelters, nursing homes, Assisted Living Facilities, apartments, a substance abuse treatment center, and a stand-alone clinic, to provide respite beds and medical care to clients in need.

- The programs provide a vast array of services to address immediate and potential physical, mental, and behavioral health issues. All collaborate with existing community agencies to maximize available resources and better integrate their clients into the community post-discharge.

- This evaluation describes the set of benefits and challenges associated with each model of service provision. In addition, it shares the collective wisdom of these experienced respite service providers about how to avoid – and address – barriers, and capitalize on community strengths and resources.

**Most of the individuals these respite programs serve have multiple, severe, and complex needs.**

*Many have long histories with homelessness:*

- two-fifths had been homeless for *one or more years* prior to receiving respite care.

*Most respite clients arrive with multiple, severe and complex health needs.*

- Clinicians rated the severity of their primary admitting diagnoses an average of three on a four-point scale; most common diagnoses fell into the categories of injuries and poisoning, diseases of the skin and respiratory system problems – all directly resulting from and/or exacerbated by life on the streets. At admission, seven out of ten clients had at least one diagnosis in addition to their primary admitting diagnosis, most commonly in the "mental disorders" category and with an average severity rating of two out of four. And, 342 new diagnoses were made for 14% of the clients during the respite stay.

*The psycho-social needs of these respite clients are great.*

- The vast majority of the clients arrived at respite alone, without any family or social supports.
- They lack access to resources: two-thirds had no access to a source of primary care, and half had no health insurance or income. Most receive health care from hospitals: three-quarters had been to a hospital emergency department at least once in the prior month, and 60% had spent one or more days hospitalized in the same time period.
- A majority entered the respite program with documented or suspected psychiatric problems (51%), alcohol problems (62%), and/or drug problems (56%), though about half this many reported they had received treatment for any of these issues.

**Respite care improves quality of life.**

The average length of stay in these programs is two weeks, and over half leave before treatment is completed. Nevertheless, by program discharge, many respite clients experienced improvements not only in health status, but also in other areas critical to their overall health such as access to health care, health insurance, income, and housing.

- Severity of primary diagnoses dropped a full point on the scale. And, while just one-third had a regular source of primary care when admitted, half did by the time of discharge.
- Access to income sources improved, including an increase from 23% to 33% of those with food stamps.
- Housing status improved: the percentage listing the hospital as their housing status fell from 34% at admission to 8% at discharge, and the percentage on the street dropped from 13% to just 4%.
- Clinicians working with these respite clients perceived that two-thirds had benefited from the respite environment during their stay, and about half said the social interaction was beneficial and/or that the client had learned to manage their health condition. Nearly one out of ten decided to enter a treatment program after visiting respite.

These respite programs have a unique opportunity to assist individuals in not only addressing their acute health needs, but in helping them improve their overall health and the quality of their lives. In addition to expertise in multiple disciplines of care, in working with homeless persons, and in collaborating with community resources, these programs provide their clients with physical space and time to rest and stabilize their health and lives. To be effective in the long-term, however, the necessary housing, treatment programs, and services need to be available for clients when they are discharged from respite; without those resources in place many may simply end up back in a homeless shelter or on the street.

**The need for respite care is vast, and remains largely unmet.**

All of these programs, in part because they are becoming well-established and known in their communities, are facing a growing need for their respite services. They are struggling to manage this growing need with already limited resources and, often, cuts or threats of cuts in funding. The environment is such that the screening of client referrals is often rife with ethically-charged dilemmas, such as how to prioritize one individual's need over another's when beds are limited, and what to do with clients whose needs do not fit the program criteria but have no other place to go for help.

Information on the number of respite clients who were referred but not admitted, and the reasons why, are still being processed, but preliminary analyses indicate that some of the larger programs – such as Seattle, Washington's and Denver, Colorado's shelter-based programs – are unable to admit half to two-thirds of the individuals referred to them.

**Conclusions and Recommendations**

These evaluation findings suggest that for those homeless persons able to receive care in these respite programs, the experience is unequivocally beneficial to their overall health. The vast need in these communities for respite care, however, remains unmet. With care, this vital and effective resource can become the critical link in the continuum of care local communities provide homeless persons, to ultimately enable an end to homelessness.

Based on the results of this evaluation, the National Health Care for the Homeless Council makes the following recommendations:

1. **Support enhancement of respite services for these and other HCH grantees**. This evaluation clearly indicates a vast need for these services, as well as enormous potential for improving the lives of homeless individuals and addressing homelessness in their communities. It also provides important insights into pros and cons associated with a variety of respite service models, which can help HCH grantees determine what is most feasible and appropriate for their own needs. One important consideration in the enhancement of services should be the time required for the ongoing education of referring agencies on issues related to program criteria as well as homelessness and health care.
2. **Develop and promote training for Respite Coordinators and staff.** Recruiting, training, and retaining staff for these programs is challenging, and turnover is not uncommon. We recommend using the expertise developed through this pilot initiative to develop template training materials which are portable and customizable for various respite program needs. An ethics component should be included in these materials to acknowledge the dilemmas staff may face when screening referrals.
3. **Continue this data collection process**. This participatory evaluation design and data collection effort illustrates that meaningful data can be gathered at multiple sites in a variety of settings. We recommend this base of expertise be capitalized upon for follow-up data collection on these programs, to carefully track the role and effects of respite care in these communities over time. This evaluation has provided a comprehensive portrait of these respite programs and their impacts; additional data would enrich and enhance this portrait.
4. **Support cost-benefit studies**. A cost-benefit analysis of respite programs is greatly needed, but was beyond the scope of this evaluation. These data show vast reductions in discharges to hospitals, which suggest cost savings, but a more sophisticated understanding of cost-benefits associated with these various models is needed.

## ACKNOWLEDGEMENTS

This evaluation was designed, developed, and carried out in a deliberately participatory manner, to ensure the consistent involvement from those individuals most invested in using the resulting data and findings. The following individuals were actively involved in all phases of this evaluation, from the determination of its objectives and methodologies (database and survey content and design) to the documenting, reporting, and disseminating of data. Those with an asterisk (*) beside their name are acting Respite Coordinators at the time of this publication.

**Respite Program Personnel**

Bakersfield, CA
- Marie Wall*
- Judith Metcalf
- Carolyn Bolt

Denver, CO
- Lisa Thompson*
- Ruth Neil
- Puspa Das
- Lerese DelaMater

Ft. Lauderdale, FL
- Julie Solomon-Bame*
- Nadine Reeves
- Scott DiMarzo

Portland, ME
- Teresa Valente*
- Bonny Weed
- Barbara Granville

St. Louis, MO
- Zenobia Thompson*
- Annette Cook
- Stephanie Hayes
- Villie Appoo
- Calvin Tilly

New York, NY
- Karin Roach*
- Ron Williams
- Linata Charles
- Ansel Horn

Dayton, OH
- Judith Barr*
- Kristina Yancik
- Mary Collins

Portland, OR
- Kelly Goodman*
- Karen Hogue
- Cathy Spofford

Salt Lake City, Utah
- Monte Hanks*
- Adi Gundlapalli

Seattle, WA
- Trudi Fajans*
- Karen Eckert
- Leslie Enzian

**Evaluation Team**

***Evaluation Director***
Kay Felix-Aaron, MD
Chief, Clinical Quality Data Branch
Division of Clinical Quality
Bureau of Primary Health Care
Health Resources and Services Administration

***Research Specialist***
Suzanne Zerger, MA
Research Specialist
National Health Care for the Homeless Council

***Database Consultant***
Suzie Schulenberg (nee Faver)
FaverWebs
Nashville, TN

Previous evaluation team members who were also instrumental in the development of the evaluation include HRSA personnel Amy M. Taylor, MD; Barbara Wells, PhD, and Beth Han, MD; and National HCH Council staff Marsha McMurray-Avila, MCRP and Al Lucero, MA.

## INTRODUCTION AND METHODS

Being homeless – without adequate shelter – has an independent impact on an individual's ability to prevent or avoid certain health problems and on the ability to attend to and manage one's health. Factors such as overexposure to environmental elements (e.g. extreme temperatures, rain, snow, and sun), nutritional deficiencies resulting at least in part from a lack of choice in foods (e.g. food lines, shelters, garbage bins), victimization of crime and violence, and coping behaviors such as alcohol, drug or tobacco use, can all contribute to the existence and/or seriousness of health problems among homeless persons. It is not surprising, then, that homeless individuals tend to require high levels of health services, frequently obtaining their care in hospital emergency departments.

Traditionally, health delivery systems have struggled to adapt to this population's many complex needs; these struggles are only exacerbated in hospital settings by a managed care environment of medical provision. Increasingly, services and procedures are provided on an outpatient basis and hospital stays are becoming shorter. These practices rely on the ability of patients to comply with provider recommendations for recuperation at home with some support from family members or friends for basic care. Without a home or a family or friends to help, an early discharge from a hospital can be especially traumatic and increase health risks for the patient. Homeless persons are frequently discharged with prescriptions for medication they cannot afford to have filled, and/or with instructions for follow-up care they are unable to heed. For example, their housing status can impede their ability to comply with such instructions as: a safe bed to rest in, adequate restroom facilities, nutritious food, clean water, secure storage and/or refrigeration for medications, and assistance with dressing changes.

While these individuals may not be sick enough to justify hospitalization, safe alternatives for recuperation are rare. Discharged homeless patients in need of respite typically are unable to stay in emergency shelters, which often do not have resources to staff programs during the day and/or require their users to be out seeking employment; instead, they wander the streets or sit in crowded day shelters where they are exposed to more illness and may expose others to communicable diseases. Health care providers are frustrated when they are unable to follow-up on patients lost to the streets, and when medical treatment they recommend is ineffective due to incomplete recuperation. This gap in health services between hospitals and the streets can plausibly lead to negative health outcomes and an increased burden to health care systems.

One solution which has emerged to address this gap is "respite care" for homeless persons; respite care refers to recuperative or convalescent services needed by homeless people with medical problems to provide respite from the dangers of life on the streets. Respite programs, unlike 24-hour shelter beds, provide medical services, including a minimum of daily nursing care. Respite program models vary widely – both in terms of services provided and types of facilities - because they need to be designed to serve diverse client needs and use available resources.

**Health Resources and Services Administration - Respite Pilot Initiative**

In May 2000, the Health Resources and Services Administration (HRSA) made $1.2 million in grant funds available to support ten medical respite care demonstration projects. The funding for this Respite Pilot Initiative was provided specifically for Health Care for the Homeless grantees which were already supporting a respite program; it was further focused on medical respite care, rather than respite for mental illness or substance abuse.

The Health Care for the Homeless grantee organizations funded by the Respite Pilot Initiative to enhance their respite services include free-standing non-profit organizations as well as organizations associated with public health departments, community health centers, and hospitals. (See list of grantees, below) The

grantees have varying length of experience providing respite services to homeless persons, ranging from two to ten years. They began implementing their expanded respite services funded by the HRSA grant between March 2000 and September 2001.

**********

**RESPITE PILOT INITIATIVE GRANTEES**

Bowery Residents Committee (New York, New York)
Clinica Sierra Vista Rest and Recovery (Bakersfield, California)
Colorado Coalition for the Homeless: Medical Respite Care Program (Denver, Colorado)
Grace Hill Neighborhood Health Centers (St. Louis, Missouri)
John Masters Respite Program (Portland, Maine)
Multnomah County Health Department Rallying Rooms (Portland, Oregon)
North Broward Hospital District HCH Respite Program (Ft. Lauderdale, Florida)
Respite Care Program (Dayton, Ohio)
Seattle-King County Pioneer Square Clinic Medical Respite Program (Seattle, Washington)
Wasatch Homeless Health Care (Salt Lake City, Utah)

**********

**Respite Pilot Initiative Evaluation**

One of the intended outcomes of this Respite Pilot Initiative was to evaluate the efficacy of different respite program models in achieving positive health outcomes for homeless patients, so the grant provided support for an evaluation and care was taken to select a variety of respite models. (The next section of this report describes the various models in more detail.)

The specific aims of the evaluation are:

- To identify and document the differing models of care for the delivery of respite services; and,
- To assess the effect of respite services on the health of homeless people during their stay in respite.

Evaluation Design Process

Beginning in December 2000, the HRSA convened the Respite Coordinators from each of the ten grantees, both in-person and via conference call, to work with staff from the National Health Care for the Homeless Council (NHCHC) to design the evaluation. An Evaluation Team comprised of staff from both the HRSA and the NHCHC worked together on the initial design of the evaluation and development of key evaluation questions. Next, both the detailed content (data elements, wording of questions, etc.) and methodology (database, surveys, forms) of the evaluation were thoroughly discussed in various forums, and agreed upon by all ten Respite Coordinators and other program staff, prior to data collection. Following this intensive interactive design process, each data collection instrument was pilot-tested by at least two of the programs.

In addition to ensuring a higher quality evaluation, one of the motives for this participatory design process was to enable the development of data collection tools that might be useful for other respite programs in the future. It is rare for HCH projects to collect standardized data and transmit them electronically, so this evaluation provided a unique opportunity to pilot test these data collection possibilities and to enhance evaluation skills at the HCH project level.

Evaluation team members then drafted and submitted detailed applications for approval from the HRSA Human Subjects Committee and the Office of Management and Budget. The Human Subjects Committee waived the necessity of an Institutional Review Board for this evaluation. In addition, a Certificate of Confidentiality was obtained to protect the privacy of clients from compelled disclosure. Respite Coordinators were also apprised of all HIPAA (Health Insurance Portability and Accountability Act) requirements relevant to the evaluation.

Evaluation Overview

The evaluation consists of data collected at both program and client levels. Specific data sources for each are described within the report - only a general overview is provided here.

*Program-level data* – obtained through surveys and interviews – are helpful in providing detailed descriptions of each of the respite models, including rules and procedures as well as facilities, staffing and services. In addition, interviews with Respite Coordinators provide insight into lessons learned from their experiences, and the advantages and disadvantages of the models they are using to provide respite care. These data were collected between February 2003 and July 2005.

*Client-level data* provide descriptions of client characteristics, health needs, and housing and resource statuses at both admission and discharge, to determine what services are provided during their stay in respite, and to understand reasons for exiting the respite program. For all respite program clients who consented to have information about themselves and their respite stay (anonymously) shared with the evaluation team, the programs collected data on an ongoing basis and submitted it quarterly. Respite staff officially commenced data collection on clients in mid-July 2003 and submitted data through March 2005.

**This Report**

This report is organized into two general sections: the first section summarizes the results of the program-level data, and the second section summarizes results from all sources of client-level data. The purpose of this report is to describe the Respite Pilot Initiative Evaluation, and to present findings from all data sources, particularly as they relate to the evaluation aims.

## PROGRAM-LEVEL DATA

### P.1 DATA SOURCES

Two data sources were used to collect descriptive information on the respite programs. At both the beginning and the end of the data collection period, each of the 10 Respite Coordinators (and support staff) completed:

1) mailed Program Surveys (see Appendix A.4 for a copy); and,

2) telephone interviews (approximately 45 minutes).

The results from these program-level data sources are summarized in this section, and are intended to provide descriptions of each of the models, supplemented with qualitative responses from the Coordinators about the benefits and challenges associated with their program model, and lessons learned about providing respite care to homeless persons. At the end of this evaluation process, Respite Coordinators were asked again to complete the Program Survey and follow-up interview to capture programmatic changes which may have occurred, as well as changes in perspectives about model effectiveness.

### P.2 PROGRAM MODEL OVERVIEW

All of these programs are components of HCH grantees, situated as follows:

| HEALTH CARE FOR THE HOMELESS (HCH) GRANTEES | |
|---|---|
| | **Number of Programs** |
| Public Health Department | 3 |
| Free-standing non-profit organization | 2 |
| Hospital | 2 |
| Community Health Center | 2 |
| Coalition | 1 |

Though respite programs can be categorized in a variety of ways, this report will use the following framework of four distinct "models" adapted from a HRSA summary of grantee applications. Following a general description of the program model taxonomy, a slightly more detailed description is provided for the grantees within each category. Table 1, following these descriptions, provides some additional detail.

**Shelter-Based**

These programs collaborate with one or more homeless shelters within their community. The shelters offer 24-hour beds, usually separate from the general shelter population, for respite patients. Health care providers visit the respite patients in the shelter daily, but generally rely on shelter staff to supervise respite patients overnight with "on-call" medical supervision available.

Colorado Coalition for the Homeless: Medical Respite Care Program (Denver, Colorado)
This program collaborates with a local shelter and a transitional living facility located seven miles apart. The Samaritan House is a traditional homeless shelter which allows the Medical Respite Care Program to use up to 15 beds; respite clients also have access to the shelter's numerous social and health services, and the Respite Coordinator is housed in this facility. The transitional living facility is an old Board and Care facility – Beacon Place – where five beds are available for respite patients; a lower level of services are available for clients placed in those beds.

Grace Hill Neighborhood Health Centers (St. Louis, Missouri)
Grace Hill has negotiated contracts with local shelters to provide respite care: these include: Family Haven and Karen House - both women's shelters, and the Harbor Light men's shelter.

Seattle-King County Pioneer Square Clinic Medical Respite Program (Seattle, Washington)
Seattle has contracts with two shelters – YWCA (for women) and the William Booth Shelter (for men) – to provide beds, laundry services, and food for respite clients. In addition, they contract with the Pioneer Square clinic to provide direct healthcare services.

**Care Facility**

These programs use a variety of care facilities to house their respite services, including nursing homes, board and care facilities, and a substance abuse treatment program. These facilities often have the benefit of administrative features already in place, such as housekeeping, security, food preparation, and 24-hour healthcare staff. Generally, the HCH program rents a number of beds used for respite care – the rent covers administrative features and nursing coverage – and the HCH program provides medical supervision, including admission and discharge oversight and daily clinical visits.

North Broward Hospital District HCH Respite Program (Ft. Lauderdale, Florida)
Clients who go to a hospital or clinic (including Health Care for the Homeless) for health care in the North Broward Hospital District and have an acute care need can be placed in an Assisted Living Facility by the Respite Coordinator.

Bowery Residents Committee (New York, New York)
When clients are admitted to the Bowery Residents Committee substance abuse treatment program, but are found to have a need for additional health care, they are allowed to stay and receive healthcare services from the respite program.

John Masters Respite Program (Portland, Maine)
This respite program is a collaboration with a local nursing home which is part of the City of Portland (as is the HCH clinic). The HCH purchases bed nights from the nursing home, and the organizations work together to provide healthcare services for their homeless respite patients.

Wasatch Homeless Health Care (Salt Lake City, Utah)
Wasatch works with several facilities to provide respite care, including a TB Housing Program, nursing homes, and local area motels and shelters. The data collected for this evaluation, however, are specific to the nursing home collaboration.

Multnomah County Health Department Rallying Rooms (Portland, Oregon)
This respite program provides beds in a residential care facility run by a community mental health agency, and owned by a housing agency.

**Free-standing**

The HCH program has control over both the facility and the medical care.

Clinica Sierra Vista Rest and Recovery (Bakersfield, California)
The Rest and Recovery program is a brand new facility designed specifically to serve homeless clients in need of respite; it is situated adjacent to the HCH clinic.

**Apartment**

One of the programs uses apartments to house respite care clients; spouses or family members can reside with the patient in the apartment. Administrative needs – such as security, housekeeping and food preparation – are handled through collaboration with community organizations, and medical supervision is provided by HCH clinicians.

Respite Care Program (Dayton, Ohio)
Four apartment units are available for respite clients, including three 1-bedroom and one 2-bedroom apartment. The Respite Coordinator's office was originally located over one of the apartments and served as storage for clients' food, cleaning and hygiene supplies, as well as a computer, reading materials, and other resources for their use. The Coordinator's office was later relocated to the HCH clinic.

The following table (Table 1) summarizes some of the basic characteristics of each of these models in slightly more detail – including the staffing arrangements and average length of stay at each. Some of these characteristics are described further in this report.

**Table 1**

| RESPITE PROGRAM OVERVIEW | | | | | | |
|---|---|---|---|---|---|---|
| **RESPITE PROGRAM NAME/LOCATION** | **MODEL** | **NURSING HOURS** | **# OF BEDS** | **PATIENTS SERVED** | **AVERAGE LENGTH OF STAY** | **STAFFING (FTE)** ***Bold indicates staff specific to respite*** |
| ***Shelter-Based*** | | | | | | |
| Colorado Coalition for the Homeless *Denver CO* | 1 Shelter-Based 1 Transitional Living Facility | 24 (nursing service on-call) | 20 | Adult men and women (families at shelter) | 30 days | **Respite Coordinator (.5) – same as RN** **Physician/MD (.05)** **RN (.5) – same as Resp. Coord.** **Case Manager (MA in Psych Counseling) (.65)** |
| HCH Pioneer Square Clinic Medical Respite Program *Seattle WA* | Shelter-Based | Mixed Day and Evening | 22 | Adult men and women | 11 days | **Respite Coordinator (.4)** **MD (.6)** **RN (3.2)** **Med Asst (1.375)** **SA counselor (1.0)** **MH counselor (.9)** **Psychiatrist (.4)** **Pharmacist (.5)** Clerk; Prog Mgr; Operations Coord |
| Grace Hill Neighborhood Health Centers *St. Louis MO* | Shelter-Based | 24 | 25 | Adult men and women | 2 weeks | **Respite Coordinator (.2)** **Case Manager (1.0)** **RN (1.0)** **Med Asst (1.0)** Physician, NP, Nutritionists et.al. through HCH clinic |
| ***Freestanding*** | | | | | | |
| Clinica Sierra Vista "Rest and Recovery" *Bakersfield CA* | Freestanding | 24 | 10 | Adult men and women | 16 days | **Respite Coordinator, RN (.1.0)** **NP (1.0)** **PA (.5)** **LVN (1.0)** **MA (1.0)** **Case Manager (1.0)** **Reception (1.0)** Contract: Janitorial and Security Collaborative agreements: Addiction treatment specialist, housing, MH counseling, disability hearings, veteran's services, medical SW, home health aides Volunteers: Clerical and clinical staff, physicians and student nurses |
| ***Care Facility*** | | | | | | |
| John Masters Respite Program *Portland ME* | Nursing Home | 24 (on-site) | 400 flexible bed days | Adult men and women | 2 weeks (max. 30-day) | **Respite Coordinator (.1)** **PA (.05)** **Case manager (53)** Contract as needed: MD, RN,LPN, Nusing Assts, Nutiritionist, BSW, Cook, Cleaning staff |

| RESPITE PROGRAM OVERVIEW, *continued* | | | | | | |
|---|---|---|---|---|---|---|
| **RESPITE PROGRAM NAME/LOCATION** | **MODEL** | **NURSING HOURS** | **# OF BEDS** | **PATIENTS SERVED** | **AVERAGE LENGTH OF STAY** | **STAFFING (FTE)** |
| ***Care Facility, cont.*** | | | | | | |
| Bowery Residents Committee<br>*New York NY* | Substance Abuse Treatment Program | 24 | 24 | Adult men and women | 14-21 days | **Respite Coordinator (1.0)**<br>**Physician/MD (.25)**<br>**Nurse Practitioner (.5)**<br>LPN<br>MSW (1.0)<br>Case Manager (1.0)<br>SA Counselor (1.0)<br>Psychiatrist (.5) |
| Wasatch Homeless Health Care<br>*Salt Lake City UT* | Nursing Home | 24 | 4-5 | Adult men and women | 19 days | **Respite Coordinator (.375)**<br>**MD (.2)**<br>**NP (.2)**<br>**Medical Asst (.07)**<br>**MSW (.05)**<br>**Case Manager (.375)**<br>**Medical records (.05)**<br>**Administrative (.125)**<br>**Pharmacist (.05)**<br>**Pharm Tech (.05)** |
| Multnomah County Health Dept "Rallying Rooms"<br>*Portland OR* | SRO rooms in Residential Care Facility | 24 | 4 | Adult men and women | 2-3 weeks | **Respite Coordinator (1.0)**<br>**RN**<br>**MSW (2.0)**<br>Contract (paid as part of room rental): RN, LPN, Nurse Aides, Medication Aides, Receptionist, Cook, Cleaning/Maintenance |
| North Broward Hospital District – HCH Respite Program in Broward County<br>*Ft. Lauderdale FL* | Assisted Living Facility | 24 on-site | 64 Free-standing 108 Assisted Living Facility | Adult men and women | Freestanding 40 days; Other – 20 days | **Respite Coordinator (1.0)**<br>**MD (1.0)**<br>**NP (1.0)**<br>**RN (1.0)**<br>**LPN (1.0)**<br>**Med Asst (2.0)**<br>Nursing Assts; BSW; SA counselor; MH counselor; Clerk; Cook; Driver; Cleaning staff |
| ***Apartments*** | | | | | | |
| Respite Care Program<br>*Dayton OH* | Aparments | 8-5pm M-F; Lifeline MD on-call | 4 units (11 beds) | Adult men and women; Families | 1-3 months | **Respite Coordinator (.10)**<br>**LISW (1.0)**<br>BSW (.3) |

**Program Facilities**

For the most part, respite clients in all of these programs share rooms with others. Of the four respondents who mentioned private rooms were available, just one had *only* private rooms to offer. Although the apartment model is the only one which expressly provides accommodations for family members of the respite client, some of the other programs are able to accommodate families when necessary.

Respite clients in each of these programs have access to a variety of rooms and facilities. All of the programs have provided a lounge and/or recreation area for clients, and all but one offer dining space. Over half offer private counseling space, pharmacy/medication and general storage, examination rooms, a kitchen, and administrative offices. Less common are dental operatorys or eye care facilities (two each had

these at post-survey). In addition to this list of rooms, several programs can also help clients gain access to classrooms, job resource centers, green space, chapels, barber shops, libraries, and exercise rooms.

At the time of the pre-survey completion five of the programs had facilities which are accessible to physically disabled persons (i.e. accessible bathrooms, elevators, etc.) while the remaining five indicated they had "partially" accessible facilities – that is, some of their sites were and some were not, so they could place patients accordingly. At the time of the post-test, seven indicated accessibility while three still provided partially accessible facilities.

**Table 2**

| PROGRAM FACILITIES | | |
|---|---|---|
| | **Number of Responses** (*Multiple Responses Accepted*) | |
| | **Pre** | **Post** |
| **Client Rooms** | | |
| Shared rooms for clients (roommates), including dormitory-style accommodations such as shelters | 8 | 9 |
| Private rooms for respite clients – no roommates | 4 | 4 |
| Beds/accommodations for client's family members | 1 | 2 |
| **Additional Rooms** | | |
| Lounge/recreation area | 10 | 10 |
| Dining space/cafeteria | 9 | 9 |
| Private counseling space | 9 | 7 |
| Pharmacy/Medication storage | 8 | 8 |
| Administrative Offices | 8 | 6 |
| Examination rooms* | 8 | 6 |
| Kitchen (area and facilities for food preparation) | 7 | 6 |
| Storage facilities (general) | 7 | 8 |
| Dental operatory | 3 | 2 |
| Eye care | 2 | 2 |
| Other** | 5 | 4 |

*The number of examination rooms available were: two (n=4); or three (n=2).
**Other" responses included: classroom, job resource center, chapel, barber shop, book/library room, green space, chiropractic services, and exercise room.

Determining an appropriate location for respite facilities can pose some challenges, as noted in the following comments:

- Prior to locating their free-standing respite facility next to the Health Care for the Homeless clinic in Bakersfield, California, they had located it on an isolated, beautiful ranch. *"We thought…get the people out of the area away from the trouble (drugs/alcohol). It's a good idea, but they won't go. And there were a lot of logistical problems. We [subsequently] moved here in close proximity to all of that, and it's never been a problem."*

- Locating the apartments for staff in Dayton, Ohio, also posed some challenges: *"The location is not a respected location in our community – patients are afraid, some refuse to go out there."* Because of concern for the neighborhood, patients are not free to roam, and there is very limited green space. These same reasons made hiring staff willing to work in the location difficult. The Dayton program is actively seeking an alternative location to house their respite services.

A Note on Collaborating

All of these models rely heavily on successful collaborative relationships and arrangements with existing community resources and services. Following are a few "lessons learned" from respite staff involved in the development of these collaborations:

Open communication is all-important. For example, one Respite Coordinator commented that regular meetings with shelter staff were *"even more critical sometimes than administrators' meetings, for the smooth ongoing relationship with line staff."* Other typical comments were: *"Keep communication open if at all possible."* or simply, *"Communicate, communicate, communicate."*

Maintaining flexibility is critical to the success of these collaborations,: *"Our middle name is flexible. That's how we survive." "Rules are rules, but you have to bend them."*

Developing relationships, they stressed, takes time and should begin as early in the planning phases as possible. A couple of comments illustrate this point: *"The groundwork has to be laid long before the funding comes through. …Anticipate the needs of the future – start laying the groundwork." And, "Be really really specific – delineate what you want from the facility. …Have everything down in writing right from the very beginning.'*

**P.3 ADMISSION CRITERIA AND POLICIES**

**Admission Criteria**

To be admitted to these respite programs, clients must be homeless according to the Bureau of Primary Health Care[1] and be an adult; most (n=7) also require that they be unaccompanied by family members.

As shown in Table 3 below, all of the programs have admission criteria related to health conditions and capacities for self-care, though in general care facilities are better able than the other models to accommodate clients who are not ambulatory, need oxygen, and cannot administer their own medications.

Although most of these programs (n=9) require that clients cannot actively use alcohol or other drugs during their respite stay, most can serve clients with mental illness and/or criminal backgrounds. Most of the shelter-based programs do not prohibit clients with a history of violence.

Regardless of admission criteria, however, all of these respite programs strive to achieve an often difficult balance between the needs of the homeless client referred to them and the respite resources they have available to them (which may be restricted by collaborative agencies). Respite Coordinators and other respite program staff do whatever they are able to accommodate the clients referred to them either within their respite programs or by assisting in finding them a more suitable placement. As one Coordinator put it, *"we are committed to providing care for homeless people"* – and this commitment is undeterred by respite program admission criteria.

[1] A homeless individual is defined in section 330(h) as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing."

**Table 3**

| ADMISSION CRITERIA<br>*Clients admitted to our respite program must...* | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Shelter-Based | | | Freestanding | Care Facility | | | | | Apts |
| **Criteria** | **CO** | **MO** | **WA** | **CA** | **OR** | **UT** | **FL** | **ME** | **NY** | **OH** |
| ***Demographic*** | | | | | | | | | | |
| Be currently homeless | X | X | X | X | X | X | X | X | X | X |
| Be an adult | X | X | X | X | X | X | X | X | X | X |
| Be alone (no family members allowed) | | | X | X | X | X | X | X | X | |
| ***Health Status/Capacity*** | | | | | | | | | | |
| Be ambulatory | | X | | X | | | | | | X |
| Be continent | X | X | X | X | X | X | X | | X | X |
| Not require intravenous fluids | | X | X | X | X | | X | X | | |
| Be able to administer their own medications | X | X | X | X | X | | | | | X |
| Not have certain health conditions or diseases* | X | | | X | | | X | | | |
| Not require oxygen therapy | | X | | X | X | | | | | |
| ***Background/Behaviors*** | | | | | | | | | | |
| Not have diagnosis of severe, persistent mental illness | | | | | | X | | | | X |
| Not actively using alcohol or other drugs | X | X | | X | X | X | X | X | | X |
| Not have history of violence | | | | | X | | X | X | | |
| Not have a criminal background (felony) | | | | | | | | | | |
| Other** | | X | X | X | X | | X | X | | |

*This includes active TB, infectious diseases such as chicken pox, and decubitis greater than stage II, and actively suicidal
**"Other" responses included agreement signed by client regarding violent behavior towards staff or other clients; health need not warranting 24-hour nursing care; health condition that can be expected to improve in a limited time; not convicted of sexual offense involving a minor; no high-risk domestic violence issues; motivation to participate; and no benzodiazepines for alcohol withdrawal in prior 24 hours.

These respite programs have built-in flexibility on policies of length of stay and readmission limits. Most either determine length of stay limits on a case-by-case basis or place no limit at all (at pre-survey, 8 did one of these, at post-survey, 7 did). And all either place no limit on the number of times a client may be readmitted, or evaluate this on a case-by-case basis as well. This is not to say, however, that these programs do not impose clear, enforceable rules on clients they accommodate; in fact, all but one require clients to sign a written contract or agreement before being admitted. *"We think it's really important to have tight, enforceable rules from the beginning. [Have] clear goals from the beginning, so they can be part of that goal planning."*

Rather, these programs strive to provide a broad structure within which they are best able to provide healthcare for homeless people. For example, all of the programs have a specific length-of-stay ideal in mind for the clients they serve, based largely on the goal of serving the maximum number of clients they can within their resources, but they also realize that:

1) they cannot always predict the needs of clients they admit into their programs (*"We thought we'd get someone with the flu or pneumonia, but we've had incredibly bad stuff – a horribly burned guy who got burned at*

*his campsite, another guy got hit by a train and had his arms amputated…"),* and in many cases new needs emerge during the respite stay; and,

2) they want to connect clients to additional services such as employment, housing, substance abuse services, etc. if possible, to care for their health in the most holistic sense. Staff may decide to extend a client's length of stay, for example, if it means being able to get that client into a treatment or housing program.

**Table 4**

| OFFICIAL ADMISSION RULES | | |
|---|---|---|
| | **Pre** | **Post** |
| **Length of Stay** | | |
| Yes, but the limit is determined on a case-by-case basis | 7 | 5 |
| Yes, client can only stay __ days* | 2 | 3 |
| No limit on the length of stay | 1 | 2 |
| **Re-admissions** | | |
| No limit on the number of times a client may be readmitted | 9 | 6 |
| Yes, but the number of readmissions is determined on a case-by-case basis | 1 | 4 |
| Yes, client can only be re-admitted __ times per year | 0 | 0 |
| Not applicable – we do not allow clients to be readmitted | 0 | 0 |
| **Clients sign an agreement or contract** | | |
| Yes | 9 | 9 |
| Not at this time | 1 | 1 |

* At pre-test, these limits were 21 days and 30 days; at post-test they were 21, 30, and 120 days.

**Defining a Successful Discharge**

Respite Coordinators were asked to define what they meant by a "successfully discharged" client. Nearly all said they would consider a discharge successful if, at minimum, the client's primary admitting diagnosis had been stabilized. Other common elements to a successful discharge were: educating the client about managing and caring about their health, and providing or linking the client to needed services. All agreed, though, with the general sentiment that "*No matter what you do, a successful outcome is not always in your control*" or, as another Coordinator put it, *"It varies and it depends."*

***"In most respite cases, we are forced to discharge our patients back to the shelter or a similar setting. We are still without the resources to "end" homelessness. We struggle with this dilemma constantly and assist patients with any possible housing application. The issue is that the waiting lists are 1 to 3 years for subsidized housing through local housing authorities and 3 to 6 months for transitional housing through a local shelter when the list is open for***

"Success" for respite clients is largely tempered by the resources and services available in their programs and communities. Although respite offers a unique opportunity to help individuals get their lives back on track by reconnecting them to community resources and services they might need, affordable housing remains the ultimate solution to ending their homelessness. When housing and other important services are not available, the respite program is rendered yet another temporary stop-gap when it may otherwise be the final conduit in fighting homelessness. All of these Respite Coordinators struggle with this fact, and with the need to acknowledge that "success" often means sending their clients back to where they came from.

**P.4 STAFF**

Given the delicate and complex balance these programs must play on a daily basis to accommodate the needs of homeless clients, it is not surprising that staffing arrangements reflect that complexity. As shown in Table 1 (above ), each program has a core staff who provide direct primary healthcare to their respite clients and coordination services. They vary widely, however, in terms of the number and type of staff their respite clients have access to, and in terms of how their programs pay for and coordinate the work of their staff.

Respite Coordinators indicated that in some cases staff positions are combined. For example, Colorado's Respite Coordinator is half Respite Coordinator and half Clinic Manager for the shelter-based clinic; in Florida, the substance abuse counselor and mental health counselor are the same FTE.

And, as is also clear from Table 1, these respite programs generally have only a small number of staff who are exclusively associated with the respite programs – they collaborate with other agencies or programs, contract out, or find volunteer staff who can provide the necessary expertise to care for their patients. In Maine, no positions are exclusively respite employees – their HCH staff run the program (coordinator, case manager) and provide counseling and medical consultation, and the nursing home staff provide 24-hour care on-site.

When Respite Coordinators were asked what type of staff they have on-site 24 hours per day/7 days per week, their responses included: resident coordinators; facility staff (e.g. shelter or nursing home staff); and nurses' aides or nurses. All of these respite programs have emergency back-up plans; seven have medical staff – either an MD or RN - available on-call; three programs have other arrangements in place (sometimes in addition to on-call medical staff), such as hospital/emergency room communication mechanisms, and one program (New York) has medical providers available on-site to respite clients 24 hours per day/7 days per week.

On the whole, staffing arrangements seem to be working well in the respite programs – particularly when they overlap in duties. In Seattle, Washington, for example, staff find it helpful that the nurses in the shelters they collaborate with also work with their respite program: *"Shelter nurses work in respite, so the transition is smooth. They know the program."* As noted separately in the report, however, nearly half of the programs desire to increase the number of staff they currently have available.

A few Respite Coordinators noted that one of the issues they have confronted with the agencies they collaborate with to provide respite beds is effective timing. For example, one collaborative agency requires 24 hours notice before they will accept someone into respite, while another needs clients to arrive prior to three o'clock in the afternoon. Others simply do not have sufficient staff in evening/night or weekend hours to accept new clients during those times. Clearly, these timing restrictions can also limit the types of clients and health care needs the respite programs are able to accommodate – for example, the program requiring a full day's notice to prepare a respite bed is not ideal for someone with short-term respite needs.

**Conducting Assessments**

The assessment process whereby these respite programs determine which referrals they can and should accept is absolutely key, so a great deal of the interview discussions about staffing issues centered on this topic. Following are some of the "lessons learned" the Respite Coordinators shared, and opinions about the most effective assessment staffing and procedures.

Most of these Respite Coordinators strongly recommend that assessments be conducted face-to-face when possible due to staff turnover and the tendency of hospitals to be "goal-oriented" to get clients into respite. One Coordinator put it this way, "*"Just have one person making the decision. In the beginning we learned the need to do on-site assessment. Hospitals will lie, and discharge planning people change constantly. We probably reject three-quarters of the referrals from the hospitals."* In some cases - due to staffing limitations - programs can only take referrals over the telephone before admitting a client. In either case, Respite Coordinators stress that the staff receiving referrals be very familiar with the program, be able to communicate the admitting criteria clearly and effectively, and strictly adhere to the criteria. They further recommend that a person with a medical background is best-equipped to do an informed screening or assessment.

Even when admission criteria are clearly communicated and adhered to, however, the person conducting assessments must always consider the future need they may need to turn away to provide services for the individual in front of them. This prioritization process leads to some ethically-charged dilemmas for these staff; Table 5 below illustrates some specific examples these respite staff have faced.

**Table 5**

**ASSESSMENT DECISIONS : ETHICAL DILEMMAS**

- A patient is referred to the respite program from a local church. The patient is not a legal citizen and therefore does not qualify for any medical state or federal benefits and will not qualify for these benefits in the future. The patient has end stage renal disease and is requiring dialysis three times a week. His vision is impaired and he is not able to get around independently. He is also wheelchair bound. The church is unable to house the patient, but is willing to transport him to and from dialysis. They have found a dialysis center in town that is willing to offer free services. Do you accept this patient into respite, knowing that he is likely to stay in the program for an unforeseeable length of time when you only have a limited number of beds, a flexible, but limited length of stay and limited resources to care for him etc. If you don't accept him, there are currently no other options for him. … **What do you do when referrals don't fit the program requirements, but there are no other community resources available for your patients?**

- A man arrives at front door of the shelter. He has had heart surgery in the last several months, but is in no acute distress. All the shelter beds are full except for one medical respite bed in your program and it is unlikely you will have the bed filled before the end of the day. Do you save the bed for the night knowing that you will likely be able to fill it from someone who is acutely ill being discharged from the hospital tomorrow, or do you give the bed to the man in front of you who has nowhere else to sleep that night? It also happens to be snowing.

- You develop a professional and therapeutic relationship with a client in the program. The client stays his maximum length of stay in the shelter and is then discharged. The client continues to come back to the shelter to speak with you, to ask for cough drops, bus tokens, warm gloves after his are stolen. At what point or do you refuse to offer services to this person who is no longer in your program, and now homeless and living on the streets?

- A referring nurse from the hospital presents a patient as being extremely difficult to deal with and suggests that he may have a personality disorder. Should this information affect your decision of taking this patient over another patient with a similar medical concern?

- You've accepted a patient into your program who ends up needing dialysis 3 times a week. You offer transportation assistance to patients in the form of bus tokens, but this particular patient is exhausting your allocated supply for the whole program. He does not yet qualify for any other transportation assistance. Do you limit his bus tokens knowing that he has no other way to get to and from dialysis? Do you spend money from your "clients' needs" account to purchase him a bus pass or should you maintain that all limited resources are equally distributed amongst all patients?

- If someone violates the shelter's zero tolerance policy and is discharged from the shelter and then later presents back to the respite program needing care, how do you prioritize this person vs. someone who hasn't yet utilized any services in the program?

- **"You have two [individuals] who are referred to the shelter with similar medical issues. You have one bed available. How do you decide who you will give the bed to?"**

To alleviate some of the difficulty negotiating the referral and admission processes, respite staff spend a great deal of time and energy educating staff at hospitals, shelters, and other agencies about their programs and what they can and cannot do for clients. Often, education additionally needs to focus on preconceived biases about homelessness generally and/or specific stigmas about medical, mental health or behavioral issues. Education requires ongoing effort because of high turnover among these institutions. As one Coordinator stated it, *"[You] cannot understate how much energy it takes to educate."*
Some programs have developed sophisticated modes for this communication to make the process more efficient: in California, for example, a homeless collaborative consisting of numerous homeless care

providers in the community convene monthly; other respite programs schedule regular presentations at various agencies. In addition, many of the respite programs find students from nursing schools and medical residents to be a valuable component of their work, particularly in the role it plays in educating people – including future hospital staff - about homelessness and respite care.

**Staff Challenges**

Understandably, finding, training, and retaining effective staff for these programs can be quite challenging. Several programs have already experienced staff turnover in key positions, including more than half which have changed Respite Coordinators since the beginning of the Pilot Initiative. Some of the qualities Coordinators said were critical for staff included deep commitment, creativity and flexibility, and an ability to be "*be comfortable with the dark side of life.*"

Asked to identify their greatest challenge in dealing with staff issues, the most frequent responses from Respite Coordinators were: retaining quality staff, particularly when able to offer only relatively low salaries; maintaining optimal staff coverage given fluctuations in program needs; and, effectively communicating with staff on an ongoing basis, particularly for programs sited in multiple locations.

As noted in previous comments, training can be helpful for staff making referrals (e.g. hospitals), but also for staff in shelters working with respite patients. The presence of mental health expertise is also very helpful, as many of the respite patients bring with them both complex mental and physical health needs. Seattle's program, for example, has a part-time psychiatrist on staff, which they consider an important strength. *"A lot of our patients have long-term mental health needs that have never been treated. A multidisciplinary team is really key."* This program also has a chemical dependency worker who follows up with clients three months after they leave the respite program to facilitate longer-term benefit. A Respite Coordinator from another program cited examples of the importance of identifying depression during the initial intake, which she had done in several situations ("*The respite was an opportunity to help [the client's] quality of life for the rest of their life."* ). Yet another Coordinator urged: *"[We] need to look at mental health issues, NOT just medical….[or] you're missing out on the bigger picture."*

**P.5 SERVICES**

As shown in the table below, these Respite Programs are providing and/or making available a wide range of services to most effectively serve their homeless clients. In addition to medical services to care for physical health, they are all providing case management services and health education to provide for their needs following exit from their program. All are clearly committed to providing the most comprehensive range of services possible within their available resources.

The importance of "enabling" services should not be understated. All of the programs provide cleaning, food, laundry, transportation, interpreters, and most provide security services for their clients – either on-site or through arrangements with outside organizations. When asked to comment on services in interviews, enabling services also seemed to cause the most frustration. For example, after numerous problems with regular cab services (*"Cab drivers don't want to take Medicaid reimbursement because there's no tip involved."),* the Seattle program finally negotiated a contract with the Department of Human Services which enabled them to place respite staff on-site at the hospital to work directly with taxicab agencies. This strategy has been enormously successful for them. Most programs also agree that "*Having a cafeteria onsite is optimal*" to ensure quality of food and the ability to meet special dietary requirements for their clients. Because this is clearly not an option for some of these programs, they have attempted collaborations with food delivery services – such as with Meals on Wheels – with varying success. Finding affordable and

effective security has also been problematic for some of these programs, particularly the apartment model and the free-standing model. The latter has particularly struggled to find affordable and appropriate security services: "*We have had a lot of trouble with security thinking they run a prison – there's a fine balance between watching and controlling.*"

**Table 6**

| RESPITE PROGRAM SERVICES | | | | |
|---|---|---|---|---|
| | **Where Services are Available*** | | | |
| | **On-site** | **Off-site** | **Referral** | **Not Available for Respite Clients** |
| Medical services – Nursing | 10 | 5 | 2 | 0 |
| Case management | 10 | 5 | 2 | 0 |
| Health education/promotion | 10 | 6 | 4 | 0 |
| Discharge planning | 10 | 3 | 0 | 0 |
| Counseling (general) | 10 | 6 | 5 | 0 |
| Entitlements counseling | 9 | 5 | 6 | 0 |
| Housing placement | 8 | 5 | 5 | 1 |
| Recreation [a] | 8 | 2 | 2 | 2 |
| Medical services – MD | 6 | 8 | 6 | 0 |
| Mental health services | 6 | 7 | 7 | 0 |
| Spiritual [b] | 5 | 3 | 2 | 4 |
| Supplemental oxygen | 5 | 4 | 5 | 1 |
| Job services | 3 | 4 | 6 | 1 |
| Education | 3 | 4 | 5 | 2 |
| Non-medical de-tox | 3 | 3 | 6 | 2 |
| Substance abuse treatment | 3 | 6 | 8 | 0 |
| IV | 3 | 5 | 6 | 3 |
| Podiatry | 3 | 6 | 6 | 0 |
| Dental services | 2 | 7 | 5 | 0 |
| Medical de-tox | 2 | 4 | 7 | 0 |
| Infectious disease specialist | 2 | 7 | 7 | 0 |
| Vision | 2 | 8 | 8 | 0 |
| Cardiology | 1 | 7 | 7 | 0 |
| Dermatology | 1 | 9 | 7 | 0 |
| Other [c] | 2 | 0 | 1 | 0 |
| **Enabling Services** | | | | |
| Janitorial/cleaning | 10 | 1 | 0 | 0 |
| Food services | 9 | 1 | 0 | 0 |
| Laundry | 9 | 1 | 0 | 0 |
| Transportation | 8 | 3 | 3 | 0 |
| Interpreter | 8 | 2 | 2 | 0 |
| Security | 6 | 0 | 0 | 4 |

*On-site: service provided on-site or at HCH clinic or at parent clinic; Off-site: service provided off-site (at HCH clinic or affiliated clinic); Referral: service provided through referral to unrelated organization; payment for these services varies across programs and services.

[a] Includes television, movies, field trips, games, recreational groups, therapy, and crafts.

[b] Includes transport to church upon request and hospital or shelter chaplains.

[c] One site also provides high risk OB care; another has links to local health departments for TB control and hepatitis C case finding follow-up.

### P.6 COMMUNITY RESOURCES AND ENVIRONMENT

The availability, accessibility, and quality of key community resources can provide important benefits and/or barriers to programs attempting to provide services for homeless individuals. When Respite Coordinators were asked to indicate which of several community resources they believed were "readily accessible" to homeless persons in their communities, it was clear that housing – permanent and transitional – is not accessible to homeless persons in most of these respite program communities. Much more likely to be accessible to these individuals are hospitals – non-Emergency as well as Emergency, shelters, and primary care clinics. Most variable is the accessibility of outpatient and inpatient mental health services (approximately as many respondents agreed as disagreed), and outpatient services for substance abuse. It is plausible that the (in)accessibility of these resources directly affects how effectively respite care staff can help ensure long-term positive outcomes for their patients.

**Table 7**

| COMMUNITY RESOURCES *READILY ACCESSIBLE* TO HOMELESS PERSONS<br>*(Mean Scores on Scale: 1=Strongly Agree to 5=Strongly Disagree)* | | |
|---|---|---|
| | **Pre** | **Post** |
| Permanent housing | 4.2 | 4.4 |
| Outpatient mental health services | 3.0 | 4.0 |
| Transitional housing | 3.6 | 3.9 |
| Inpatient mental health services | 2.9 | 3.9 |
| Residential treatment for substance abuse | 3.1 | 3.6 |
| Outpatient services for substance abuse | 2.6 | 3.4 |
| Hospitals (non-Emergency services) | 2.5 | 2.5 |
| Shelters | 2.2 | 2.3 |
| Hospital Emergency Rooms | 1.5 | 2.1 |
| Primary Care Clinics | 1.7 | 2.0 |

Other issues which affect the quality of services these Respite Program staff are able to provide for their homeless clients include the funding environment (such as Medicaid eligibility, state and local funding restrictions), public attitudes toward substance abuse or substance abusers as well as toward homelessness generally, lack of entitlements or public benefits, criminalization of homelessness, and even the climate. Understanding these contextual factors and barriers will be key when interpreting both short and long-term outcomes patients receiving respite care are able to achieve. As shown in Table 8, the Respite Coordinators on average agreed or strongly agreed that each of these issues has had a negative impact on the quality of services they have been able to provide (mean scores of 1.5 – 2.8 at post-survey). They unanimously agreed that the funding environment in their community had had a negative impact on their services, and all but one said public attitudes toward substance abusers did. Most agreed that lack of entitlements or public benefits and/or public attitudes toward homelessness were having a negative impact, but respondents were more divided about the impacts of the climate or criminalization of homelessness.

**Table 8**

| ENVIRONMENTAL ISSUES WITH NEGATIVE IMPACT ON SERVICE QUALITY<br>*(Mean Score on Scale: 1=Strongly Agree to 5=Strongly Disagree)* | | |
|---|---|---|
| | **Pre** | **Post** |
| Funding environment (Medicaid eligibility, state or local funding, etc.) | 1.3 | 1.5 |
| Public attitudes toward substance abuse or substance abusers | 1.7 | 1.9 |
| Public attitude towards homelessness | 2.2 | 1.9 |
| Criminalization of (laws and/or policies against) homelessness | 2.4 | 2.0 |
| Lack of entitlements or public benefits | 1.7 | 2.1 |
| Climate/weather | 2.5 | 2.8 |

### P.7 FUTURE CHANGES

Regardless of the length of time these programs have been formally providing respite care, all of them anticipate making at least some changes in the next 2-3 years. A majority (n=7) expect to serve more clients, yet just four anticipate expanding facilities or increasing staff.

**Table 9**

| PROGRAM CHANGES ANTICIPATED OVER NEXT 2-3 YEARS | | |
|---|---|---|
| | **Pre** | **Post** |
| Serve more clients | 7 | 7 |
| Expand facilities | 5 | 4 |
| Increase staff | 4 | 4 |
| Coordinate with other organizations | 3 | 4 |
| Expand current services and/or programs | 3 | 3 |
| Add new programs or services | 3 | 2 |
| Change locations | 3 | 1 |
| Serve about the same number of clients | 2 | 1 |
| Change methods of delivering services | 2 | 1 |
| Change geographic area served | 1 | 1 |
| No changes anticipated | 0 | 1 |
| Change admission criteria | 2 | 0 |
| Serve fewer clients | 1 | 0 |
| Reduce facilities | 1 | 0 |
| Decrease staff | 1 | 0 |
| Make other changes | 3 | 1 |

### P.8 PROGRAM MODEL EFFECTIVENESS

All of the Respite Coordinators rate their current program models effective for the clients they serve, with ratings averaging 8.5 on a scale of 1 (not at all effective) to 10 (extremely effective); their scores ranged only slightly, from 8-10 at post-survey.

That said, however, just half (n=5) said they would continue to use the same model even if they had all of the necessary resources available. The others said that they would definitely use a different model altogether (n=3), or that they might opt for a different model given sufficient resources (n=2). All of those interested in exploring alternate models agreed that they would want a more flexible, expanded program.

**Table 10**

| PROGRAM MODEL EFFECTIVENESS | | | | | |
|---|---|---|---|---|---|
| Given what you know now about delivering respite services in your community, please rate the effectiveness of your program model for the clients you serve. (*Mean Rating on Scale: 1 -Not at all effective to 10-Extremely effective*) | | | | | |
| | **Overall** | **Shelter-Based** | **Free-standing** | **Care Facility** | **Apartments** |
| **Pre** | **8.6** | 8.3 | 9.0 | 9.0 | 7.0 |
| **Post** | **8.5** | 9.0 | 10.0 | 8.6 | 8.0 |

In interviews, Respite Coordinators were asked to identify some of the main benefits and challenges to their particular program models. On the whole, all of them consider their program models effective, though it appears that the apartment model is not currently considered optimal, and there is some variation in response to the other models. Following is a brief summary, by program model, of their responses.

**Shelter-Based**

One of the most important benefits of the shelter-based model is its resourceful approach to respite care, as beds and services are already available. The range of services varies by shelter, but may include food preparation, transportation, pastoral support, cleaning, classes, 24-hour staffing, and security. These Respite Coordinators spoke about the cost-efficiency of this model, making comments like the following- *"There's a whole lot of merit to the shelter-based facility. These resources already exist in the community, so money goes toward the patients."* Exposure to other shelter residents can also be a benefit, particularly when shelters are connected to transitional programming or housing. (*"Our clients are exposed to people working their way out of emergency shelter system."*)

The primary challenge to making this model work is the ability to collaborate successfully with shelters which may have conflicting or contradictory missions or procedures. For example, if a shelter has a clean and sober requirement, a respite program with a harm-reduction approach must find a way to work with the shelter. The following comments reflect some of this frustration: *"We don't have control over our beds. We're not the final disciplinarian – we can't work in harm reduction."* And, *"Over the weekend, they have zero tolerance, so if the respite client violates [the rules] they're automatically discharged from the shelter."*

Many shelters are also very structured and have strict requirements for their residents,; for example, if residents are required to do chores, but respite clients are too sick to comply, staff have to negotiate special treatment. ("*For the shelter to run smoothly, residents are required to do chores, [so when] we try make exceptions for [our clients] we meet resistance." "When we have real sick people – chronic medical issues – they run into problems upholding the rules. They're rules are not necessarily restrictive, in fact are generally universal." "I'd like to see more control over the dietary considerations for our clients."*)

When the respite beds are not reserved solely for respite clients, the respite program cannot be as flexible in determining who and when a respite client may be admitted. This is compounded when shelter staff also have final say over who gets discharged from the bed. Because respite programs cannot guarantee shelters they will be occupying X number of beds, some shelters may resist getting involved in a collaborative relationship in the first place. Similarly, when the beds are not separate from other shelter beds and are mixed in with the general shelter population, it can be more difficult to track clients and provide services and care.

The level of need that can be met within this model tends to be limited, though this depends on the shelter environment and resources. In general, though, clients with acute needs who have some mobility tend to

be better served by this model.

**Free-Standing**

The control over the program conditions – services, staff, rules and regulations – is considered an important benefit of this model. And, a free-standing respite program is generally able to serve clients with far greater medical and/or psycho-social needs.

This program model is also the most costly, however, since it is not using a pre-existing facility, and it must fund 24/7 staff. It can also be difficult to find an appropriate location for the facility, and to sufficiently and securely fund a facility of adequate size and design.

**Apartments**

The initial motive for this model was a need to house TB patients and families with children who had communicable diseases; this model addresses these types of cases extremely well. The model allows families to stay together, to have privacy in a restful environment, and to have access to all amenities (showers, laundry, kitchen, etc.). And, getting community backing for this model was easy for this program: *"they really rallied behind getting us pots and pans. PR-wise, it's the easiest program we've had."* The program is being held up as a model in the 10-year plan to end homelessness in this community.

Yet this program model is especially limited in terms of the number of clients who can be served, and in their type and level of medical need. Clients receiving respite care in this program model must be able to toilet, bathe, feed themselves, and not be wheelchair bound. As mentioned above, this model was designed to address specific needs, yet those needs turned out not to be as common as anticipated; because the program is the only one providing respite care in the community, they have attempted to serve a far greater diversity and complexity of needs and have struggled to address them within their program model.

As noted previously, the location of these apartments in an unrespected area posed challenges for patients (proximity to alcohol sales) and staff reluctant to work there. Respite staff suggest an apartment model may work more effectively if it were a stand-alone program with numerous apartments and several staff on-site.

**Care Facility**

A key strength of this model – as with the shelter model – is its efficient use of existing resources. The services provided tend to be more comprehensive than those provided in shelters; nursing homes and assisted living facilities, for example, frequently have medical providers and social workers or case managers on site, more dietary options, more privacy, medical beds, better security, and more flexible rules.

Programs are frequently connected to much broader systems of care. In Florida, for example, clients can access specialty referrals, mental health, medications, hospital, and primary care, and in New York, those who come into the respite program are integrated into a huge network of support both for the BOC and the health care system. This enables respite clients to receive added value and services that are not expressly covered under the respite grant.

The only challenges associated with this model are, again, some limitations in terms of the clients who can be served; this includes the nursing home facility which cannot serve people with short-term respite needs, and the substance abuse treatment facility only able to serve actively substance abusing clients. The latter can also be seen as a benefit, however, particularly because some other programs are unable to serve clients who are active substance users. Many of the challenges associated with ALFs and nursing homes are similar

to those faced by the shelter models: limited control over space/beds, restrictions on client needs and characteristics, and potential conflict with rules and regulations imposed by the collaborative agency.

As with the shelter model, staff relations require ongoing education/communicating efforts. Yet both the environments and the other clientele being served by the institution are different, which creates variations in the solutions needed. Nursing homes, for example, have health codes, and while staff may be more aware of medical issues they may not be as accustomed to working with homeless persons or some of the behaviors associated with mental illness and substance use.

**Overall Challenges**

All of these programs, in part because they are becoming well-established and known in their communities, are facing a growing need for respite services in their communities. Many respite staff report not only more clients being referred, but sicker ones as well. Typical comments included: *"Clients are sicker, and [have] a lot more mental health issues;" "The medical needs are just incredible;"* and, *"Too many people know about it now. I can think of six hospitals that are calling weekly if not daily."*

The programs are struggling to manage this growing need with already limited resources and, often, cuts or threats of cuts in funding. In Colorado, for example, the number of beds available for respite clients was 50 at the outset of this evaluation and has since been reduced to 20. One of the Assisted Living Facilities the Florida program was working with closed its doors. And in Maine, the nursing home housing their respite clients decided to limit the number of people they can have in respite at one time to two; this coincided with being "*overwhelmed with need in our area*" as the HCH clinic saw its numbers doubled in the past year. (A policy of open access to Medicaid in Maine, based on an estimated maximum of 1400 signing up, ended when that number quadrupled.) Utah saw their nursing home's daily rate increase from $88 in 2000 to $130 in 2005, which has severely restricted the number of clients they can serve. All of the programs patchwork funds to serve their respite clients, a necessary practice which brings its own challenges, not the least of which is that the loss of one fund will likely effect the others. As one Coordinator put it, *"The problem with working with the clients holistically is that money doesn't come that way, systems aren't set up that way."*

***"[This respite program] really has been a safe haven for them from the street. I don't think we can take it away from our community, it would leave such a huge gap."***

***"Respite has become a vehicle for outreach in bringing together different agencies."***

***"'Harry' was a mean drunk. Now he's getting a trailer in the mountains and planting flowers. When he got here, he didn't have a chance on earth."***

**Overall Benefits**

Despite external and internal challenges, *all* of these respite programs are effectively caring for homeless persons who critically need health care. All are connected to an active HCH system which they can link their respite clients to if they have no existing source of primary care. The model of care being used to provide respite services each brings with it its own set of strengths and challenges; what is *most* important is not how the services are financed or provided but that they exist as a resource in their communities. All of these respite staff urgently want and strive to increase the capacity of their respite services and the ability of those services to address greater and more complex need. The next section of this report further illustrates how and the extent to which these programs are mending the lives for those clients they are able to serve.

# CLIENT-LEVEL DATA

## C.1 DATA SOURCES

Each of the respite programs provided the following data on their clients for this evaluation.

**Consent forms**

Program staff asked each client admitted to the respite program whether he/she would be willing to have data collected on them during their stay - with no identifying information about them personally – shared for evaluation purposes. Programs retained a signed copy of the consent form for their files, and provided a photocopied consent form for each client, with names blacked out, to the evaluation team. (Copies of the template Consent Form and consent form procedures are appended in A.2 of this report.) The latter had only client ID numbers assigned by the program, which were matched to the data sent in the database to ensure consent had been obtained.

**Client Refusal Form**

This form indicates the number of clients who received respite services from the programs during each quarter, but who had declined the offer to sign the evaluation consent form.

**Client Database**

For those clients who signed consent forms, program staff recorded data in an Access database for the duration of their respite stay. They then electronically submitted data from that database on those clients who had been discharged during each quarter. (See A.3 for a paper-version of this database, and A.5 for a copy of the User Manual which accompanied the database and provided detailed instructions for the collection, entry, and electronic submission of these data.)

**Non-Admittance Forms**

Non-Admittance forms were used to capture general data on those clients who were referred but not admitted to the respite programs during each quarter; data elements include the referral source and the reason for the non-admit.

This section of the report summarizes data from all of these sources except non-admittance forms (data are still being processed).

A total of 1349 clients from these ten programs consented to share their data for this evaluation, and an additional 115 clients were invited to participate but refused; the overall response rate for this evaluation was 92%. Table 1 below summarizes these numbers by site. Over half of the clients included are from the Seattle, Washington (36%) and St. Louis, Missouri (21%) program data. Client refusal rates vary by program, but are highest in Bakersfield, California, due largely to the high proportion of undocumented immigrants they serve who are reluctant to share personal information even when confidentiality is assured.

**Table 1**

| CLIENT-LEVEL ADMISSIONS DATA | | | | |
|---|---|---|---|---|
| | Client Database (N=1349) | | Client Refusals (N=115) | |
| | Number | % of Sample | Number | % of Site's Total Clients |
| California, Bakersfield | 43 | 3% | 10 | 23% |
| Colorado, Denver | 175 | 13% | 6 | 3% |
| Florida, Ft. Lauderdale | 129 | 10% | 2 | 2% |
| Maine, Portland | 26 | 2% | 0 | 0% |
| Missouri, St. Louis | 289 | 21% | 45 | 16% |
| New York, New York City | 83 | 6% | 12 | 15% |
| Ohio, Dayton | 37 | 3% | 0 | 0% |
| Oregon, Portland | 36 | 3% | 4 | 11% |
| Utah, Salt Lake City | 39 | 3% | 0 | 0% |
| Washington, Seattle | 492 | 36% | 36 | 7% |

## C.2 CLIENT CHARACTERISTICS

### Demographic Characteristics

Most of the clients in these respite programs are male (78%); the average age is 48 years, though this ranged from 17-91 years. (Note: most admission criteria exclude individuals under the age of 18.) Two-thirds have education levels of high school graduate or GED (38%) or less (27%).

Two-fifths (40%) of the clients receiving respite care this quarter indicated their race as "white", one-third (32%) identified themselves as Black or African American, and four percent as American Indian. Approximately one-tenth of the clients indicated their ethnicity as Mexican, Puerto Rican or some other Hispanic ethnicity.

A large majority (88%) of the clients were born in the United States, but those who were not came from over 35 different countries. Forty (3%) of the clients identified themselves as refugees, and twenty (2%) as migrant workers. Native languages primarily included English and Spanish; just 37 (3%) indicated a need for an interpreter during their stay.

The vast majority of these respite clients arrive to these programs alone; very few (5%) were married or with a partner at the time they were admitted.

**Table 2**

| CLIENT DEMOGRAPHIC CHARACTERISTICS (N=1349) | | |
|---|---|---|
| | **Number** | **Percent** |
| **Gender** | | |
| Male | 1056 | 78% |
| Female | 292 | 22% |
| Transgender | | |
| **Education** | | |
| <12 Grade | 365 | 27% |
| High school graduate/GED | 515 | 38% |
| Vocational/Technical schooling | 76 | 6% |
| Some college | 235 | 17% |
| College graduate | 46 | 3% |
| Some graduate school | 15 | 1% |
| Unknown/No Response | 88 | 7% |
| **Age** | | |
| Range | 17-91 | |
| Mean | 48 years | |
| **Ethnicity**: ***Are you Hispanic, Spanish, or Latino?*** | | |
| No | 1206 | 89% |
| Mexican/Mexican American/Chicano | 68 | 5% |
| Puerto Rican | 20 | 2% |
| Other | 28 | 2% |
| Unknown/No Response | 27 | 2% |
| **Race** | *Multiple responses accepted* | |
| White | 541 | 40% |
| Black or African American | 426 | 32% |
| American Indian or Alaska Native | 49 | 4% |
| Native Hawaiian or other Pacific Islander | 6 | <1% |
| Asian | 5 | <1% |
| Multiple races/Other | 9 | <1% |
| Unknown | 4 | <1% |
| **Country of Origin** | | |
| United States | 1182 | 88% |
| Mexico | 34 | 3% |
| Central America | 24 | 2% |
| Europe | 11 | <1% |
| Africa | 6 | <1% |
| Asia | 5 | <1% |
| Other | 3 | <1% |
| Middle East | 2 | <1% |
| Other/Unknown | 82 | 6% |
| **Migrant/Seasonal Worker** (*yes only*) | 20 | 2% |
| **Refugee** (*yes only*) | 40 | 3% |

Table 2

| CLIENT DEMOGRAPHIC CHARACTERISTICS, *continued* (N=1349) | | |
|---|---|---|
| | **Number** | **Percent** |
| **Family Status** | | |
| Single/Never Married | 723 | 54% |
| Divorced | 369 | 27% |
| Separated | 121 | 9% |
| Married | 50 | 4% |
| Widowed | 54 | 4% |
| Living with a partner | 11 | 1% |
| Unknown/No Response | 5 | 2% |
| **Accompanied by family members?** | | |
| Alone | 1314 | 97% |
| With partner or child(ren) | 21 | 1% |
| Unknown/No response | 14 | 1% |

Percents may not total 100 due to rounding.

**Veteran Characteristics**

One-fifth (n=260 or 19%) of the clients identified themselves as war veterans; this included 15% who had received an honorable discharge, 2% with no honorable discharge, and 2% for whom discharge status was not known. Of these self-identified veterans: nearly half (44%) served during the Vietnam Era, and 29% served during Peacetime; and, one-third (34%) had served "in-country."

**Table 3**

| VETERAN CHARACTERISTICS (N=260) | | |
|---|---|---|
| | **Number** | **Percent** |
| **Veteran Status** | | |
| Vet-honorable discharge | 205 | 15% |
| Vet-not honorable discharge | 26 | 2% |
| Vet-unknown discharge status | 29 | 2% |
| **If Veteran – era served** | | |
| Vietnam Era | 115 | 44% |
| Peacetime | 76 | 29% |
| Gulf War | 5 | 2% |
| Korean War | 5 | 2% |
| WWII | 1 | <1% |
| Unknown | 58 | 22% |
| **If Veteran, Served "In-Country?" (*yes only*)** | 88 | 34% |

Percents may not total 100 due to rounding.

**Homelessness Characteristics**

More than one-quarter (27%) of the respite clients became homeless for the first time before they reached age 30, but half (51%) had their first homeless episode sometime between ages 31 and 50 years. On average, they became homeless for the first time at age 38 years, though this ranged from 1 to 87 years.

Most of these clients became homeless for the first time in the same city (63%) where they were receiving respite care, or in the same state, but a different city (11%). Approximately one-fifth (19%) had become homeless in a state other than the one in which they received respite care.

The individuals served by these respite programs have spent a great deal of time without a home. Two-fifths (43%) of these clients had been homeless for one or more years prior to receiving respite care; just one-tenth (12%) had been homeless less than one month.

**Table 4**

| HOMELESSNESS CHARACTERISTICS (N=1349) | | |
|---|---|---|
| **Age when first became homeless** | **Number** | **Percent** |
| 1-20 years | 133 | 10% |
| 21-30 years | 231 | 17% |
| 31-40 years | 329 | 24% |
| 41-50 years | 370 | 27% |
| 51-60 years | 157 | 12% |
| 61 years and older | 28 | 2% |
| Unknown/No Response | 101 | 7% |
| *Range* | 1-87 yrs | |
| *Mean* | 38 years | |
| **Location when first homeless** | | |
| This city | 850 | 63% |
| This state – another city | 146 | 11% |
| Other state | 262 | 19% |
| Other country | 8 | <1% |
| Unknown/No Response | 83 | 6% |
| **Months Spent Homeless (this episode)** | | |
| < 1 month | 160 | 12% |
| 1-6 months | 377 | 28% |
| 7-11 months | 156 | 12% |
| 1-3 years | 311 | 23% |
| > 3 years | 270 | 20% |
| Unknown/No Response | 75 | 6% |

Percents may not total 100 due to rounding.

### C.3 REFERRAL SOURCES AND EXPECTED LENGTH OF STAY

***NOTE: Throughout the remainder of this report, the unit of analysis will be admissions, rather than clients.***

Hospitals referred a majority (61%) of the clients served in these respite programs, mostly from inpatient units but also outpatient and Emergency Departments. Health Care for the Homeless clinics and programs provided an additional fifth (20%) of the referrals. One-tenth each came from non-HCH programs in the community (10%) such as homeless shelters or non-HCH clinics, or from other sources (8%) including the clients themselves.

The referring agency supplied at least some medications for clients about half (49%) of the time.

**Table 5**

| REFERRAL SOURCES (N=1507) | | |
|---|---|---|
| | **Number** | **Percent** |
| | | |
| **Hospitals** | ***920*** | ***61%*** |
| Hospital Inpatient | 696 | 46% |
| ER/ED | 124 | 8% |
| Hospital Outpatient | 100 | 7% |
| **Health Care for the Homeless (HCH)** | ***299*** | ***20%*** |
| HCH Clinic | 276 | 18% |
| HCH Program (mental health, substance abuse, social work, case management) | 16 | 1% |
| HCH Outreach | 7 | <1% |
| **Non-HCH Clinics and Programs** | ***151*** | ***10%*** |
| Shelter | 45 | 3% |
| Other Program (mental health, substance abuse, social work, case management) | 40 | 3% |
| Other Clinic (non-HCH) | 36 | 2% |
| Transitional Program | 15 | 1% |
| Other Outreach | 8 | <1% |
| Drop-in Center | 7 | <1% |
| **Other** | ***128*** | ***8%*** |
| Self-referred | 71 | 5% |
| Other (unspecified) | 54 | 4% |
| Jail/Prison | 3 | <1% |
| **Unknown/No Response** | ***9*** | ***<1%*** |

Percents may not total 100 due to rounding.

Respite staff were asked at admission to estimate approximately how long they expected the client to stay in their program. Three-quarters (76%) of the estimates were for stays of two weeks or less. Two weeks was the most common expected length of stay – this was the estimate for 37% of the admissions. These estimates are consistent with overall program averages (see Program section, Table 1).

**Table 6**

| EXPECTED LENGTH OF STAY (N=1507) | | |
|---|---|---|
| | **Number** | **Percent** |
| 1-7 days | 523 | 35% |
| 8-14 days | 621 | 41% |
| 15-21 days | 75 | 5% |
| 22-28 days | 19 | 1% |
| 29 or more days | 164 | 11% |
| Unknown/No Response | 105 | 7% |

Percents may not total 100 due to rounding.

## C.4 CLIENTS' HEALTH AND TREATMENT HISTORY AT ADMISSION

### Health Status

Respite staff recorded the ICD-9 code associated with the primary diagnosis for each client, and for up to seven additional diagnoses. As Table 7 clearly illustrates, these clients were admitted into respite care with a wide variety of diagnoses. One-fifth (21%) of the primary diagnoses fell into the "Injury and Poisoning" category; the second most common category was "Diseases of the Skin and Subcutaneous Tissue" (18%).

The majority (n=1051 or 70%) of admissions had at least one additional diagnosis upon admission into respite; additional diagnoses numbered 2,403. The most common additional diagnoses fell into the Mental Disorders category (44%). Thus, although mental disorders were rarely the primary admitted diagnoses for clients, they comprise a significant complicating factor in their overall health and care.

The following comments by respite staff provide some examples of the complex medical and social needs their clients bring with them to their program. (Note: These comments have been edited slightly to ensure client confidentiality.)

**********

*"Client was in Respite to have his right thumb re-broken and set as it had been fractured and was not properly set. Client was referred to Respite by {the shelter} as he was unable to work, which is a requirement while in that setting."*

*"Patient was found in diabetic coma after being discharged from a shelter. He came to us via hospital. He'd been off all medications and had no coverage."*

*"Client was asked to leave before she came up on women's shelter wait list due to suspected heroin use and needles found all over her room. Her methadone treatment coverage had been cut several months earlier and she reports relapsing."*

*"Client has multiple medical issues (uncontrolled diabetes, cirrhosis, asthma, pancreatitis, foot ulcers and is on methadone for heroin dependence and was recently on antabuse for alcoholism. His MD suspects cognitive impairment."*

**********

**Table 7**

| ADMITTING DIAGNOSES (NUMBERS OF DIAGNOSES LISTED BY ICD-9 CODE CATEGORIES) | | | | |
|---|---|---|---|---|
| | Primary Diagnosis (N=1507) | | Additional Admitting Diagnoses (N=2403) | |
| | Number | Percent | Number | Percent |
| Injury and Poisoning | 316 | 21% | 90 | 4% |
| Diseases of the Skin and Subcutaneous Tissue | 276 | 18% | 58 | 2% |
| Diseases of the Respiratory System | 164 | 11% | 133 | 6% |
| Diseases of the Circulatory System | 132 | 9% | 257 | 11% |
| Diseases of the Digestive System | 103 | 7% | 187 | 8% |
| Diseases of the Musculoskeletal System and Connective Tissue | 90 | 6% | 82 | 3% |
| Persons Encountering Health Services in Other Circumstances | 80 | 5% | 26 | 1% |
| Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders | 62 | 4% | 167 | 7% |
| Infectious and Parasitic Diseases | 57 | 4% | 101 | 4% |
| Symptoms, Signs, and Ill-Defined Conditions | 44 | 3% | 101 | 4% |
| Mental Disorders | 39 | 3% | 1051 | 44% |
| Diseases of the Nervous System and Sense Organs | 37 | 2% | 33 | 1% |
| Diseases of the Genitourinary System | 34 | 2% | 28 | 1% |
| Neoplasms | 30 | 2% | 21 | 1% |
| Persons with a Condition Influencing Their Health Status | 11 | <1% | 5 | <1% |
| Persons Encountering Health Services for Specific Procedures and Aftercare | 10 | <1% | 5 | <1% |
| Diseases of the Blood and Blood-forming Organs | 6 | <1% | 35 | 1% |
| Congenital Anomalies | 6 | <1% | 5 | <1% |
| Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations | 5 | <1% | 0 | 0% |
| Persons with Need for Isolation, Other Potential Health Hazards and Prophylactic Measures | 2 | <1% | 4 | <1% |
| Persons with Potential Health Hazards Related to Personal and Family History | 2 | <1% | 2 | <1% |
| Accidental Falls | 1 | <1% | 0 | 0% |
| Complications of Pregnancy, Childbirth, and the Puerperium | 0 | 0% | 3 | <1% |
| Persons with Potential Health Hazards Related to Communicable Diseases | 0 | 0% | 9 | <1% |

Respite staff recorded the severity of each of these admitting diagnoses on a scale ranging from zero to four (scale is summarized in Table 8, below). Nearly two-thirds of the primary diagnoses were rated either as a 3 "Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring" (33%) or a 4 "Symptoms poorly controlled, history of re-hospitalizations" (30%) on the severity scale. Additional admitting diagnoses were most commonly rated a 2 "Symptoms controlled with difficulty – affecting daily functioning, patient needs ongoing monitoring," though 40% were rated even higher in severity.

Although the rating scale for severity of diagnoses is not technically comprised of levels equidistant from each other, a rough summary of severity (and changes in severity) was made by assigning numeric values and

calculating the mean. The mean rating of primary diagnoses was 2.9 at admission, and the mean ratings of additional diagnoses was 2.2.

**Table 8**

| ADMITTING DIAGNOSES - SEVERITY | | |
|---|---|---|
| | **Primary Diagnosis (N=1507)** | **Additional Admitting Diagnoses (N=2403)** |
| 4- Symptoms poorly controlled, history of re-hospitalizations | 30% | 14% |
| 3- Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring | 33% | 26% |
| 2- Symptoms controlled with difficulty – affecting daily functioning; patient needs ongoing monitoring | 28% | 35% |
| 1- Symptoms well controlled with current treatment | 7% | 22% |
| 0- Asymptomatic, no treatment needed at this time | 1% | 3% |
| Unknown | 1% | 1% |
| ***Mean Rating*** | ***2.9*** | ***2.2*** |

**Hospitalization and Treatment History**

Three-quarters (n=1155 or 77%) of the admissions had been to an Emergency Room or Emergency Department at least once in the prior 30 days (ranging from 1-15 visits). On average, these individuals had visited an Emergency unit at a hospital twice in the previous month.

A majority (n=915 or 60%) of admissions had been hospitalized at least one day during the month prior to their respite visit; the total number of hospitalization days ranged from 1 to 30 days. Of those who had spent time in the hospital, two-thirds spent one week or less, though the average number of days spent in the hospital was eight days.

For one-third (33%) of these admissions, clients had documented diagnoses of psychiatric problems, and two-fifths had documented alcohol (42%) and/or drug (40%) problems. Adding "suspected, but undiagnosed" problems for these admissions, though, raises these totals to half (51%) with psychiatric problems and three-fifths with alcohol (62%) and/or drug (56%) problems.

Nevertheless, just 16% of the clients admitted had reportedly ever been hospitalized for mental health reasons, and about one-quarter had received drug (25%) or alcohol (28%) treatment.

**Table 9**

| CLIENTS' HOSPITALIZATION AND TREATMENT HISTORY | | |
|---|---|---|
| | **Number** | **Percent** |
| ER/ED visits in last 30 days | **(N=1155)** | |
| Range | 1-15 visits | |
| Mean Number of Visits | 2 visits | |
| Days hospitalized last 30 days | **(N=915)** | |
| Range | 1-30 days | |
| Mean Number of Visits | 8 days | |
| **Psychiatric problems** | **(N=1507)** | |
| Documented diagnosis | 504 | 33% |
| Suspected – no diagnosis yet | 271 | 18% |
| No problem | 583 | 39% |
| Unknown/No Response | 149 | 10% |
| *Ever hospitalized for mental health (yes responses only)* | *234* | *16%* |
| **Alcohol problems** | | |
| Documented diagnosis | 632 | 42% |
| Suspected – no diagnosis yet | 298 | 20% |
| No problem | 457 | 30% |
| Unknown/No Response | 120 | 8% |
| *Ever in treatment for alcohol (yes responses only)* | *428* | *28%* |
| **Drug problems** | | |
| Documented diagnosis | 601 | 40% |
| Suspected – no diagnosis yet | 245 | 16% |
| No problem | 545 | 36% |
| Unknown/No Response | 116 | 8% |
| *Ever in treatment for drugs (yes responses only)* | *380* | *25%* |

Percents may not total 100 due to rounding.

### C.5 TREATMENT DURING RESPITE STAY

An additional 342 *new* diagnoses were made during the clients' stay in respite care; these were made for 210 or 14% of the admissions. On average, the severity rating for these new diagnoses was approximately a 2 rating (symptoms controlled with difficulty).

**Table 10**

| NEW DIAGNOSES MADE DURING RESPITE STAY (ICD-9 CODE CATEGORIES) (N=342) | | |
|---|---|---|
| | **Number** | **Percent** |
| Mental Disorders | 61 | 18% |
| Infectious and Parasitic Diseases | 54 | 16% |
| Symptoms, Signs, and Ill-Defined Conditions | 41 | 12% |
| Diseases of the Circulatory System | 33 | 10% |
| Diseases of the Digestive System | 29 | 8% |
| Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders | 23 | 7% |
| Diseases of the Blood and Blood-forming Organs | 18 | 5% |
| Diseases of the Nervous System and Sense Organs | 15 | 4% |
| Diseases of the Genitourinary System | 14 | 4% |
| Diseases of the Skin and Subcutaneous Tissue | 14 | 4% |
| Injury and Poisoning | 12 | 4% |
| Diseases of the Respiratory System | 11 | 3% |
| Diseases of the Musculoskeletal System and Connective Tissue | 8 | 2% |
| Persons with Potential Health Hazards Related to Communicable Diseases | 4 | 1% |
| Neoplasms | 2 | <1% |
| Complications of Pregnancy, Childbirth and the Puerperium | 1 | <1% |
| Persons with a Condition Influencing their Health Status | 1 | <1% |
| Persons Encountering Health Services in Other Circumstances | 1 | <1% |

Information about the number of medications used by clients during their respite stay was available for 1432 (95%) of the admissions. The number of medications prescribed and/or provided for clients during these admissions ranged from zero to 21, with a mean average of six medications per admission. One-quarter of these admissions involved three or four medications.

All respite clients received medical encounters from at least one type of medical professional during their stay – most commonly, they were in contact with Registered Nurses or Medical Assistants on-site. For example, 84% of the admissions involved encounters from a Registered Nurse during their stay, and 62% with a Medical Assistant. Encounters with Medical Doctors were more apt to occur off-site (67%) or by referral (37%) than on-site (22%). Future analyses of these data will use these encounter data to approximate care costs for respite clients in these programs.

Two-thirds (67%) of the admissions also involved encounter(s) with a case manager on-site. However, as is clear from Table 11, below, a wide variety of services could be provided to clients – generally on-site - including substance abuse services in individual or group settings, mental health counseling and services, dentist visits, and employment and education services. Substance abuse and mental health problems are prevalent, but because these are not the primary focus of the care, clients must be both physically health enough and willing to participate in encounters with professionals to address these.

**Table 11**

| ENCOUNTERS DURING RESPITE STAY (*Percentage of encounters per total admissions*) | | | |
|---|---|---|---|
| | **Where Encounter Occurred*** | | |
| | **On-Site** | **Off-Site** | **Referral** |
| **Medical Encounters** | | | |
| RN – Registered Nurse | 84% | 27% | 17% |
| Medical Assistant | 62% | 14% | <1% |
| NP/PA – Nurse Practitioner -Physicians' Assistant | 23% | 11% | 2% |
| MD – Medical Doctor | 22% | 67% | 37% |
| LPN – Licensed Practical Nurse | 8% | 1% | 0% |
| **Other Encounters** | | | |
| Case management | 67% | 6% | 5% |
| Substance abuse services – to individual | 11% | 1% | 1% |
| Dentist | 9% | 3% | 2% |
| Substance abuse services – to group | 8% | 3% | 1% |
| Employment/education | 8% | <1% | 1% |
| Mental health counseling - to individual | 5% | 3% | 2% |
| Hygienist | 2% | <1% | 0% |
| Mental health counseling – to group | 2% | 1% | <1% |
| Mental health services by Psychiatrist | 2% | 9% | 3% |
| Mental health services by Psychiatric Nurse Practitioner | 2% | 1% | 1% |
| Physical therapy | <1% | <1% | <1% |
| Nutritionist | 1% | <1% | <1% |

*On-Site: Service provided on-site or at a HCH clinic or at a parent clinic; Off-Site: Service provided off-site (at HCH clinic or affiliated clinic); Referral: Service provided through referral to an unrelated organization.

During the respite stay, staff also are often able to provide additional treatments for clients. For example, two-fifths (42%) of the admissions included prescriptions for narcotics; more than one-quarter included PPD tests placed (30%) and/or read (28%). Other clients received vaccines or tests for diseases.

**Table 12**

| ADDITIONAL TREATMENTS PROVIDED DURING RESPITE STAY (N=1507 ***Multiple Responses Accepted***) | | |
|---|---|---|
| | **Number** | **Percent** |
| Narcotics prescribed | 632 | 42% |
| PPD Test Placed | 446 | 30% |
| PPD Read | 420 | 28% |
| Pneumovax | 138 | 9% |
| TB Screen | 51 | 3% |
| Flu vaccine | 39 | 3% |
| Other vaccine | 34 | 2% |
| Hepatitis B vaccine | 24 | 2% |
| HIV Test | 23 | 2% |
| Oxygen | 14 | 1% |
| Hepatitis A vaccine | 13 | 1% |
| IV Therapy | 9 | <1% |

## C.6 STATUS COMPARISONS AT ADMISSION AND DISCHARGE

This section of the report provides some summary tables which compare health, health insurance, housing and income status between the time of admission and discharge, providing some indication of the general impacts these respite programs are having on clients' lives. It is important to bear in mind, when interpreting outcomes, the medical and social complexities these clients bring with them to these respite programs, and the fact that these programs are set up to affect health outcomes – all others are simply added benefits

### Diagnoses

Respite staff assessed the severity of the clients' primary admitting diagnosis at both admission and discharge. Table 13 illustrates the marked improvement in this diagnoses over the respite stay. While the primary diagnosis for 30% of the admissions was deemed to have poorly controlled symptoms and a history of re-hospitalizations, just 9% of them were rated this poorly at discharge. At the other end of the scale, just 8% of admitting diagnoses were rated as "symptoms well controlled with current treatment" or "asymptomatic" at admission, while these ratings were assigned the same diagnoses for nearly half (46%) at discharge. On average, the severity ratings dropped a full level on this scale from a 3 to a 2 between respite admission and discharge. It should be noted that these findings are presented for all admissions when possible, including those who left AWOL or prematurely against medical advice.

**Table 13**

| *COMPARISON: ADMISSION AND DISCHARGE*<br>PRIMARY DIAGNOSIS SEVERITY RATINGS<br>(N=1507) | | |
|---|---|---|
| | **At Admission** | **At Discharge** |
| 4- Symptoms poorly controlled, history of re-hospitalizations | 30% | 10% |
| 3- Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring | 33% | 20% |
| 2- Symptoms controlled with difficulty – affecting daily functioning; patient needs ongoing monitoring | 28% | 19% |
| 1- Symptoms well controlled with current treatment | 7% | 23% |
| 0- Asymptomatic, no treatment needed at this time | 1% | 9% |
| Unknown | 1% | 19% |
| ***Mean Rating*** | ***2.9*** | ***1.9*** |

Percents may not total 100 due to rounding.

**Health Care and Health Insurance**

The focus of these respite programs is not only to stabilize the physical health of clients, but also to enable them to better manage their health upon discharge. Key to the latter is respite staffs' desire to help clients acquire sources of primary care and health insurance resources whenever possible. During this evaluation, just one-third (34%) of clients had a regular source of primary care upon admission into the respite program, but by discharge one-half (49%) did. Improvements were also made in helping clients access health insurance resources – by discharge 28% had access to Medicaid (compared to 23% at admission), and 16% had access to a local or state health plan (compared to 12% at admission). More fundamentally, at admission 53% had no health insurance whatsoever, but by discharge this was the case for just 44% of the clients.

**Table 14**

| *COMPARISON: ADMISSION AND DISCHARGE*<br>SOURCE OF HEALTH CARE AND HEALTH INSURANCE<br>(N=1507) | | |
|---|---|---|
| | **At Admission** | **At Discharge** |
| **Health Care** | | |
| Has regular source of primary care (*yes responses only*) | 34% | 49% |
| Enrolled in managed care (*yes responses only*) | 4% | 5% |
| **Health Insurance** | ***Multiple Responses Accepted*** | |
| No insurance | 53% | 44% |
| Medicaid | 23% | 28% |
| Local or state plan | 12% | 16% |
| Medicare | 9% | 9% |
| VA Health Care | 7% | 7% |
| Private insurance | <1% | <1% |
| Other insurance | <1% | 2% |

*Other insurance includes workers compensation and pending applications for Medicaid.

**Housing**

Many of these admissions reflect improvements in housing status for clients. The most marked improvements include a drop in the percentage residing in hospitals (from 34% at admission to 8% at discharge), on the streets (13% at admission, 4% at discharge), or in doubled-up housing situations (11% admission, 6% discharge). While acquiring housing for clients is not a mandate of these respite programs, they are clearly enabling some to access improved housing situations. Housing status at discharge was unknown for one-third (32%) of clients; this compares to the proportion of clients who leave the program AWOL or by administrative discharge (see next section).

**Table 15**

| *COMPARISON: ADMISSION AND DISCHARGE*<br>HOUSING STATUS<br>(N=1507) | | |
|---|---|---|
| | **At Admission** | **At Discharge** |
| Hospital | 34% | 8% |
| Shelter | 23% | 29% |
| Street/camp | 13% | 4% |
| Doubled up/family or friends | 11% | 6% |
| Hotel/Motel | 4% | 2% |
| Treatment program | 3% | 6% |
| Own house/apartment – acquired housing | 2% | 5% |
| Vehicle | 2% | 0% |
| Prison/jail | 1% | 0% |
| Transitional housing | 1% | 3% |
| Nursing home | 0% | 1% |
| Other | 2% | 5% |
| Unknown/No Response | 2% | 32% |

Percents may not total 100 due to rounding.

**Income Source(s)**

Some clients left the program with income sources they did not have when they were admitted. For example, over half (53%) had no income sources when admitted to the respite program, but by discharge this fell to 44%. The largest improvement was in accessing food stamps for clients – at intake just 23% had access to food stamps, but by discharge this increased to 32%.

**Table 16**

| *COMPARISON: ADMISSION AND DISCHARGE*<br>INCOME SOURCE(S)<br>(N=1507 *Multiple Responses Accepted*) | | |
|---|---|---|
| | **At Admission** | **At Discharge** |
| None | 53% | 44% |
| Food stamps | 23% | 32% |
| SSI – Supplemental Security Income | 11% | 13% |
| General assistance/other public assistance | 11% | 14% |
| SSDI – Disability | 9% | 10% |
| VA financial benefits | 3% | 3% |
| SSA/Retired – Social Security | 2% | 2% |
| TANF (formerly AFDC or welfare) | <1% | <1% |
| Unemployment benefits | 1% | 1% |
| Workers compensation | <1% | <1% |
| Family/friends | <1% | 1% |
| Employed | 1% | 3% |
| Job training | <1% | 1% |
| Pension/Trust | <1% | <1% |
| Other income | 1% | 2% |
| Income unknown | 6% | 7% |

### C.7 EXITING THE RESPITE PROGRAM

Two-fifths (41%) of the clients admitted and discharged from these respite programs during this evaluation period left the program because they had completed their treatment. Sixteen percent of those admitted were discharged from the program for administrative reasons, such as failing to adhere to program rules and regulations. An additional quarter of the admissions ended their respite stay by leaving AWOL (15%) or prematurely against medical advice (9%). Eight percent of those admitted were discharged to the hospital for additional care.

**Table 17**

| REASON FOR EXIT (N=1507) | | |
|---|---|---|
| | **Number** | **Percent** |
| Completed treatment | 611 | 41% |
| Administrative discharge | 234 | 16% |
| AWOL | 219 | 15% |
| Left against medical advice | 142 | 9% |
| Admitted to hospital | 114 | 8% |
| Death | 3 | <1% |
| Other | 147 | 10% |
| Unknown/No Response | 37 | 2% |

Percents may not total 100 due to rounding.

Respite staff were asked to provide additional comments regarding their clients' discharge if they wished; see Appendix A.1 for a summary of some of those comments, organized according to the "reason for exit" category seen in Table 13. These comments are helpful in understanding some of the complexity behind discharge decisions, and in the successes achieved during respite stays. (Note: Comments have been edited to remove identifying information about any specific client.)

Respite clinical staff were also asked to note whether the discharged client may have received one or more of four general types of benefits (listed in Table 18, below). These responses are solely the clinicians' personal perceptions of how the client benefited from their experience in the respite program. These clinicians felt a majority (66%) of their respite clients had benefited from the restful environment their program provided, and/or from social interaction (55%) during their respite stay. They also noted that about half (48%) of the clients had learned to manage their health condition during their admission. Nearly one-tenth (8%), according to these clinicians, said their client had decided to enter some type of treatment program during their stay in the respite program.

The clinicians who made these assessments were primarily nurses (40%) or social workers/ counselors (29%). A few Nurse Practitioners (5%) and Physicians (<1%) responded, while the remainder (27%) did not identify their clinical discipline.

Table 18

| CLINICIAN ASSESSMENT OF PROGRAM'S GENERAL BENEFITS TO CLIENT (N=1507 *Yes Responses Only)* | | |
|---|---|---|
| | **Number** | **Percent "Yes"** |
| Benefited from respite environment | 995 | 66% |
| Benefited from social interaction | 831 | 55% |
| Learned to manage health condition | 722 | 48% |
| Decided to enter treatment program | 127 | 8% |

## C.8 CLIENTS NOT ADMITTED TO RESPITE PROGRAM

During each quarter, respite staff were asked to record some very general information about those clients who were referred to their respite programs but ended up not being admitted for some reason. The general information requested included: the date; the referral source; the medical reason for the referral; and the reason the client was not admitted. Though a template form was provided to programs for this purpose, programs which were already using different forms for the same purpose were allowed to use those to avoid duplicative effort. Though most of these data have been processed at the time of this report, preliminary analyses indicate that some of the larger programs, such as those in Seattle and Denver, are unable to admit half to two-thirds of the individuals referred to them.

# APPENDIX A.1
# RESPITE COORDINATORS' SELECTED COMMENTS

### DEFINITIONS OF A "SUCCESSFUL DISCHARGE"

*"A successful discharge would be well enough to return to previous housing situation. Stability to return – even if it's a shelter."*

*"Mostly I like [for them] to have a solid place to go when they leave, a line on benefits, a way to survive out there."*

*"Our first level of success happens medically. If they can manage whatever they came in with – even if going back to the street – that's still a success of sorts."*

*"The bottom line is we're trying to keep them from dying. Convince them that they're worth it – their health is worth taking care of."*

*"In the beginning I wanted everybody housed somewhere. Now my idea of a successful discharge is getting them back into the community to do what they were doing before the respite program. ...[I now perceive] respite... as a first step in building a relationship with them, and keeping them coming back for more."*

### COMMUNITY EDUCATION

*"We do education with shelter staff – around TB, HIV – around health issues, safety, destigmatizing the medical issues."*

*"Teaching staff in the shelters as far as hygiene needs, medication needs, preventive measures. It's really a challenge integrating an educational component into daily care."*

*"[I] would love to have the hospital staff come for a tour so they see the reality of where the clients will be staying."*

*"I would love to sit down with their staff, and to walk them through [our program]. That would help –their preconceived ideas of homelessness affect patient care."*

*"Having someone communicating regularly with the hospital discharge – with their staff turnover after relationships are developed – need to maintain ongoing contact, and that takes a lot of time."*

### CHANGING MODELS

*"I would consider the option of a free-standing respite facility. ...I would also consider providing 24 hour on-site medical staffing and admissions."*

*"Create beds for patients needing oxygen services ... and/or chronic care needs."*

*"Would continue same, but find ways to expand availability or services."*

*"We would move toward a free-standing facility with all beds in the same location."*

## REASONS FOR DISCHARGE

### Completed Treatment

*"Checked out as planned to live with friends until he can work again."*

*"Excellent stay - got primary care and psychiatric care - screened for TB & on INH treatment and smoking cessation."*

### Reasons for Discharge: Completed Treatment, *continued*

*"Client was given education, and girlfriend was referred for STD testing."*

*"Client ... was receiving food stamps while in Respite, which should continue for about 6 months (depending upon client's follow through). Client entered a housing program."*

*"Client went to a job program and is still at the shelter in a work bed at Salvation Army. Client - when he finishes the job program - can still stay at the shelter in a work bed and save his money to move. When he finishes the program he will have a job as a counselor."*

**Administrative Discharge**

*"Patient was reported by staff to be drinking alcohol over the weekend and left facility. Patient denied drinking, but admitted he left the facility and that he was aware that he was not allowed. Patient was not interested in calling .. to get into emergency housing."*

*"Client had an argument with another client in shelter while on Respite. Sent to hospital, case manager contacted for placement."*

*"Patient drank alcohol all weekend and was found on sidewalk Monday morning. 911 was called and patient was not welcomed back to the program.. Patient stated he would set up his own arrangements."*

*"Client was asked to leave when needles were found in her room. She reports relapsing after she lost coverage for her methadone maintenance program last Feb.'03. She was trying to become eligible again through some new grant monies but was physically sick."*

**Client Left AWOL**

*"Workman's Compensation was involved - they provided medical appointments and prescriptions, but not housing. Patient was last seen on Saturday - reportedly left the facility (which is not allowed) and never returned."*

*"Patient reported she had just gotten out of jail for soliciting and was chronically homeless because of drugs and alcohol. She stayed three nights in Assisted Living Facility and then left one night AWOL after she stole another residents car/SUV."*

*"Client left AWOL several times - each time he went to the hospital. He needs a long term drug treatment program.*

*Client did not want to leave Respite Care at this time. He left family environment because of drug and alcohol abuse. Referred client to Salvation Army treatment program; he left and returned to the family instead."*

**Left Against Medical Advice (AMA)**

*"Client was already in a treatment program, but because of illness the director of the shelter thought he would be harmful to other clients and discharged him. Documentation from the hospital said they would allow him to return to the treatment program."*

*"Client left against medical advice, whereabouts unknown. He was gone for one week and when he returned he entered the substance abuse treatment program."*

*"Client left Respite Care, against medical advice; two weeks later he returned and went into a substance abuse treatment program."*

*"We were able to pull together medical records of different providers. We have offered primary care to this client and provided health teaching and medications."*

**Other**

*"When patient was medically cleared and I offered to help get him into a shelter, he refused and stated he would not go to a shelter and would make his own arrangements..."*

*"Patient was a very depressed lady who reported hearing voices. I had had her before a year ago and when she was medically cleared got her into a shelter - which she left AWOL 3 weeks later."*

*"Client was able to obtain housing through a social service agency that works with folks who are HIV+, even though he's undocumented and without health insurance coverage."*

# APPENDIX A.2
# CONSENT FORM AND PROCEDURES

**CLIENT ID:**_____

## CONSENT TO PARTICIPATE

**THE PURPOSE:** Several of the respite programs like this one throughout the country are being evaluated by one of their funders, the Bureau of Primary Health Care. They would like to use the information we collect about you and the care you receive while you are here to help them improve respite programs like this one. Your name will not be connected to any of the information collected.

**WHAT WE ASK OF YOU:** If you agree to let them use the information about you, we will ask you to sign this form.

**PRIVACY AND CONFIDENTIALITY:** Your name will not be attached to any of the information we provide to the evaluators. They will have no way of knowing anything about you personally.

**YOUR CHOICE:** It is entirely up to you whether you want to have your information shared. It is VOLUNTARY. If you decide you do not want your information shared, it will not affect your relationship with this program or prevent you from receiving any of the services you need.

**RISK AND BENEFITS:** We do not know of any risk to you for agreeing to let us share your information. Again, your name will nto be attached to any information sent to the evaluators. If you agree, they will use the information to improve the services other people like you will receive.

**CERTIFICATE OF CONFIDENTIALITY:** The researchers have obtained a Certificate of Confidentiality from the Federal Government while will help protect your privacy by refusing to disclose personally-identifying information about you to people who are not connected with the study except if you request disclosure. This protection, however, does not prohibit the investigator from voluntarily reporting information. For example, if they have strong reason to believe you are abusing a child or elderly person, or you have made credible threat s of violence to others, they may report it to proper authorities.

**SIGNATURE OF SUBJECT**

BY SIGNING THIS FORM, I WILLINGLY AGREE TO LET THE PROGRAM USE MY INFORMATION FOR THIS EVALUATION.

_____
Name of Subject

_____ _____
Signature of Subject Date

**SIGNATURE OF RESPITE COORDINATOR**

I have explained the evaluation to the subject, and answered all of his/her questions. I believe that he/she understands the information described in this document and freely consents to participate.

_____
Name of Respite Coordinator or Respite Staff

_____ _____
Signature of Respite Coordinator or Respite Staff Date

# CONSENT PROCEDURES

The following protocol must be followed when obtaining client consent to participate in the Respite Pilot Initiative Evaluation.

- Regardless of whether the respite program has two separate consent forms or one consolidated consent form, the respite client must be counseled separately for the evaluation, and provide a signature for consenting specifically to the evaluation. The client must sign the consent form specifically granting permission to use his/her data as part of the evaluation.

- Each section of the evaluation consent document must be reviewed with the patient before the client signs and the respite staff member must attest in writing that he/she believes that the client understands the information described in the document and freely consents.

- The respite coordinator must write the client ID (which matches the name of the client signing the document) in the top right-hand corner of the consent document.

- Once the consent document has been signed by the client *and* the correct client ID written in the top right-hand corner, the respite coordinator should photocopy the consent document.

    - The *original*, signed consent document should be placed in a central location at the respite site and locked.

    - The signature on the *photocopy* consent document should be blacked out with a marker until it is unreadable. Please ensure the client ID is completely legible. These photocopied consent documents should be collected and sent in at the end of the quarter with the matching client data from the database. The respite coordinator will ensure that only data from clients who have agreed to participate in the study are sent to the evaluators.

Special Note on the Certificate of Confidentiality:

If at any time you are approached by someone trying to obtain protected data, we would ask that you notify the following individuals:

**Amy M. Taylor**
Acting Principal Program Manager
Division of Clinical Quality
Bureau of Primary Health Care
Health Resources and Services Administration
4350 East West Highway
Bethesda, MD 20814
Phone: 301-594-4455

**John Lozier**
Executive Director
National Health Care for the Homeless Council
1715 Greenwood
Nashville, TN 37206
Phone: 615-226-2292

This of course does not preclude you from consulting your own legal staff as well.

## APPENDIX A.3
## CLIENT DATABASE (PAPER FORM)

# HCH RESPITE PILOT INITIATIVE

FUNDED BY THE BUREAU OF PRIMARY HEALTH CARE

# Client Data

# Paper Copy of Database

PLEASE COMPLETE:

**Pilot ID** _____

**(1=Bakersfield; 2=Dayton; 3=Denver; 4=Ft. Lauderdale; 5=NYC; 6=Portland ME; 7=Portland OR; 8=Salt Lake City; 9=Seattle; 10=St. Louis)**

**Client ID** _____

**Respite Admission #** _____
*(e.g. 1st, 2nd, 3rd…)*

**Respite Admission Date** _____/_____/_____
*(Date of this admission)*

**Respite Discharge Date** _____/_____/_____
*(Date of exit from program)*

**Person Completing this Data Form**_____

## Client Information

NOTE: BOLD LETTERING INDICATES QUESTION SHOULD BE ASKED VERBATIM.

DATE OF BIRTH: **What is Your Date of Birth? ____/____/____**

GENDER: **Are you male, female, or transgender?** *(Read if necessary: A transgendered person is someone who was born one sex but who lives as the other.)* (✓ one)

- ☐ **MALE**
- ☐ **FEMALE**
- ☐ **TRANSGENDER**
- ☐ **UNKNOWN**

**Education:** WHAT IS THE HIGHEST LEVEL OF SCHOOL YOU HAVE COMPLETED OR THE HIGHEST DEGREE YOU HAVE RECEIVED**? (✓ ONE)**

- ☐ **<12 GRADE**
- ☐ **HIGH SCHOOL GRADUATE/GED**
- ☐ **VOCATIONAL/TECHNICAL SCHOOLING**
- ☐ **SOME COLLEGE**
- ☐ **COLLEGE GRADUATE**
- ☐ **SOME GRADUATE SCHOOL**
- ☐ **OTHER**
- ☐ **UNKNOWN**

**Ethnicity:** ARE YOU HISPANIC, SPANISH, OR LATINO? **(✓ ONE)**

- ☐ **NO**
- ☐ **MEXICAN/MEXICAN AMERICAN/CHICANO**
- ☐ **PUERTO RICAN**
- ☐ **CUBAN**
- ☐ **OTHER**

**Race:** WHAT DO YOU CONSIDER TO BE YOUR RACE? **(✓ ALL THAT APPLY)**

- ☐ **BLACK OR AFRICAN AMERICAN**
- ☐ **WHITE**
- ☐ **AMERICAN INDIAN OR ALASKA NATIVE**
- ☐ **ASIAN**
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**

**Country of Origin:** IN WHAT COUNTRY WERE YOU BORN? **(✓ ONE)**

- ☐ **UNITED STATES**
- ☐ **AFRICA**
- ☐ **CAMBODIA**
- ☐ **CANADA**
- ☐ **CENTRAL AMERICA**
- ☐ **CUBA**
- ☐ **DOMINICAN REPUBLIC**
- ☐ **EASTERN EUROPE**
- ☐ **HAITI**
- ☐ **JAMAICA**
- ☐ **MIDDLE EAST**
- ☐ **MEXICO**
- ☐ **PUERTO RICO**
- ☐ **RUSSIA**
- ☐ **SOUTH AMERICA**
- ☐ **VIETNAM**
- ☐ **OTHER ASIA**
- ☐ **WESTERN EUROPE**
- ☐ **OTHER**
- ☐ **UNKNOWN**

**Refugee:** DO YOU HAVE OFFICIAL STATUS AS A REFUGEE OR HAVE AN APPLICATION PENDING? **(✓ ONE)**

- ☐ **YES**
- ☐ **NO**
- ☐ **UNKNOWN**

**Migrant/Seasonal Worker:** ARE YOU A MIGRANT OR SEASONAL FARMWORKER OR AGRIBUSINESS WORKER? **(✓ ONE)**

- ☐ **YES**
- ☐ **NO**
- ☐ **UNKNOWN**

**Interpreter Language:** WHAT IS YOUR NATIVE LANGUAGE? _____

**Interpreter Needed?:** WOULD YOU LIKE A LANGUAGE INTERPRETER DURING YOUR STAY HERE?

- ☐ **YES**
- ☐ **NO**
- ☐ **UNKNOWN**

**Veteran Status:** ARE YOU NOW OR HAVE YOU EVER BEEN ON ACTIVE-DUTY MILITARY SERVICE IN THE ARMED FORCES OF THE UNITED STATES OR EVER BEEN IN THE UNITED STATES MILITARY RESERVES OR THE NATIONAL GUARD? ***(NOTE: ACTIVE DUTY IN MILITARY SERVICE DOES NOT INCLUDE TRAINING IN THE RESERVES OR NATIONAL GUARD)***

- ☐ **YES**
- ☐ **NO**
- ☐ **DON'T KNOW/REFUSED**

**Military Service Status:** IF DISCHARGED FROM MILITARY SERVICE, DID YOU RECEIVE AN HONORABLE DISCHARGE?
**(✓ ONE)**

- ☐ **YES**
- ☐ **NO**
- ☐ **DON'T KNOW/REFUSED**

**If Veteran, Era Served:** ***(IF YES TO VETERAN STATUS)*** DURING WHAT TIME PERIOD WERE YOU A VET? **(✓ ONE)**

- ☐ **PEACETIME**
- ☐ **GULF WAR**
- ☐ **VIETNAM ERA**
- ☐ **KOREAN WAR**
- ☐ **WWII**

**If Veteran, Served "In-Country?:** ***(IF YES TO VETERAN STATUS)*** DID YOU EVER SERVE IN THE COUNTRY WHERE THE CONFLICT OCCURRED? **(✓ ONE)**

- ☐ **YES**
- ☐ **NO**
- ☐ **UNKNOWN**

**Age When First Homeless:** HOW OLD WERE YOU WHEN YOU FIRST BECAME HOMELESS?

_____

**Location when 1st Homeless:** WHERE DID YOU LIVE WHEN YOU FIRST BECAME HOMELESS? **(✓ ONE)**

- ☐ **THIS CITY**
- ☐ **THIS STATE – ANOTHER CITY**
- ☐ **OTHER STATE**
- ☐ **OTHER COUNTRY**
- ☐ **UNKNOWN**

**No. of Times Homeless:** HOW MANY TIMES HAVE YOU BEEN HOMELESS?

_____

**Times Homeless this Episode:** HOW LONG (IN MONTHS) WERE YOU HOMELESS BEFORE COMING HERE? **(✓ ONE)**

- ☐ **<1 MONTH**
- ☐ **1-6 MONTHS**
- ☐ **7-11 MONTHS**
- ☐ **1-3 YEARS**
- ☐ **>3 YEARS**

## Admission

**Referral Source:** ***(WHERE CLIENT WAS REFERRED FROM)*** **(✓ ONE)**

- ☐ **ER/ED**
- ☐ **HOSPITAL INPATIENT**
- ☐ **HOSPITAL OUTPATIENT**
- ☐ **HCH CLINIC**
- ☐ **HCH OUTREACH**
- ☐ **HCH MH/SA/SW/CM**
- ☐ **OTHER CLINIC**
- ☐ **OTHER OUTREACH**
- ☐ **OTHER SA/MH/SW/CM**
- ☐ **TRANSITIONAL PROGRAM**
- ☐ **TREATMENT PROGRAM**
- ☐ **SELF-REFERRED**
- ☐ **SHELTER**
- ☐ **DROP-IN CENTER**
- ☐ **SOUP KITCHEN**
- ☐ **JAIL/PRISON**
- ☐ **POLICE**
- ☐ **OTHER**
- ☐ **UNKNOWN**

**Meds Supplied with Referral:** ***(CLIENT ARRIVED WITH MEDICATION SUPPLY – ✓BOX IF YES)*** ☐

**Expected Length of Stay in Respite (*NUMBER OF DAYS CLIENT IS EXPECTED TO BE IN RESPITE PROGRAM)***

_____

**Housing Status:** WHERE DID YOU SLEEP LAST NIGHT? **(✓ ONE)**

- ☐ **ABANDONED BUILDING**
- ☐ **DOUBLED UP**
- ☐ **HOSPITAL**
- ☐ **HOTEL/MOTEL**
- ☐ **OWN HOUSE/APARTMENT**
- ☐ **PRISON/JAIL**
- ☐ **SHELTER**
- ☐ **STREET/CAMP**
- ☐ **TRANSITIONAL HOUSING**
- ☐ **TREATMENT PROGRAM**
- ☐ **VEHICLE**
- ☐ **OTHER**
- ☐ **UNKNOWN**

**Family Status:** ARE YOU NOW: MARRIED, WIDOWED, DIVORCED, SEPARATED, NEVER MARRIED, OR LIVING WITH A PARTNER? **(✓ ONE)**

- ☐ **MARRIED**
- ☐ **WIDOWED**
- ☐ **DIVORCED**
- ☐ **SEPARATED**
- ☐ **NEVER MARRIED**
- ☐ **LIVING WITH A PARTNER**
- ☐ **NO RESPONSE**

**Accompanied:** ***(WAS CLIENT ACCOMPANIED IN THE RESPITE PROGRAM WITH ANY FAMILY MEMBERS)?*** **(✓ ONE)**

- ☐ **ALONE**
- ☐ **WITH PARTNER**
- ☐ **WITH CHILD(REN)**
- ☐ **WITH PARTNER AND CHILD(REN)**
- ☐ **NO RESPONSE**

**ER/ED Visits Last 30 Days:** ***(HOW MANY TIMES HAS CLIENT USED ER/ED IN THE LAST 30 DAYS?)***

_____ **TIMES**

**Days Hospitalized Last 30 Days:** ***(HOW MANY DAYS HAS CLIENT SPENT HOSPITALIZED IN THE LAST 30 DAYS?)***

_____ **DAYS**

**Psych:** ***(DOES CLIENT HAVE ANY PSYCHIATRIC PROBLEMS?)*** **(✓ ONE)**

- ☐ **DOCUMENTED DX**
- ☐ **SUSPECTED – NO DX YET**
- ☐ **NO PROBLEM**
- ☐ **UNKNOWN**

**Ever Hospitalized for MH:** ***(WAS THE CLIENT EVER HOSPITALIZED FOR A PSYCHIATRIC PROBLEM?)***

***✓BOX IF YES)*** ☐

**Alcohol:** ***(DOES CLIENT HAVE A CURRENT ALCOHOL PROBLEM?)*** **(✓ ONE)**

- ☐ **DOCUMENTED DX**
- ☐ **SUSPECTED – NO DX YET**
- ☐ **NO PROBLEM**
- ☐ **UNKNOWN**

**Ever in TX for Alcohol:** ***(WAS THE CLIENT EVER IN A TREATMENT PROGRAM FOR AN ALCOHOL PROBLEM?)***

***✓BOX IF YES*** ☐

**Drugs:** ***(DOES CLIENT HAVE A CURRENT DRUG PROBLEM?)*** **(✓ ONE)**

- ☐ **DOCUMENTED DX**
- ☐ **SUSPECTED – NO DX YET**
- ☐ **NO PROBLEM**
- ☐ **UNKNOWN**

**Ever in TX for Drugs:** ***(WAS THE CLIENT EVER IN A TREATMENT PROGRAM FOR A DRUG ADDICTION?)***

***✓BOX IF YES*** ☐

# Discharge

**Reason for Exit:** ***(REASON FOR EXIT FROM PROGRAM)*** **(✓ ONE)**

- ☐ **COMPLETED TREATMENT**
- ☐ **ADMIN. DISCHARGE**
- ☐ **LEFT AMA**
- ☐ **AWOL**
- ☐ **ADMITTED TO HOSPITAL**
- ☐ **DEATH**
- ☐ **OTHER**
- ☐ **UNKNOWN**

**Housing Status:** ***(HOUSING STATUS AT TIME OF EXIT)*** **(✓ ONE)**

- ☐ **ACQUIRED HOUSING**
- ☐ **TRANSITIONAL PROGRAM**
- ☐ **FRIENDS OR FAMILY**
- ☐ **HOTEL/MOTEL**
- ☐ **HOSPITAL**
- ☐ **NURSING HOME**
- ☐ **SHELTER**
- ☐ **ENTERED TX PROGRAM**
- ☐ **STREET**
- ☐ **OTHER**
- ☐ **UNKNOWN**

**Clinician Assessment of Program's General Benefits to Client**

***(PLEASE ✓ONE: :*** **☐ PHYSICIAN ☐NURSE ☐SOCIAL WORKER/COUNSELOR)**

**(✓ ALL THAT APPLY)**

- ☐ **LEARNED TO MANAGE HEALTH CONDITION(S)** ***(LEARNED TO MANAGE HEALTH CONDITION(S) – "SELF-CARE")***
- ☐ **BENEFITED FROM SOCIAL INTERACTION** ***(CLIENT BENEFITED FROM SOCIAL INTERACTION WITH STAFF AND/OR OTHER CLIENTS)***
- ☐ **BENEFITED FROM RESPITE ENVIRONMENT** ***(CLIENT BENEFITED FROM THE RESPITE ENVIRONMENT (NUTRITION, SAFETY, SECURITY, ETC.)***
- ☐ **DECIDED TO ENTER TX PROGRAM** ***(CLIENT MADE DECISION TO ENTER RESIDENTIAL TX PROGRAM FOR SUBSTANCE ABUSE)***

**Comments**: ***(ADDITIONAL COMMENTS REGARDING HOW CLIENT HAS BENEFITED)***

## Severity Ratings

| | ICD 9 Codes | Severity Rating** | |
|---|---|---|---|
| | | At Admission | At Discharge |
| PRIMARY ADMITTING DX | | | |
| PRIMARY DISCHARGE DX | | | |
| **Additional known diagnoses or pre-existing conditions, include both medical and psychiatric** | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **NEW diagnoses made during respite stay, include both medical and psychiatric** | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

** Codes for all Severity ratings and Status reporting are as follows:

0 – asymptomatic, no tx needed,
1-Sx well controlled with current tx
2-Sx controlled with difficulty – must monitor
3-Sx poorly controlled – frequent tx/rx adjustment
4-Sx poorly controlled – hx of rehospitalization

| Source of Health Care | | |
|---|---|---|
| | At Admission | At Discharge |
| **Enrolled in managed care** *(Health care – of whatever source – provided through managed care plan at time of admission and discharge)* | ☐ | ☐ |
| *Has regular source of primary care* *(Client has regular source of primary care established at time of admission and discharge)* | ☐ | ☐ |

| Source of Health Insurance | | |
|---|---|---|
| | At Admission | At Discharge |
| | | |
| **No insurance** | ☐ | ☐ |
| **Medicaid** | ☐ | ☐ |
| **Medicare** | ☐ | ☐ |
| **Other public plan** *(has insurance through a local/state-financed plan)* | ☐ | ☐ |
| **VA** | ☐ | ☐ |
| **Private Insurance** | ☐ | ☐ |
| **Other (please specify:** _____ _____ | ☐ | ☐ |

| Sources of Income | | |
|---|---|---|
| | At Admission | At Discharge |
| **None** | ☐ | ☐ |
| **SSI** – *Supplemental Security Income* | ☐ | ☐ |
| **SSDI** - *Disability* | ☐ | ☐ |
| **SSA/Retired** *(receiving social security - retired)* | ☐ | ☐ |
| **General assistance/other public assistance** | ☐ | ☐ |
| **TANF (***Temporary Aid to Needy Families, formerly AFDC, aka welfare)* | ☐ | ☐ |
| **Food stamps** | ☐ | ☐ |
| **Family/friends** | ☐ | ☐ |
| **VA benefits** | ☐ | ☐ |
| **Pension/trust** | ☐ | ☐ |
| **Child support** | ☐ | ☐ |
| **Unemployment** | ☐ | ☐ |
| **Workers comp** | ☐ | ☐ |
| **Employed** | ☐ | ☐ |
| **Student** | ☐ | ☐ |
| **Job training** | ☐ | ☐ |

| NUMBER OF *MEDICAL* ENCOUNTERS DURING STAY | | | |
|---|---|---|---|
| **Medical services provided by…** | **On-Site** | **Off-Site** | **Referral** |
| **MD** (*Medical Doctor)* | ☐ | ☐ | ☐ |
| **NP/PA** (*Nurse Practitioner/Physicians' Assistant)* | ☐ | ☐ | ☐ |
| **RN** *(Registered Nurse)* | ☐ | ☐ | ☐ |
| **LPN** *(Licensed Practical Nurse)* | ☐ | ☐ | ☐ |
| **Med Asst** *(Medical Assistant)* | ☐ | ☐ | ☐ |

*** On-Site**: service provided on-site or at HCH clinic or at parent clinic; **Off-Site**: service provided off-site (at HCH clinic or affiliated clinic); **Referral**: service provided through referral to unrelated organization

| NUMBER OF *OTHER* ENCOUNTERS DURING STAY | | | |
|---|---|---|---|
| **Medical services provided by…** | **On-Site** | **Off-Site** | **Referral** |
| **Dentist** | ☐ | ☐ | ☐ |
| **Hygienist** *(Dental care provided by hygienist)* | ☐ | ☐ | ☐ |
| **Med detox** *(Medical detox provided)* | ☐ | ☐ | ☐ |
| **Non-med detox** *(Non-medical or social detox provided)* | ☐ | ☐ | ☐ |
| **SA-individual** *(Substance abuse services provided to individual*) | ☐ | ☐ | ☐ |
| **SA-group** *(Substance abuse services provided in group)* | ☐ | ☐ | ☐ |
| **MH-MD** *(Mental health services provided by psychiatrist)* | ☐ | ☐ | ☐ |
| **MH-psych NP** *(Mental health services provided by psychiatric nurse practitioner)* | ☐ | ☐ | ☐ |
| **MH-counseling** *(Mental health services provided individually)* | ☐ | ☐ | ☐ |
| **MH-group** (*Mental health services provided in group)* | ☐ | ☐ | ☐ |
| **Case mgmt** *(Case management or social services encounters)* | ☐ | ☐ | ☐ |
| **Physical therapy** | ☐ | ☐ | ☐ |
| **Job/Educ** *(Employment or education services provided)* | ☐ | ☐ | ☐ |

*** On-Site**: service provided on-site or at HCH clinic or at parent clinic; **Off-Site**: service provided off-site (at HCH clinic or affiliated clinic); **Referral**: service provided through referral to unrelated organization

# OF MEDICATIONS PRESCRIBED AND PROVIDED DURING RESPITE STAY _____

TREATMENTS PROVIDED DURING STAY (✓ all that apply)

- ☐ Narcotics
- ☐ Oxygen
- ☐ PPD Test Placed
- ☐ PD Read
- ☐ HIV Test
- ☐ Hep B Vaccine
- ☐ Hep A Vaccine
- ☐ Flu Vaccine
- ☐ Pneumovax
- ☐ Other immunizations updated

# APPENDIX A.4
# PROGRAM SURVEY

**HCH RESPITE PILOT INITIATIVE**
FUNDED BY THE BUREAU OF PRIMARY HEALTH CARE

# PROGRAM SURVEY
# FOR RESPITE COORDINATORS

Thank you in advance for your help in completing this survey. If you have any questions, please call Suzanne Zerger, National health Care for the Homeless Research Specialist, at 416.656.0780.

PLEASE COMPLETE:

Date Survey Completed (MM/DD/YY): __ __ / __ __ / __ __

Name of Respondent:_____

Respite Program Name: _____

City, State:_____

## SECTION A: ORGANIZATIONAL STRUCTURE

A1) Is the HCH grantee organization a (*Check One*)

- ❑ Community Health Center (CHC)
- ❑ Public Health Department
- ❑ Coalition
- ❑ Free-standing non-profit organization
- ❑ Hospital

A2) When did your program begin providing (any) respite services to homeless persons?

_____/ _____
Month Year

A3) When did your program actually begin implementing expanded respite services resulting from your Bureau of Primary Health Care grant?

_____/ _____
Month Year

## SECTION B: FACILITY

B1) Which of the following best describes the facility location? *(Check All That Apply)*

- ❑ Free-standing facility
- ❑ Shelter
- ❑ Motels
- ❑ Nursing homes
- ❑ Assisted living facility
- ❑ Substance abuse treatment program
- ❑ Other *(Specify:_____)*

B2) How many beds do you currently have available for clients requiring respite care? (If you do not have a consistent number, please indicate the maximum number of beds available for respite care.)

_____
*Total/Maximum # of beds available*

B3) In your respite care facility(ies), do you have: *(Check All That Apply)*

- ❑ Private rooms for respite clients (no roommates)
- ❑ Shared rooms for clients (roommates), including dormitory-style accommodations such as shelters
- ❑ Beds/accommodations for client's family members

B4) Please indicate which types of rooms you have in your respite program facility(ies) and/or available for you respite clients' use. *(Check All That Apply)*

- ❑ Kitchen (area and facilities for food preparation)
- ❑ Dining space/cafeteria
- ❑ Lounge/recreation area
- ❑ Storage facilities (general)
- ❑ Pharmacy/Medication storage
- ❑ Administrative offices
- ❑ Examination rooms *(How Many? _____)*
- ❑ Dental operatory
- ❑ Eye care
- ❑ Private counseling space
- ❑ Other *(Specify:_____)*

B5) Is/are your facility(ies) accessible to physically disabled persons? (i.e. bathrooms, elevators)

- ❑ Yes
- ❑ No
- ❑ Partially *(Please Explain:_____)*

## SECTION C: STAFFING

C1) For each of the following types of employees, please list the number of FTEs for each and indicate whether they are an employee with your HCH respite program, a contract employee, or an unpaid employee (through a volunteer or collaborative arrangement).

| | **Number of Full-Time Equivalents (FTEs)** | **HCH Respite Program Employee (✓ if Yes)** | **Contract Employee (✓ if Yes)** | **Unpaid (Volunteer or Collaboration) (✓ if Yes)** |
|---|---|---|---|---|
| Respite Program Director or Coordinator | | ❑ | ❑ | ❑ |
| Physician/MD or DO | | ❑ | ❑ | ❑ |
| Nurse Practitioner (NP) | | ❑ | ❑ | ❑ |
| Physician's Assistant (PA) | | ❑ | ❑ | ❑ |
| Registered Nurse (RN) | | ❑ | ❑ | ❑ |
| Licensed Practical Nurse (LPN) | | ❑ | ❑ | ❑ |
| Nursing Assistants/Nurses Aides | | ❑ | ❑ | ❑ |
| Medical Assistant | | ❑ | ❑ | ❑ |
| Nutritionists | | ❑ | ❑ | ❑ |
| Social Worker (BSW) | | ❑ | ❑ | ❑ |
| Social Worker (MSW) | | ❑ | ❑ | ❑ |
| Case Manager | | ❑ | ❑ | ❑ |
| Substance Abuse Counselor | | ❑ | ❑ | ❑ |
| Mental Health Counselor | | ❑ | ❑ | ❑ |
| Psychiatrist | | ❑ | ❑ | ❑ |
| Psychiatric Nurse | | ❑ | ❑ | ❑ |
| Psychiatric Nurse Practitioner | | ❑ | ❑ | ❑ |
| Home Health Aides | | ❑ | ❑ | ❑ |
| Receptionist/Secretary/Clerk | | ❑ | ❑ | ❑ |
| Cook | | ❑ | ❑ | ❑ |
| Driver | | ❑ | ❑ | ❑ |
| Cleaning staff/Janitorial | | ❑ | ❑ | ❑ |
| Other? *(Specify:* | | ❑ | ❑ | ❑ |

C2) Are any of these combined positions (If so, which ones)? (e.g. coordinator also works part-time as respite nurse)

C3) What type of staff is on-site 24 hours per day/7 days per week?

C4) During times when no medical providers are on-site to serve your respite clients, which of the following best describes your "emergency back-up" plan?

- ❑ Medical staff available on-call (Specify type of staff:
- ❑ Other arrangements (specify:
- ❑ Not applicable-we have medical providers available on-site to respite clients 24 hours per day/7 days per week

C5) What do you consider the biggest challenge(s) you face with your staff?

## SECTION D: SERVICES

D1) Please check (✓) where your respite clients can access the following services. If the service is not available through your respite program – either by referral or affiliation – please check the box indicating that the service is not available for your respite clients.

| | WHERE SERVICES ARE AVAILABLE * | | | |
|---|---|---|---|---|
| | ON-SITE | OFF-SITE | REFERRAL | SERVICE NOT AVAILABLE FOR RESPITE CLIENTS |
| ** **NOTE**: **On-Site**: service provided on-site or at HCH clinic or at parent clinic; **Off-Site**: service provided off-site (at HCH clinic or affiliated clinic); **Referral**: service provided through referral to unrelated organization.* | | | | |
| Medical services – MD | ❑ | ❑ | ❑ | ❑ |
| Medical services-nursing | ❑ | ❑ | ❑ | ❑ |
| Dental services | ❑ | ❑ | ❑ | ❑ |
| Case management | ❑ | ❑ | ❑ | ❑ |
| Housing placement | ❑ | ❑ | ❑ | ❑ |
| Job services | ❑ | ❑ | ❑ | ❑ |
| Health education/promotion | ❑ | ❑ | ❑ | ❑ |
| Education | ❑ | ❑ | ❑ | ❑ |
| Discharge planning | ❑ | ❑ | ❑ | ❑ |
| Entitlements counseling | ❑ | ❑ | ❑ | ❑ |
| Medical de-tox | ❑ | ❑ | ❑ | ❑ |
| Non-medical de-tox | ❑ | ❑ | ❑ | ❑ |
| Substance abuse treatment | ❑ | ❑ | ❑ | ❑ |
| Mental health services | ❑ | ❑ | ❑ | ❑ |
| Counseling (general) | ❑ | ❑ | ❑ | ❑ |
| Spiritual – *describe*:_____ | ❑ | ❑ | ❑ | ❑ |
| Recreation – *describe*:_____ | ❑ | ❑ | ❑ | ❑ |
| Cardiology | ❑ | ❑ | ❑ | ❑ |
| | WHERE SERVICES ARE AVAILABLE * | | | |

| | ON-SITE | OFF-SITE | REFERRAL | SERVICE NOT AVAILABLE FOR RESPITE CLIENTS |
|---|---|---|---|---|
| ** **NOTE**: **On-Site**: service provided on-site or at HCH clinic or at parent clinic; **Off-Site**: service provided off-site (at HCH clinic or affiliated clinic); **Referral**: service provided through referral to unrelated organization.* | | | | |
| Dermatology | ❑ | ❑ | ❑ | ❑ |
| Infectious Disease specialist | ❑ | ❑ | ❑ | ❑ |
| IV | ❑ | ❑ | ❑ | ❑ |
| Supplemental oxygen | ❑ | ❑ | ❑ | ❑ |
| Vision | ❑ | ❑ | ❑ | ❑ |
| Podiatry | ❑ | ❑ | ❑ | ❑ |
| Other – *Specify*:_____ | ❑ | ❑ | ❑ | ❑ |
| **ENABLING SERVICES** | ❑ | ❑ | ❑ | ❑ |
| Transportation | ❑ | ❑ | ❑ | ❑ |
| Food services | ❑ | ❑ | ❑ | ❑ |
| Laundry | ❑ | ❑ | ❑ | ❑ |
| Interpreter | ❑ | ❑ | ❑ | ❑ |
| Security | ❑ | ❑ | ❑ | ❑ |
| Janitorial/cleaning | ❑ | ❑ | ❑ | ❑ |

## SECTION E: ADMISSION CRITERIA AND POLICIES

*(Note: If you have written admission criteria, please attach to this survey.)*

E1) Understanding that admission criteria must be somewhat flexible, given the complexity of clients' needs and the availability of resources at a given time, please indicate which of the following criteria your program uses ***always*** or ***almost always*** in the intake process.

*Clients admitted to our respite program must (please check all that apply):*

- ❑ Be currently homeless (according to the federal definition)
- ❑ Be an adult (18 years or older)
- ❑ Be male
- ❑ Be female
- ❑ Be alone (no family members allowed)
- ❑ Be able to administer their own medications
- ❑ Be ambulatory
- ❑ Not require intravenous fluids
- ❑ Not require oxygen therapy
- ❑ Be continent
- ❑ Not actively using alcohol or other drugs
- ❑ Not have certain health conditions or diseases
  *(Specify:_____)*
- ❑ Not have diagnosis of severe, persistent mental illness
- ❑ Not have history of violence
- ❑ Not have a personality disorder
- ❑ Not have a criminal background (felony)
- ❑ Other criteria?
  *(Specify:_____)*

E2) Does your respite program officially limit the amount of time a client may stay?

- ❑ Yes, client can only stay _____ days
- ❑ Yes, but the limit is determined on a case-by-case basis
- ❑ No limit on length of stay

E3) Does your respite program officially limit the number of times a client may be re-admitted?

- ❑ Yes, client can only be re-admitted _____ times per year
- ❑ Yes, but he number of readmissions is determined on a case-by-case basis
- ❑ No limit on the number of times a client may be re-admitted
- ❑ Not applicable – we do not allow clients to be readmitted

E4) Do clients served in your respite care program sign an agreement, contract, or consent form?

- ❑ Yes *(please attach a copy of the document to this survey)*
- ❑ Not at this time

## SECTION F: COMMUNITY RESOURCES AND ENVIRONMENT

F1) For each of the community resources listed below, please check the box below the response which best indicates your agreement that the resource is on the whole, ***readily accessible to homeless persons*** in your community.

| | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* | *Resource not available in our community* |
|---|---|---|---|---|---|---|
| Hospital Emergency Rooms | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Hospitals (non-Emergency services) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Outpatient services for substance abuse | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Residential treatment for substance abuse | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Permanent housing | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Primary care clinics | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Outpatient mental health services | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Inpatient mental health services | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Shelters | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Transitional housing | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

F2) Indicate below whether you agree that the following environmental issues have ***ever*** had a ***negative impact*** on the quality of services, including respite, that you are able to provide homeless persons in your community.

| | *Strongly Agree* | *Agree* | *Undecided* | *Disagree* | *Strongly Disagree* |
|---|---|---|---|---|---|
| Public attitude toward homelessness | ❑ | ❑ | ❑ | ❑ | ❑ |
| Criminalization of (laws and/or policies against) homelessness | ❑ | ❑ | ❑ | ❑ | ❑ |
| Public attitudes toward substance abuse or substance abusers | ❑ | ❑ | ❑ | ❑ | ❑ |
| Lack of entitlements or public benefits | ❑ | ❑ | ❑ | ❑ | ❑ |
| Funding environment (Medicaid eligibility, state or local funding, etc.) | ❑ | ❑ | ❑ | ❑ | ❑ |
| Climate/weather | ❑ | ❑ | ❑ | ❑ | ❑ |

## SECTION G: FUTURE CHANGES

G1) What changes do you anticipate making in your respite services over the next 2 to 3 years?

*Our program plans to* (*Please Check All That Apply*):

- ❑ No changes anticipated
- ❑ Serve more clients
- ❑ Serve about the same number of clients
- ❑ Serve fewer clients
- ❑ Expand facilities
- ❑ Reduce facilities
- ❑ Increase staff - *Specify Type:*_____
- ❑ Decrease staff - *Specify Type:*_____
- ❑ Change locations – *Explain*: *:*_____
- ❑ Coordinate with other organizations – *Specify*: _____
- ❑ Add new programs or services – *Explain:*_____
- ❑ Expand current services and/or programs – *Which Ones?:*_____
- ❑ Reduce current services and/or programs – *Which Ones?:* _____
- ❑ Change admission criteria – *Specify*: _____
- ❑ Change geographic area served – *Explain*: _____
- ❑ Change methods of delivering services – *Explain*:_____
- ❑ Merge with another agency- *Specify*:_____
- ❑ Make other changes – *Specify*:_____

G2) Given what you know ***now*** about delivering respite services in your community, please rate the effectiveness of your program model for the clients you serve. *(Circle the best response on this scale, where 1=not at all effective and 10-extremely effective)*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| **not at all effective** | | | | **somewhat effective** | | | | | **extremely effective** |

***Why?*** _____

_____

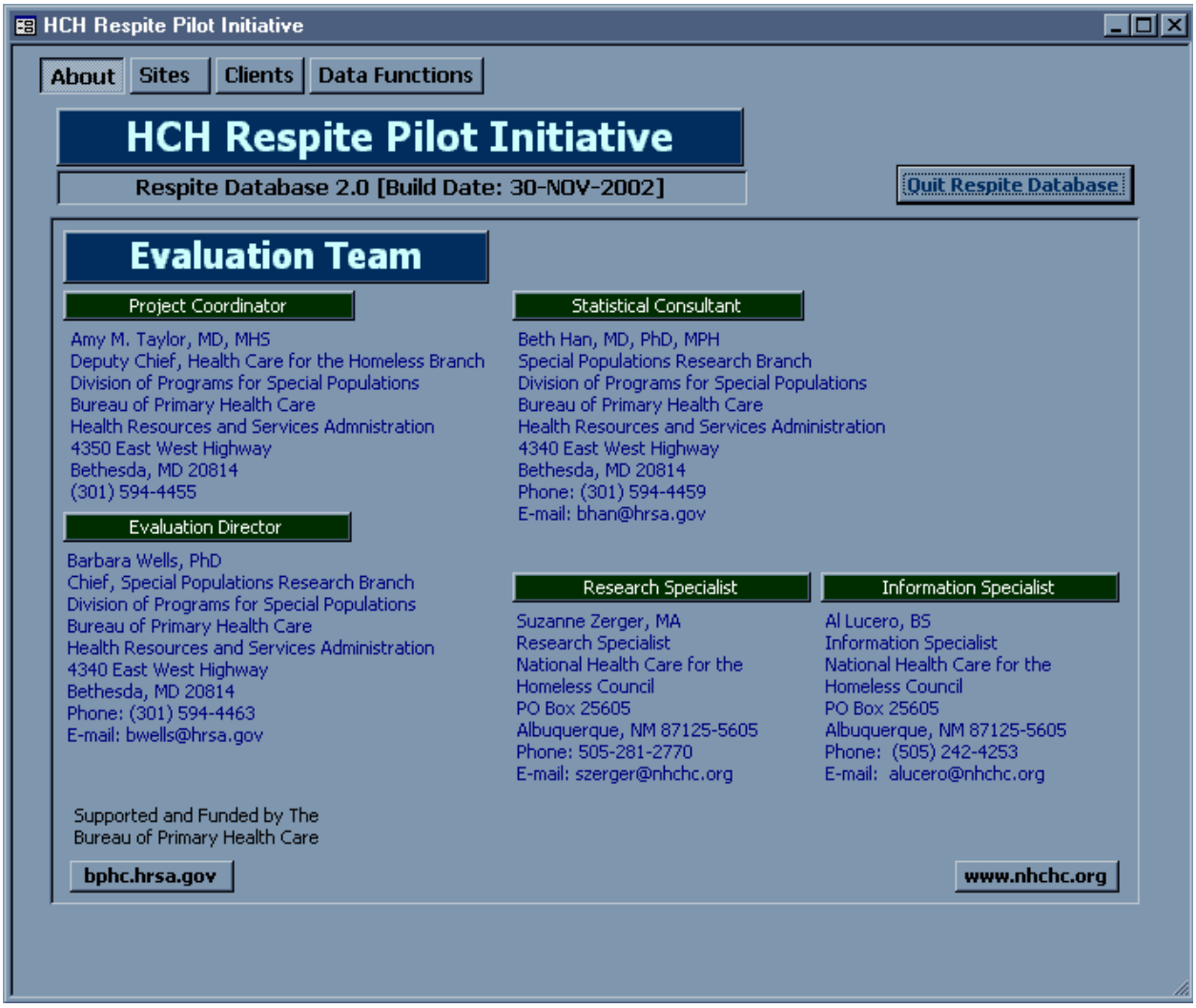
_____

_____

G3) If you had all of the necessary resources available to you, would you use the same model of service provision that you are currently using?

- ❑ Yes
- ❑ No *(Why Not?*_____*)*
- ❑ Maybe *(Explain:* _____*)*

# APPENDIX A.5
# USER MANUAL FOR DATABASE




# HCH Respite Pilot Initiative

## National Health Care for the Homeless Council

# User Manual

Supported with funding from the Bureau of Primary Health Care – www.bphc.hrsa.gov

# HCH Respite Pilot Initiative

## Data Collection Master Database

## Evaluation Objectives

Ten HCH grantees were awarded funding from BPHC in the fall of 2000 to develop medical respite services for people who are homeless. This three-year pilot project will be evaluated to:

- Identify and document the differing models of care for the delivery of respite services; and,
- Assess the effect of respite services on the health of homeless people.

## Evaluation Team


**Program Evaluation Director**

Barbara Wells, Ph.D.
Chief, Special Populations Research Branch
Division of Programs for Special Populations
Bureau of Primary Health Care
Health Resources and Services Administration
4340 East West Highway
Bethesda, MD 20814
Phone: (301) 594-4463
E-mail: bwells@hrsa.gov

**Research Specialist**

Suzanne Zerger, MA
National Health Care for the Homeless Council
P.O. Box 25605
Albuquerque, NM 87125-5605
Phone: 505-281-2770
E-mail: szerger@nhchc.org

**Statistical Consultant**

Beth Han, MD, PhD, MPH
Special Populations Research Branch
Division of Programs for Special Populations
Bureau of Primary Health Care
Health Resources and Services Administration
4340 East West Highway
Bethesda, MD 20814
Phone: (301) 594-4459
E-mail: bhan@hrsa.gov

**Information Specialist**

Al Lucero, MA
National Health Care for the Homeless Council
P.O. Box 25605
Albuquerque, NM 87125-5605
Phone: (505) 242-4253
E-mail: alucero@nhchc.org

**Project Coordinator**

Amy M. Taylor, MD, MHS
Deputy Chief, Health Care for the Homeless Branch
Division of Programs for Special Populations
Bureau of Primary Health Care
Health Resources and Services Administration
4350 East West Highway
Bethesda, MD 20814
(301) 594-4455

## Bureau of Primary Health Care


The Health Care for the Homeless Program was initially authorized under the Stewart B. McKinney Homeless Assistance Act of 1987. Title VI of the McKinney Act added Section 340 to the Public Health Service (PHS) Act, establishing the Health Care for the Homeless (HCH) Program. In 1996, the HCH Program was re-authorized under section 330(h) of the PHS Act by the Health Centers Consolidation Act.

**Mission**

The HCH program emphasizes a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

Funding of the HCH Respite Pilot Initiative reflects continuing support for that mission.

Health Care for the Homeless Program
Division of Programs for Special Populations
Bureau of Primary Health Care
4350 East-West Highway, 9th Floor
Bethesda, MD 20814
301/594-4430
301/594-2470 FAX

**Table of Contents** **Page**


**Introduction** ..... 7

**Software Requirements** ..... 8

**Opening and Closing the Database** ..... 9

**Collecting Data** ..... 11

- **Intake** ..... 12
- **Client Demographic Data** ..... 13
- **Admission Data** ..... 15
- **Discharge Data** ..... 18
- **Clinical Data** ..... Error! Bookmark not defined.
- **ICD9 Codes** ..... 22
- **Financial Data** ..... Error! Bookmark not defined.
- **Supporting Data** ..... 31
- **Data Dictionary** ..... Error! Bookmark not defined.

**Exporting Data** ..... 31

**Database Web Site** .....

**Database Properties** ..... 34

## Introduction

The implementation of the HCH Respite Pilot Initiative brings with it an exciting opportunity for collecting and analyzing data that has been somewhat elusive during the history of HCH projects. Both the limited number of pilot projects and the specific focus on respite services lend themselves to a more manageable process of data collection and evaluation than if all HCH grantees and all HCH services were involved.

The database presented in this manual represents one aspect of the data collection process that will result in an evaluation of the HCH Respite Pilot Initiative, scheduled for completion in late 2003. During 2003, the client data gathered at admission, during the stay in the program, and at discharge will provide us with demographic information on the clients served, their health status at admission and at discharge, and the services they receive during their stay in the respite program. Additional changes - from admission to discharge - in housing status, income and access to health care will also be documented. In addition to presenting numeric totals for these fields, we will analyze the data to see if certain client or service characteristics may have an impact on client outcomes.

The other aspect of the evaluation will focus on the 10 respite pilot programs – their structure, staffing, facilities, and services offered. This information will be gathered through a separate point-in-time survey of respite coordinators and will also be analyzed for possible correlation with client outcomes.

Additional benefits that may result from this evaluation project are:

- Development of data collection tools that can be used in other respite programs.
- Testing of particular data elements that may serve as a model for more universal data collection in HCH projects and/or for HCH add-ons to the UDS.
- Assessment of potential for HCH projects to collect standardized data, transmit that data electronically to a central location and to perform analysis of the data that allows for project-specific reporting, as well as comparisons across projects.
- Development and enhancement of evaluation skills at the HCH project level, through active participation in the evaluation process.

The evaluation team at the National HCH Council would like to thank all of the participants from the 10 pilot projects, the BPHC, and the Boston HCH Program for their enthusiasm and support for this initiative.

December 2002

## Software Requirements

The following requirements are specified by Microsoft in the Knowledge Database article:

**ODE97: System Requirements for Microsoft Office 97 (ODE) (Q162893)**

The information in this article applies to:
- Microsoft Access 97
- Microsoft Office 97 Developer Edition

**SUMMARY**
This article contains a listing of the hardware/system configuration and software requirements needed to install Microsoft Office 97 Developer Edition Tools.

**MORE INFORMATION**

**Hardware/System Configuration Requirements**
One of the following operating systems:

Microsoft Windows 95/98/2000
Microsoft Windows NT Server or Workstation version 3.51 with Service Pack 5
Microsoft Windows NT Server or Workstation version 4.0 with Service Pack 2

- Personal or multimedia computer with a 486 or higher processor
  Random Access Memory (RAM)

  12 (megabytes) MB of RAM required to run on Microsoft Windows 95
  16 (megabytes) MB of RAM to run on Microsoft Windows NT
  More memory may be required to run additional applications simultaneously.

- CD-ROM drive
  VGA resolution or higher video adapter (Super VGA (SVGA) 256-color is recommended)
  Microsoft Mouse, Microsoft IntelliMouse, or compatible pointing device
  Hard Disk Space (requirements are approximate)

  25 MB for a Custom setup
  29 MB for a Complete setup

**Software Requirements**

- Must have Microsoft Access 97 or Microsoft Office 97, Professional Edition installed on computer. The Office Professional Edition compact disc is included with Microsoft Office 97, Developer Edition.
- You can use the following supported networks:

  Microsoft Windows 95
  Microsoft Windows NT
  Novell Netware
  With Windows NT, you must be the administrator or have administrative rights in order to install.

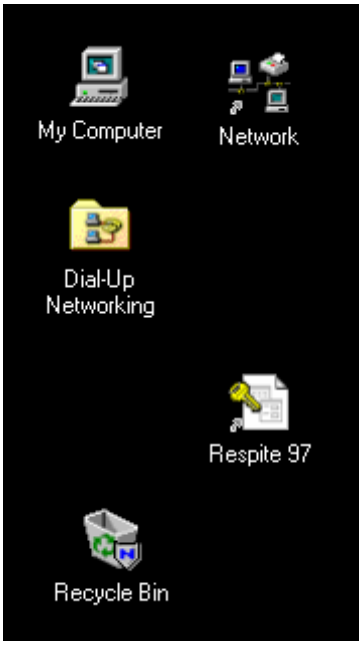
**Additional Items or Services Required to Use Certain Features**
- 9600 or higher-baud modem (14,400 baud is recommended)
  Multimedia computer required to access sound and other multimedia effects
  Microsoft Mail, Microsoft Exchange, Internet SMTP/POP3, or other MAPI-compliant messaging software required to use e-mail
- The Publish To The Web feature in Microsoft Access requires Microsoft Internet Information Server for Windows NT or Microsoft Personal Web Server for Windows 95
  Microsoft Exchange Server for certain advanced workgroup functionality in Microsoft Outlook
- Some Internet functionality may require Internet access and payment of a separate fee to an Internet service provider

Document Location: http://support.microsoft.com/default.aspx?scid=kb;EN-US;q162893

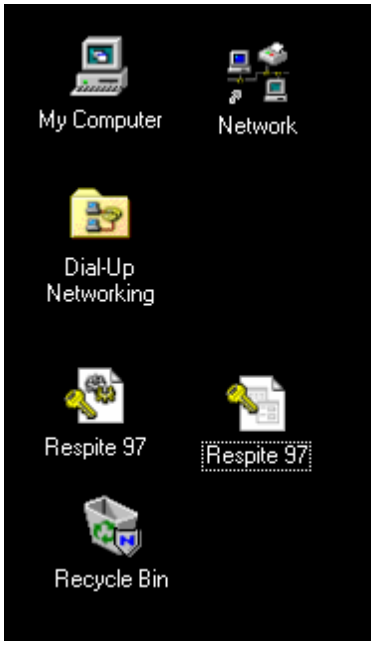
## Opening and Closing the Database

The Respite Database should be opened by double-clicking on the icon that represents the database file. If the file is not located on the Windows Desktop, a shortcut may be created on the desktop which points to the database file. In either case, the file should be opened by double-clicking on the appropriate icon. When the database is open, you may see another icon appear. This icon is a record-locking icon for Microsoft Access and should be ignored.

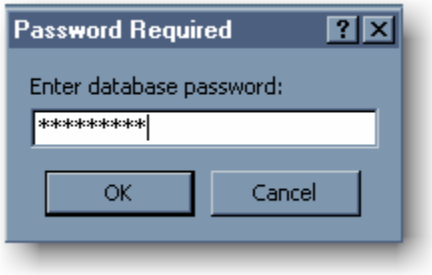

Respite Database icon on Desktop: Double-click to open




Respite Database shortcut icon on Desktop: Double-click to open

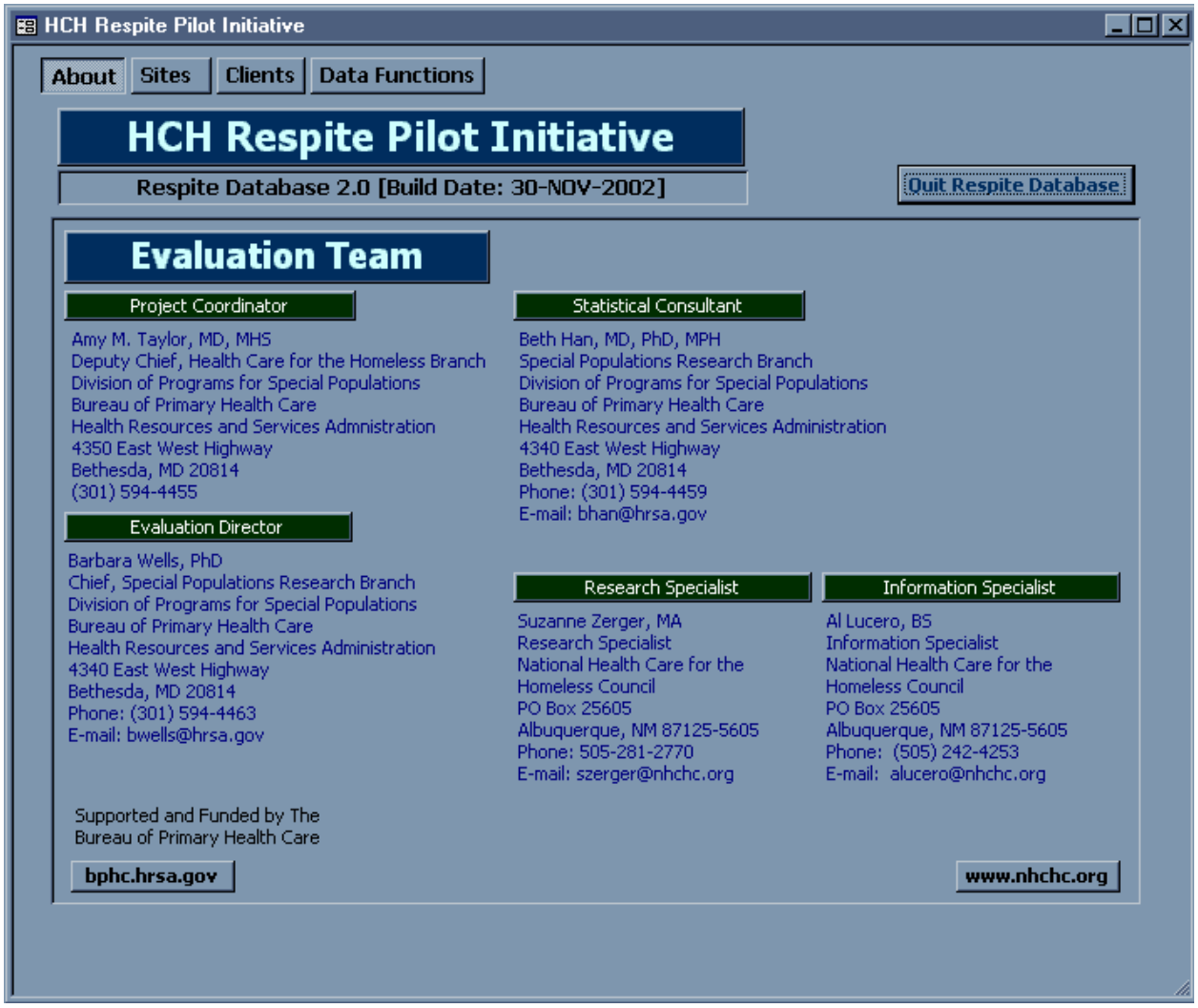



Respite Database record-locking icon on Desktop: Appears when database is open




**If you lose or forget the password you will not be able to open the application or access your data.**

When the Respite Database is opened by double-clicking the appropriate icon, the application will automatically load the main database form. The main database form contains all of the forms available to the Respite pilot grantees. The main form is designed in Tab format, so each of the available forms in the database can be accessed by selecting the appropriate tab button located at the top of the main form. These tab buttons are: **About**, **Sites**, **Clients**, and **Data Functions**. When the database is first opened, the **About** tab is always displayed first.




The **About** tab contains the title form for the database application and contact information for the NHCHC Evaluation Team.

The **Sites** tab contains the form for selecting the site for which the user will enter data in the **Clients** tab.

> **You must select a site in order for the client information to be assigned to the correct site.**

You may use this form for entering or updating site description and contact information.

The **Clients** tab contains the primary form for entering client data and accessing other client data functions.

The **Data Functions** tab contains the form for exporting quarterly data.

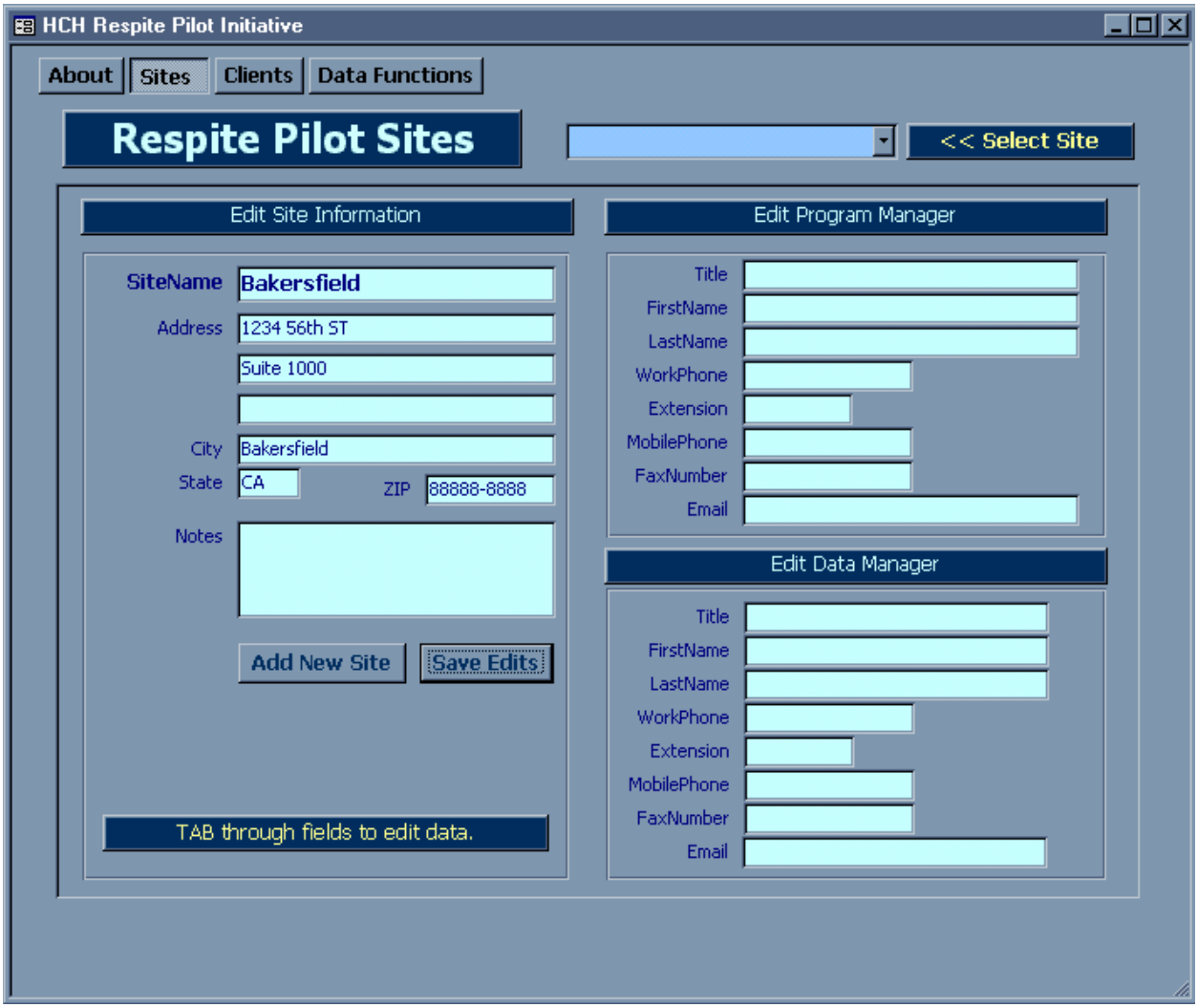
You may **Quit** the Respite Database application in the following ways:

- Click on the top right **x** of the application window
- Select **Exit** from the **File** drop-down menu
- Press the **Quit Respite Database** button on the **About** tab

## Entering Data

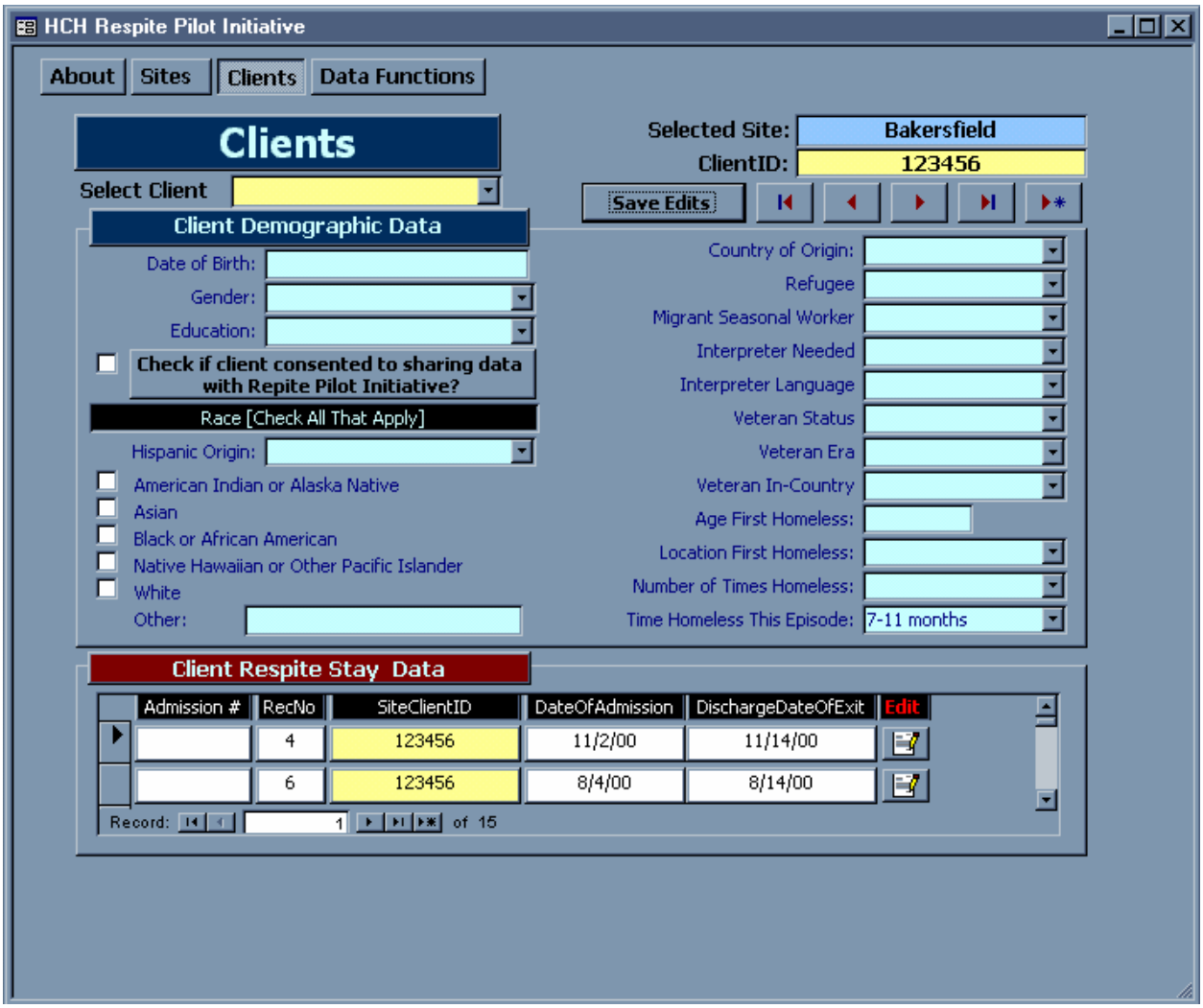
The **Sites** tab contains the form for selecting the site for which the user will enter data in the **Clients** tab.

**You must select a site in order for the client information to be assigned to the correct site.**




Once you have selected the appropriate site, click on the **Clients** tab to go to the data entry form.

## Client Intake Data




**The checkbox indicating *the client's consent to sharing data* must be checked in order for that data to be included in the Respite Pilot Initiative evaluation.**

The top portion of the **Clients** tab contains the initial intake data as well as several navigation and report functions.

| Button | Function |
|---|---|
| Save | Saves the current record and corresponding data |
| First | Navigates to the first record based on selected site |
| Previous | Navigates to the previous record based on selected site |
| Next | Navigates to the next record based on selected site |
| Last | Navigates to the last record based on selected site |
| New | Creates a new client record for selected site |

| Label | Field Description | Field Choices |
|---|---|---|
| SiteID | Name of Site | No choice - indicates selection made in the Sites tab |
| Client ID | Client identifier | Use client ID as assigned at your own site |
| Date of Admission | Indicates date of admission for client | Enter date format in mm/dd/yyyy format |
| Admission Number | Indicates this admission number for client | Any whole number |
| Discharge Date | Indicates date of discharge for client | Enter date format in mm/dd/yyyy format |

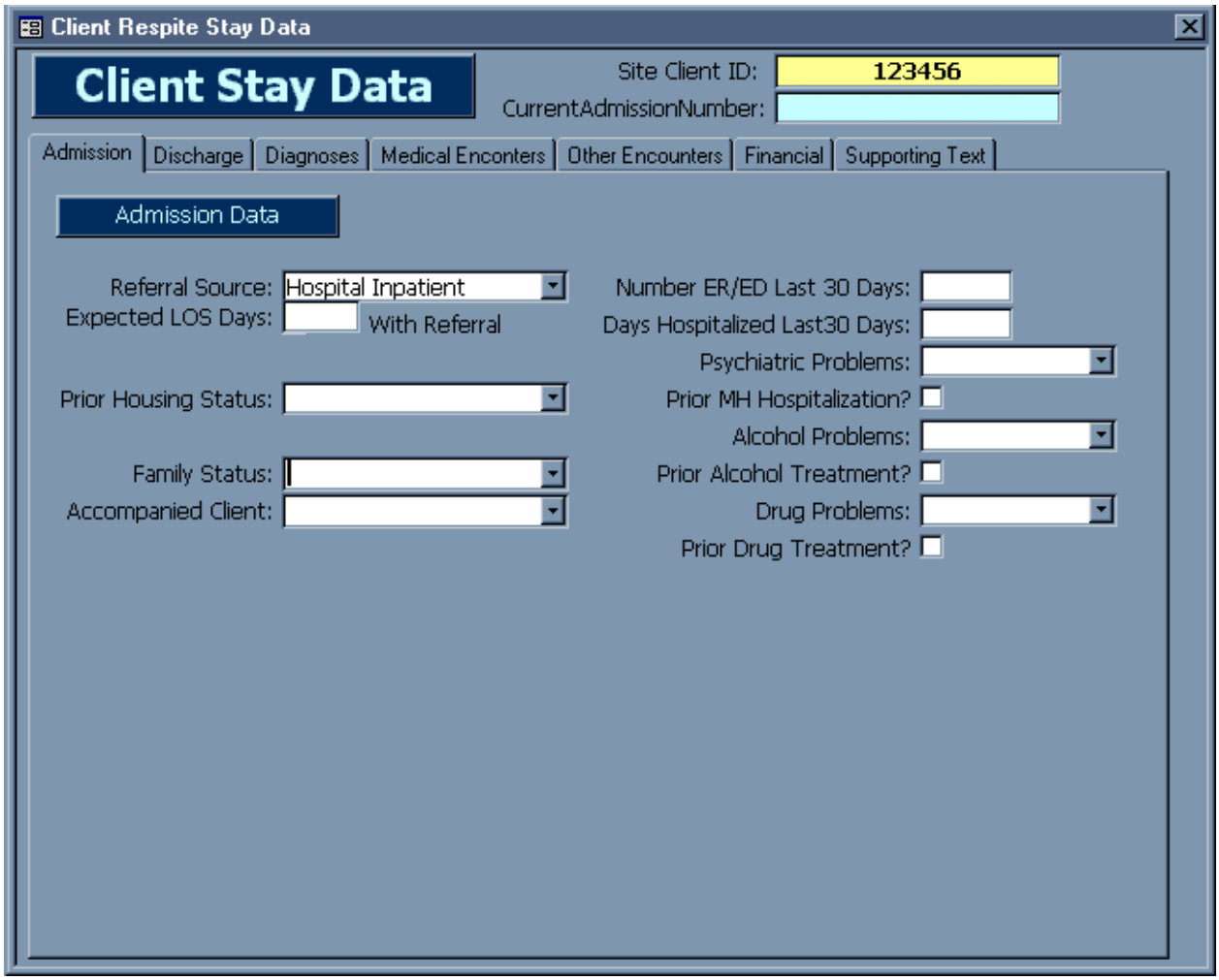
## Client Demographic Data

**PLEASE NOTE: * INDICATES INTAKE PERSON ASKS CLIENTS THESE QUESTIONS AS WRITTEN**

| Label | Field Description | Field Choices |
|---|---|---|
| ***Date of Birth** | ***What is your date of birth?*** | Enter date as mm/dd/yyyy |
| ***Gender of Client** | ***Are you male, female, or transgender?*** (Read if necessary: A transgendered person is someone who was born one sex but who lives as the other.) | Male<br>Female<br>Transgender<br>Unknown |
| ***Education** | ***What is the highest level of school you have completed or the highest degree you have received?*** | <12<br>HS grad/GED<br>Voc/tech<br>Some college<br>College grad<br>Some graduate school<br>Other<br>Unknown |
| ***Hispanic Origin** | ***Are you Hispanic, Spanish, or Latino?*** | No<br>Mexican/Mexican American/Chicano<br>Puerto Rican<br>Cuban<br>Other |
| ***Race** | ***What do you consider to be your race?*** | *Check all that apply* |
| **American Indian or Alaskan Native** | Race or Ethnicity of Client is American Indian or Alaskan Native | Check if yes |
| **Asian** | Race or ethnicity of client is Asian | Check if yes |

| Label | Field Description | Field Choices |
|---|---|---|
| **Black or African American** | Race or ethnicity of client is Black or African American | Check if yes |
| **Native Hawaiian or Other Pacific Islander** | Race or ethnicity of client is Native Hawaiian or Other Pacific Islander | Check if yes |
| **White** | Race or ethnicity of client is White | Check if yes |
| **Other** | Race or ethnicity of client is Other | Specify |
| ***Country of Origin** | ***In what country were you born?*** | Name of country will auto-enter as you begin typing |
| ***Refugee** | ***Do you have official status as a refugee or have an application pending?*** | No<br>Yes<br>Unknown |
| ***Migrant Seasonal Worker** | ***Are you a migrant or seasonal farmworker or agribusiness worker?*** | Yes<br>No<br>Unknown |
| ***Interpreter Language** | ***What is your native language?*** | Specify (language name will auto-enter as you begin typing) |
| ***Interpreter Needed** | ***Would you like a language interpreter during your stay here?*** | Yes<br>No<br>Unknown |
| ***Veteran Status** | ***Are you now or have you ever been on active-duty military service in the Armed Forces of the United States or ever been in the United States Military Reserves or the National Guard?*** (Active duty in military service does not include training in the reserves or National Guard) | Yes<br>No<br>Don't Know/Refused |
| ***Military Service Status** | ***If discharged from military service, did you receive an honorable discharge?*** | Yes<br>No<br>Don't Know/Refused |
| ***If veteran, era served** | *If yes to veteran status:* ***During what time period were you a veteran?*** | Peacetime<br>Gulf War<br>Vietnam Era<br>Korean War<br>World War II<br>Uknown |
| ***If veteran, served " in-country"?** | *If yes to veteran status:* ***Did you ever serve in the country where the conflict occurred?*** | Yes<br>No<br>Unknown |
| ***Age First Homeless** | ***How old were you when you first became homeless?*** | Age in years |
| ***Location First Homeless** | ***Where did you live when you first became homeless?*** | This city<br>This state – other city<br>Other state<br>Other country<br>Unknown |
| ***Number of Times Homeless** | ***How many times have you been homeless?*** | Number of times/episodes of homelessness |
| ***Time Homeless This Episode** | ***How long (in months) were you homeless before coming here?*** | <1 month<br>1-6 months<br>7-11 months<br>1-3 years<br>>3 years |

## Admission Data

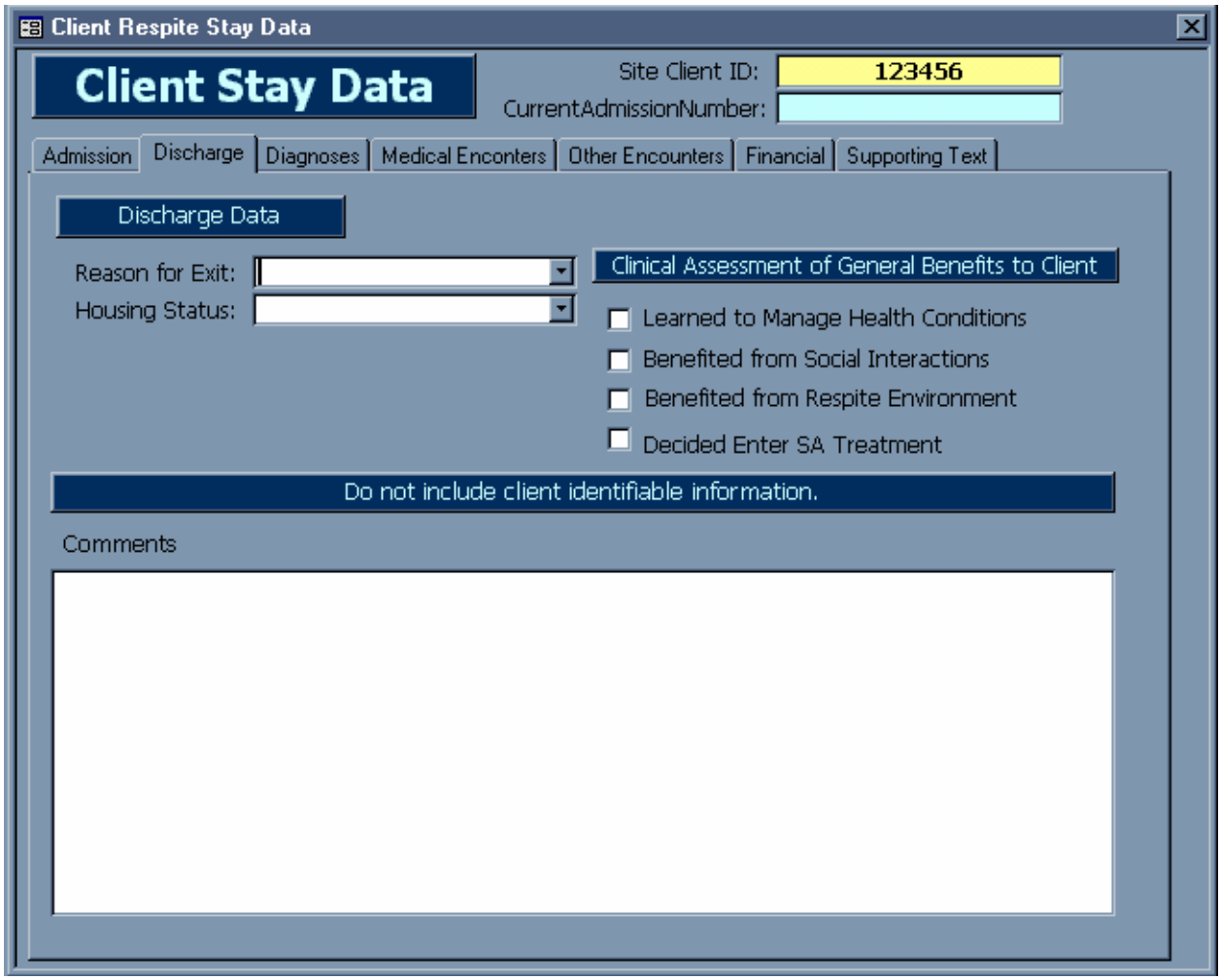


*** INDICATES INTAKE PERSON ASKS CLIENTS THESE QUESTIONS AS WRITTEN**

| Label | Field Description | Field Choices |
|---|---|---|
| **Referral Source** | Source of client referral | ER/ED<br>Hospital – Inpatient<br>Hospital – Outpatient<br>HCH clinic<br>HCH outreach<br>HCH program (mental health, substance abuse, case management, social work)<br>Treatment program (substance abuse)<br>Other clinic (non-HCH)<br>Other outreach (non-HCH)<br>Other MH/SA/CM/SW program (non-HCH)<br>Transitional/residential program<br>Self-referred<br>Shelter<br>Drop-in center<br>Soup kitchen<br>Jail/prison<br>Police<br>Other<br>Unknown |
| **Meds With Referral** | Client arrived with medication supply from referral source | Check if yes |
| **Expected LOS Days** | Expected length of stay at site (in days) | Specify number of days |
| ***Housing Status** | ***Where did you sleep last night?*** | Abandoned building<br>Doubled-up (with family or friends)<br>Hospital<br>Hotel/motel<br>Nursing home<br>Own house or apartment<br>Prison or jail<br>Shelter<br>Street or camp<br>Transitional housing<br>Treatment program<br>Vehicle<br>Other<br>Unknown |
| ***Family Status** | ***Are you now: Married, Widowed, Divorced, Separated, Never Married, or Living with a partner?*** | Married<br>Widowed<br>Divorced<br>Separated<br>Never Married<br>Living with a partner<br>Unknown |
| **Accompanied Client** | Was the client accompanied during their stay in the respite program with any family members? | Alone<br>With spouse<br>With partner<br>With child(ren)<br>With partner/spouse and child(ren) |

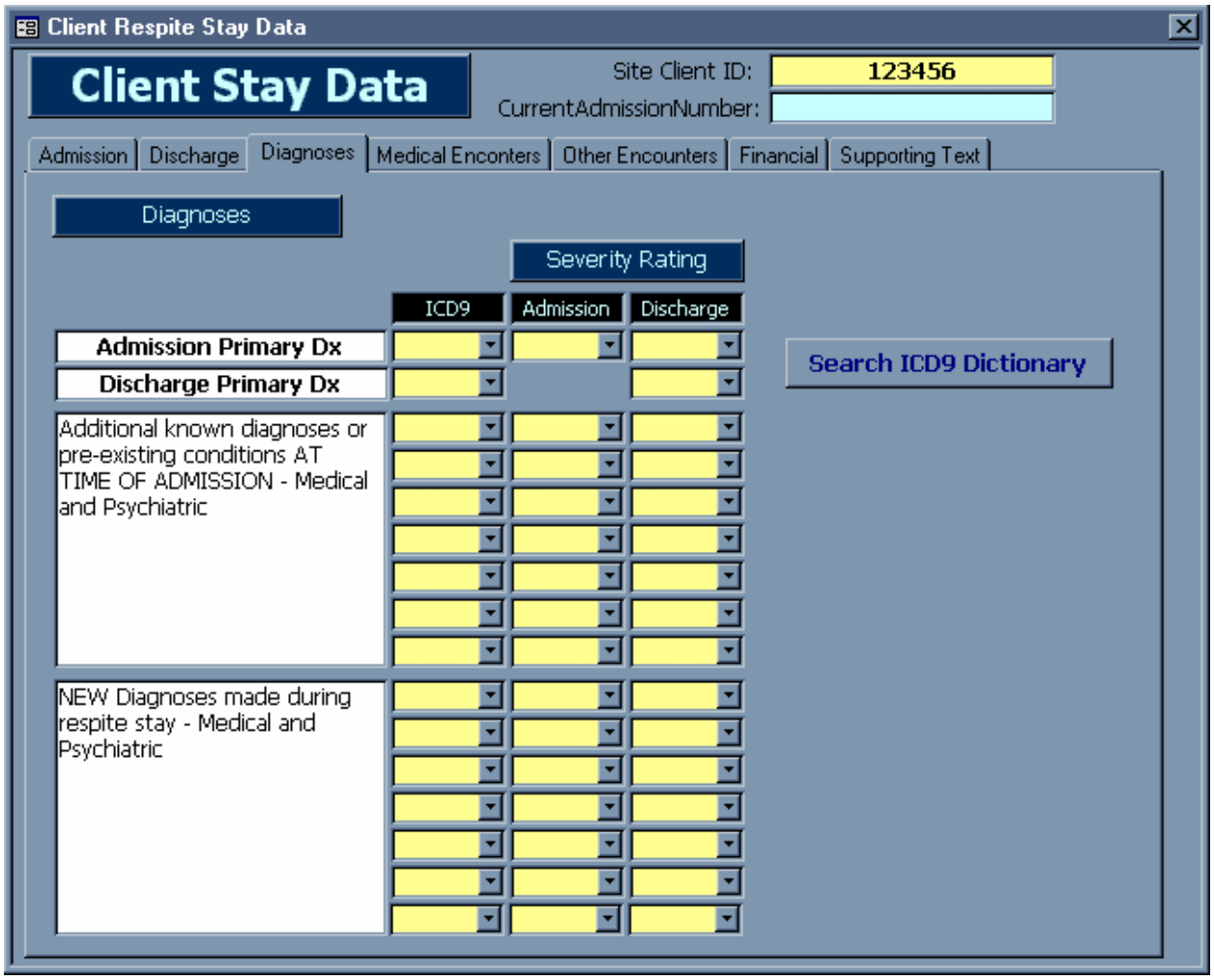
| Label | Field Description | Field Choices |
|---|---|---|
| **ER/ED Visits Last 30 Days** | How many times has the client used the emergency room or emergency department in the last 30 days? | Specify number of visits |
| **Days Hospitalized Last 30 Days** | How many days has the client spent hospitalized in the last 30 days? | Specify number of days |
| **Psychiatric Problems** | Does the client have any psychiatric problems? | Documented diagnosis – see list<br>Suspected – no diagnosis yet<br>No problem<br>Unknown |
| **Prior MH Hospitalization?** | Was the client ever hospitalized for a psychiatric problem? | Check if yes |
| **Alcohol Problems** | Does the client have any alcohol problems? | Documented diagnosis – see list<br>Suspected – no diagnosis yet<br>No problem<br>Unknown |
| **Prior Alcohol Treatment?** | Was the client ever in a treatment program for an alcohol problem? | Check if yes |
| **Drug Problems** | Does the client have any drug problems? | Documented diagnosis – see list<br>Suspected – no diagnosis yet<br>No problem<br>Unknown |
| **Prior Drug Treatment?** | Was the client ever in a treatment program for drug addiction? | Check if yes |

## Discharge Data



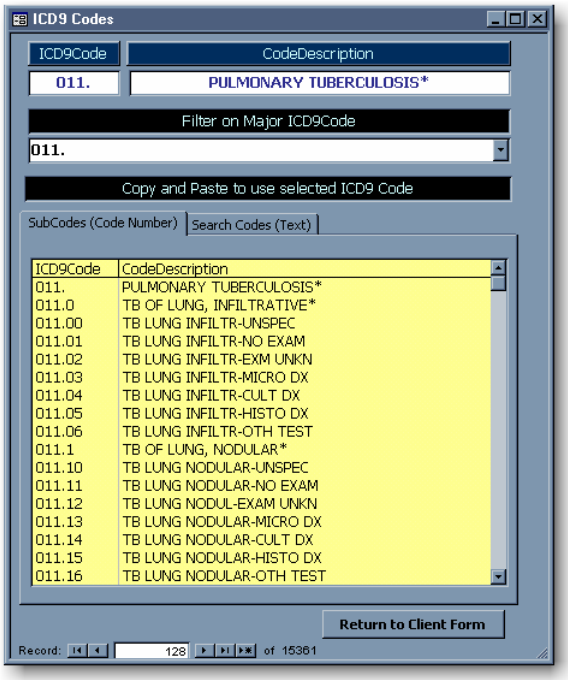
| Label | Field Description | Field Choices |
|---|---|---|
| **Reason for Exit** | Reason for exit from program | Completed treatment<br>Administrative discharge (told to leave due to infraction of rules, etc.)<br>Left AMA (Left against medical advice)<br>AWOL (disappeared without notice)<br>Admitted to hospital<br>Death<br>Other<br>Unknown |
| **Housing Status** | Housing status at time of exit (Where was client discharged to?) | Abandoned building<br>Doubled-up (with family or friends)<br>Hospital<br>Hotel/motel<br>Nursing home<br>Own house/apartment (acquired housing)<br>Prison or jail<br>Shelter<br>Street or camp<br>Transitional housing program<br>Treatment program<br>Vehicle<br>Other<br>Unknown |
| **Discharge Comments** | Add other comments on how client has benefited (or not) from respite program | Enter comments |
| **Learned to Manage Health Conditions** | Client learned how to manage health conditions – "self-care" | Check if yes |
| **Benefited from Social Interactions** | Client benefited from interaction with staff and/or other clients | Check if yes |
| **Benefited from Respite Environment** | Client benefited from the respite environment (nutrition, safety, security, other physical aspects of program) | Check if yes |
| **Decided to Enter Treatment** | Client made decision to enter treatment program for substance abuse | Check if yes |

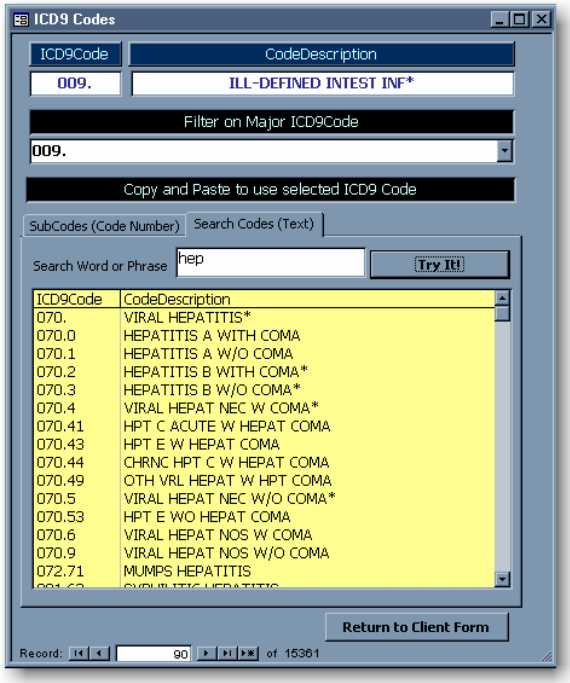
## Diagnoses Data



| Label | Field Description | Field Choices |
|---|---|---|
| **AdmissionDiagnosisPrimary** | ICD-9 code for primary admitting diagnosis | Enter appropriate code |
| **DischargeDiagnosisPrimary** | ICD-9 code for discharge diagnosis (if different from primary admitting diagnosis) | Enter appropriate code |
| **Additional diagnoses (1-7)** | ICD-9 codes for any additional diagnoses (medical or psychiatric) or known pre-existing conditions at time of admission | Enter appropriate code(s) |
| **NEW diagnoses (1-7)** | ICD-9 codes for any new diagnoses (medical or psychiatric) discovered during respite stay | Enter appropriate code(s) |
| **Severity Rating – Admission**<br>- - - - - - - - - - - - - - - - - -<br>**Severity Rating - Discharge** | Severity rating for diagnosis at time of admission (or when new diagnosis is discovered) for all diagnoses except primary discharge diagnosis<br>- - - - - - - - - - - - - - - - - - - -<br>Severity rating for diagnosis at time of discharge (for all diagnoses) | 0-Asymptomatic, no treatment needed at this time<br>1-Symptoms well-controlled with current therapy<br>2-Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring<br>3-Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring<br>4-Symptoms poorly controlled, history of rehospitalization(s) |

## ICD9 Codes




The **ICD9 Codes** are formatted in the following manner:

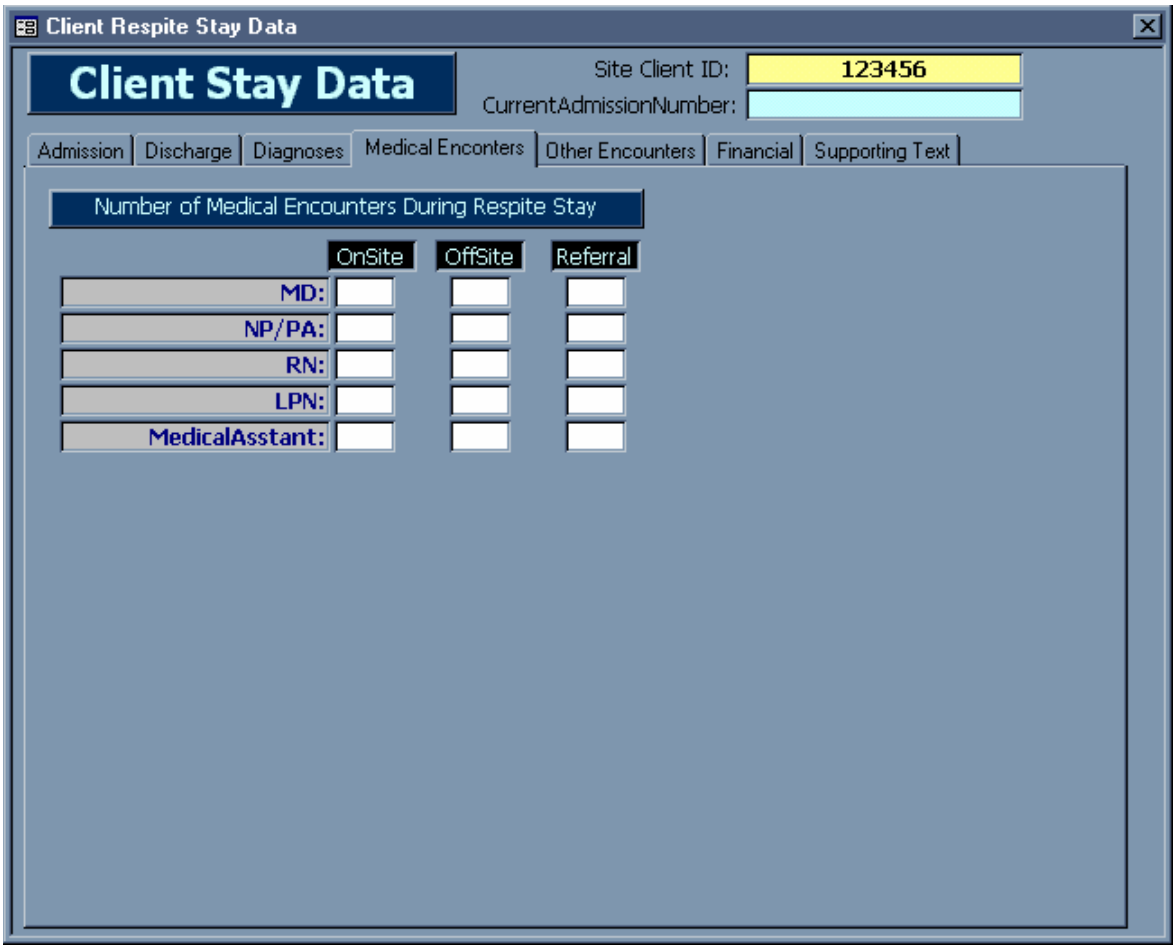
nnn.mmm Where nnn is the major ICD9 Code and mmm are the SubCodes associated with each major ICD9 Code.

The **ICD9 Codes** popup form contains a complete listing of the ICD9 codes, SubCodes, and a search function. The search function permits a search of all the ICD9 codes based on a single key word. Multiple key word searches are not permitted in this form. The ICD9 Codes popup form contains two tabs: **SubCodes** and **Search Codes**.

| Button | Function |
|---|---|
| Try It! | Searches the ICD9 Code descriptions for the key word entered in the **Search Word or Phrase** text box and updates the ICD9 Codes list containing the key word |
| Return to Client Form | Closes the **ICD9 Codes** form and returns to the **Clients** tab |
| Record | Standard record navigation bar for Microsoft Access forms |

| Label | Field Description | Field Choices |
|---|---|---|
| Jump to Major ICD9Code | Major ICD9 codes and descriptions | Major ICD9 Codes: only **nnn.** codes are listed in the list, select major ICD9 Codes or begin typing (Fill-in-as-you-type feature) |
| ICD9 Code and CodeDescription | List of ICD9 Codes and Descriptions | Filtered list of major ICD9 Codes and SubCodes |

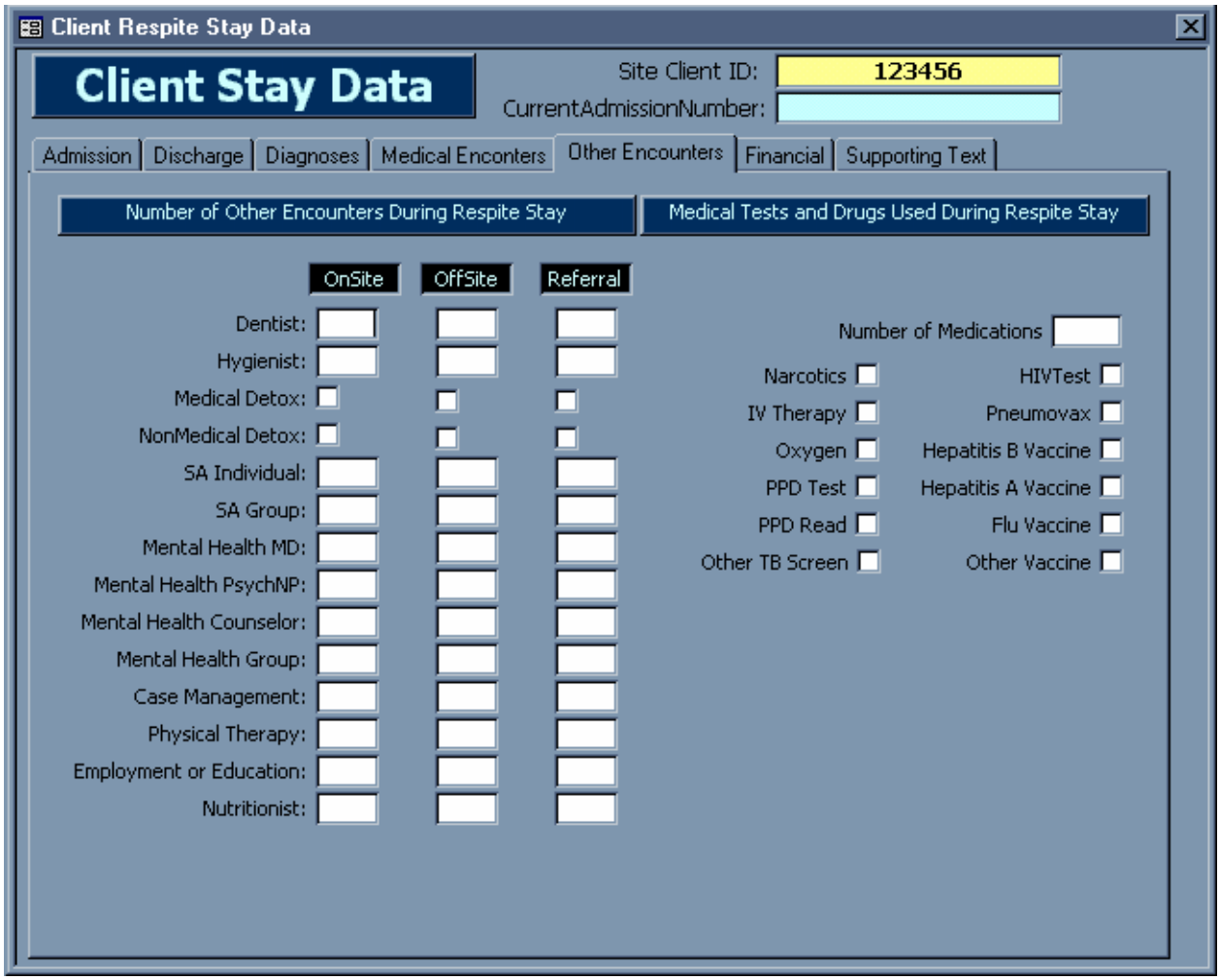
## Medical Encounters




- **OnSite** = Any encounters delivered on-site at the respite program
- **OffSite** = Any encounters delivered off-site, either at the HCH clinic or an affiliated clinic, i.e., of the grantee agency
- **Referral** = Any encounter delivered through referral to an unrelated organization, i.e., not HCH or grantee agency

| Label | Field Description | Field Choices |
|---|---|---|
| **MD** | Medical services provided by a physician, either MD or DO (not including psychiatrists) | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **NP/PA** | Medical services provided by a nurse practitioner or physician's assistant | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **RN** | Medical services provided by a registered nurse | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **LPN** | Medical services provided by a licensed practical nurse or equivalent | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Medical Assistant** | Medical services provided by a medical assistant or equivalent | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |

## Other Encounters



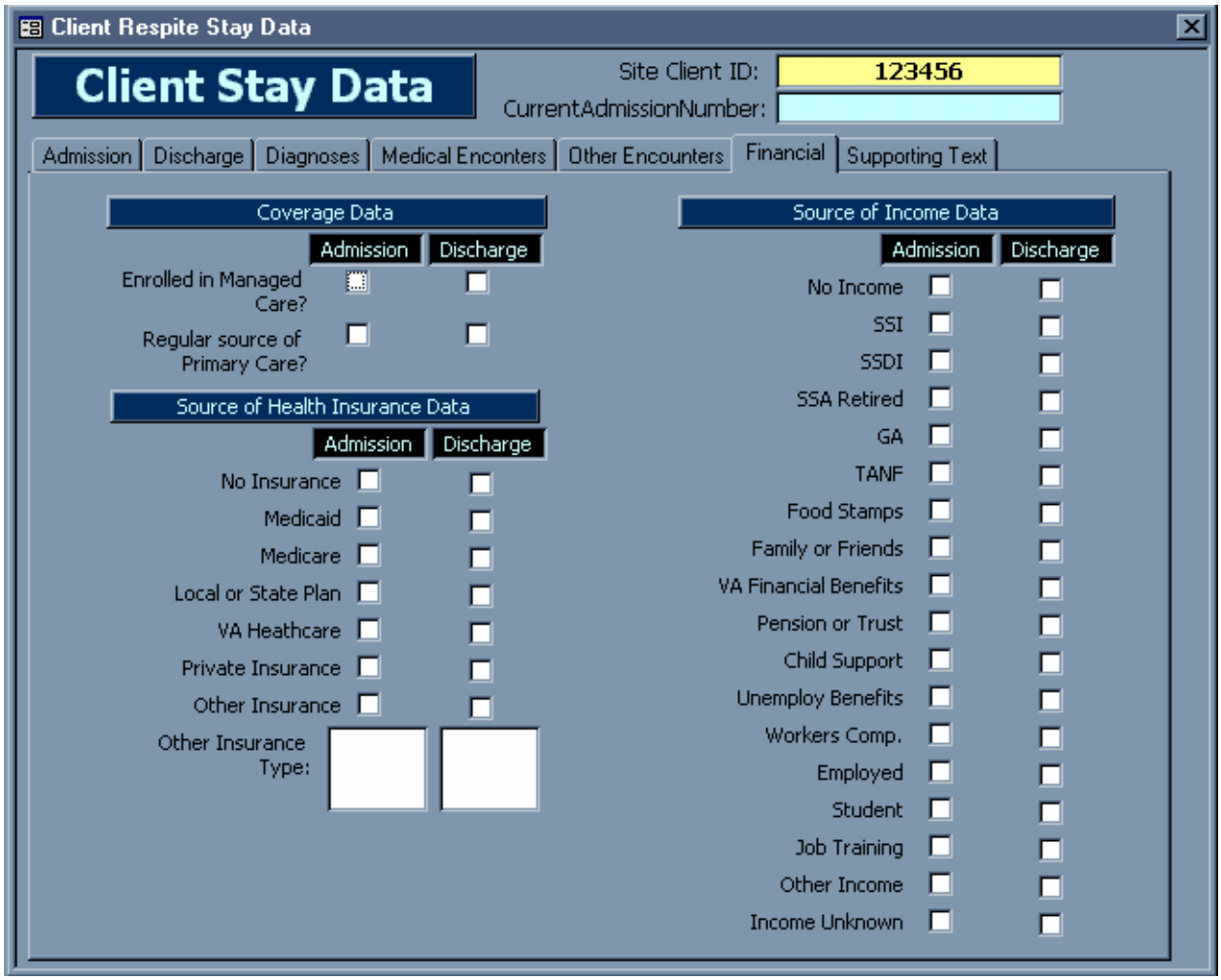
- **OnSite** = Any encounters delivered on-site at the respite program
- **OffSite** = Any encounters delivered off-site, either at the HCH clinic or an affiliated clinic, i.e., of the grantee agency
- **Referral** = Any encounter delivered through referral to an unrelated organization, i.e., not HCH or grantee agency

| Label | Field Description | Field Choices |
|---|---|---|
| **Dentist** | Dental care provided by a dentist | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Hygienist** | Dental care provided by a dental hygienist | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Medical Detox** | Medical detox provided to client | Check appropriate box if provided OnSite, OffSite and/or by Referral |
| **Non-Medical Detox** | Non-medical or social detox provided to client | Check appropriate box if provided OnSite, OffSite and/or by Referral |
| **Substance Abuse Individual** | Substance abuse services provided to client individually (other than detox) | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Substance Abuse Group** | Substance abuse services provided to the client in a group setting (other than detox) | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Mental Health MD** | Mental health services provided by a psychiatrist to client individually | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Mental Health PsychNP** | Mental health services provided by a psychiatric nurse practitioner to client individually | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Mental Health Counselor** | Mental health services provided by a counselor (not MD or NP) to client individually | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Mental Health Group** | Mental health services provided to client in a group setting (by any type of provider) | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Case Management** | Case management or social services – may be provided by social worker or case manager or other staff | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Physical Therapy** | Physical therapy encounters | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |
| **Employment or Education** | Employment or education services, e.g., job training, literacy, ESL, etc. | Enter number of encounters in appropriate box for OnSite, OffSite and/or Referral |

## Other Encounters: Medical Tests and Drugs

| Label | Field Description | Field Choices |
|---|---|---|
| **Number of Medications** | Number of different medications used by client during respite stay – may be prescribed before respite stay by referring agency or during respite stay | Enter number of distinct medications (not number of doses) |
| **Narcotics** | Narcotics were prescribed for the client either by referring agency or during respite stay – intent is to learn if narcotics are present on-site | Check if yes |
| **IV Therapy** | Client received IV therapy during respite stay | Check if yes |
| **Oxygen** | Client received oxygen during respite stay | Check if yes |
| **PPD Test** | Client had a PPD skin test for TB placed during respite stay | Check if PPD was placed |
| **PPD Read** | Client had PPD skin test for TB read during respite stay | Check if PPD skin test was read |
| **HIV Test** | Client was tested for HIV during respite stay | Check if test was done |
| **Pneumovax** | Client received Pneumovax during respite stay | Check if yes |
| **Hepatitis B Vaccine** | Client received hepatitis B vaccine during respite stay | Check if yes |
| **Hepatitis A Vaccine** | Client received hepatitis A vaccine during respite stay | Check if yes |
| **Flu Vaccine** | Client received flu vaccine during respite stay | Check if yes |
| **Other Vaccine** | Any other immunizations are brought up-to-date during client's respite stay | Check if yes |

## Financial


Client Respite Stay Data
Client Stay Data
Site Client ID:
123456
CurrentAdmissionNumber:
Admission
Discharge
Diagnoses
Medical Enconters
Other Encounters
Financial
Supporting Text
Coverage Data
Admission
Discharge
Enrolled in Managed Care?
Regular source of Primary Care?
Source of Health Insurance Data
Admission
Discharge
No Insurance
Medicaid
Medicare
Local or State Plan
VA Heathcare
Private Insurance
Other Insurance
Other Insurance Type:
Source of Income Data
Admission
Discharge
No Income
SSI
SSDI
SSA Retired
GA
TANF
Food Stamps
Family or Friends
VA Financial Benefits
Pension or Trust
Child Support
Unemploy Benefits
Workers Comp.
Employed
Student
Job Training
Other Income
Income Unknown

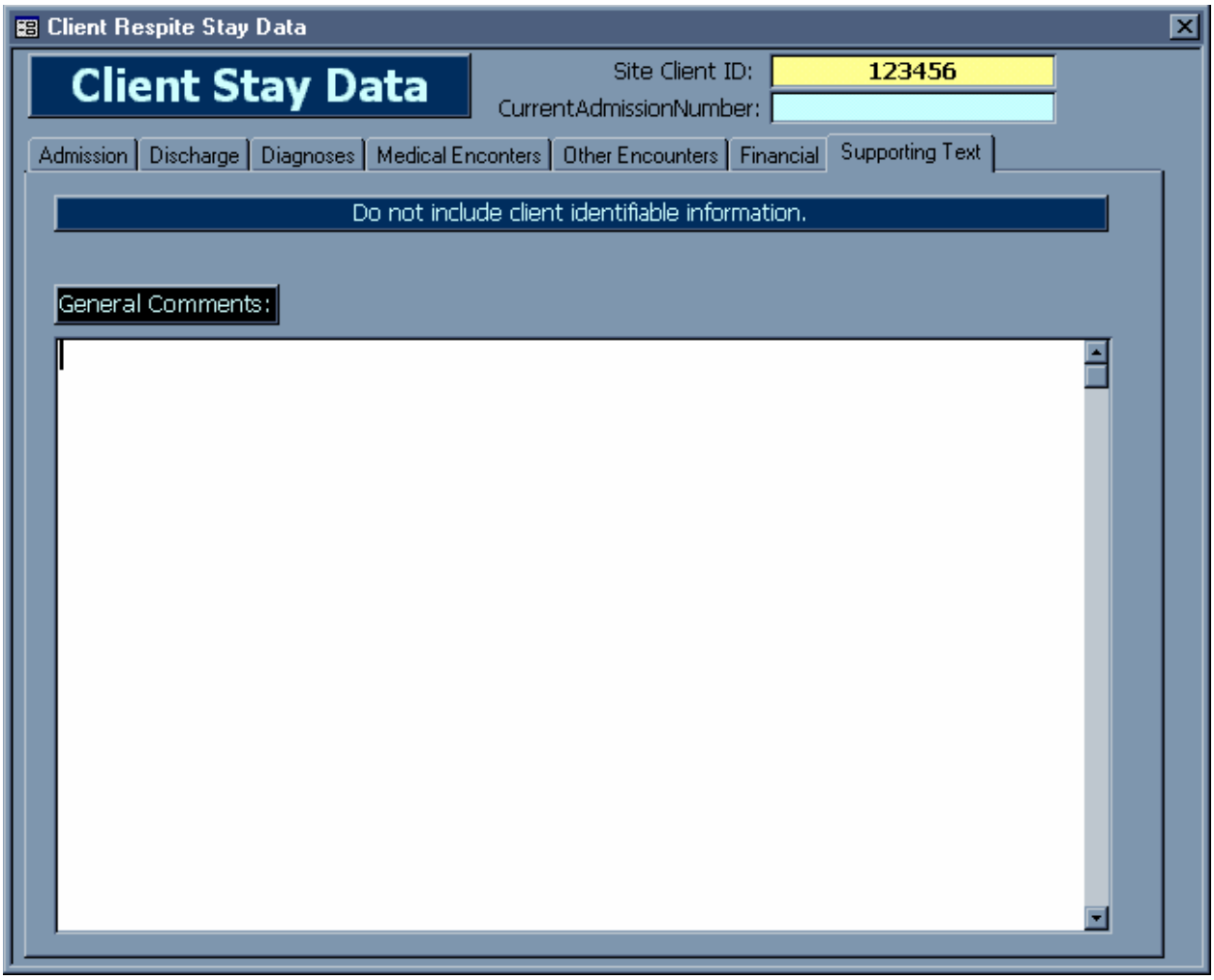
## Financial Data: Coverage and Source of Insurance Data

| Label | Field Description | Field Choices |
|---|---|---|
| ***Coverage Data*** | | |
| **Enrolled in Managed Care** | Health care (of whatever source) is provided through a managed care plan at time of admission | Check if yes in appropriate box for admission and/or discharge |
| **Regular source of Primary Care?** | Client has a regular source of primary care established | Check if yes in appropriate box for admission and/or discharge |
| ***Source of Health Insurance*** | | |
| **No Insurance** | Client has no health insurance coverage | Check if yes in appropriate box for admission and/or discharge |
| **Medicaid** | Client is enrolled in Medicaid | Check if yes in appropriate box for admission and/or discharge |
| **Medicare** | Client is enrolled in Medicare | Check if yes in appropriate box for admission and/or discharge |
| **Local or State Plan** | Client has health insurance through another public health plan – state, county, local, etc. | Check if yes in appropriate box for admission and/or discharge |
| **VA Healthcare** | Client receives health care through the VA system | Check if yes in appropriate box for admission and/or discharge |
| **Private Insurance** | Client has private health insurance coverage | Check if yes in appropriate box for admission and/or discharge |
| **Other Insurance** | Client has other insurance coverage | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |

## Financial Data: Source of Income Data

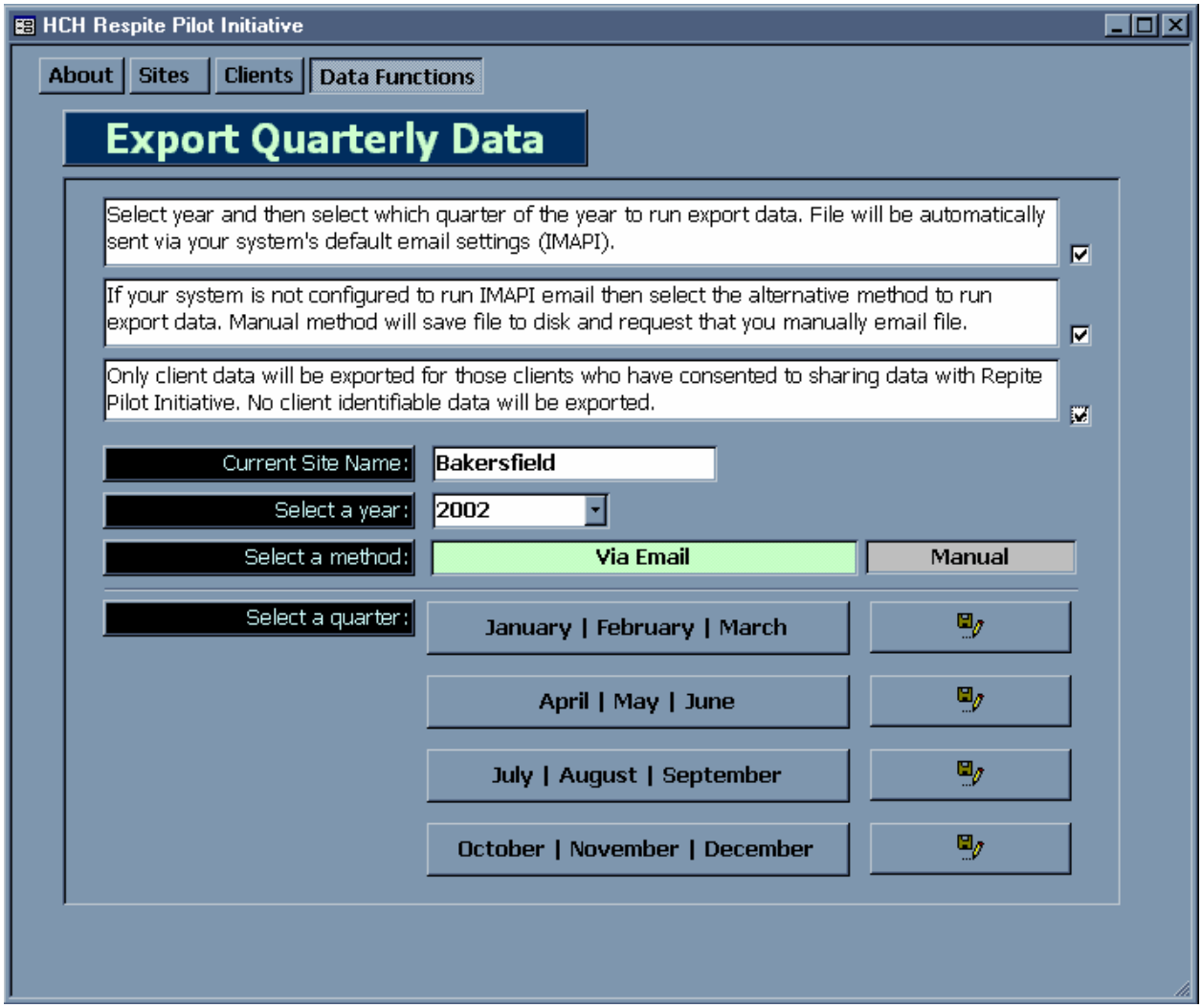
| Label | Field Description | Field Choices |
|---|---|---|
| ***Source of Income*** | | |
| **No Income** | Client has no income | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **SSI** | Client is receiving Supplemental Security Income (SSI) | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **SSDI** | Client is receiving disability payments (SSDI) | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **SSA Retired** | Client is receiving Social Security benefits (retirement) | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **GA** | Client is receiving General Assistance (GA) or other public assistance from the state or local level | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **TANF** | Client is receiving Temporary Aid to Needy Families (TANF) – formerly AFDC, also known as welfare | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Food Stamps** | Client is receiving food stamps | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Family or Friends** | Client is receiving financial help from family and/or friends | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **VA Financial Benefits** | Client is receiving VA benefits (financial benefits, not health care) | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Pension or Trust** | Client is receiving income from a pension or trust fund (non-VA) | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Child Support** | Client is receiving income from child support payments | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Unemploy Benefits** | Client is receiving unemployment benefits | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Workers Comp** | Client is receiving income from Workers' Compensation | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Employed** | Client is receiving income from employment | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Student** | Client is a student | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Job Training** | Client is in a job training program | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Other Income** | Client is receiving other income, not specified above | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |
| **Income Unknown** | Client's income status is unknown | Check if yes in appropriate box for admission and/or discharge AND specify type in text box |

## Supporting Text (General Comments)




| Label | Field Description | Field Choices |
|---|---|---|
| **General Comments [Paste Text]** | General Comments memo field | Type text or past text from other source into memo text box |

## Exporting Data



The **Exporting Data** tab contains the currently available data functions for the Respite Database. These functions are currently limited to exporting quarterly client data. The export function will export the client data to a **Microsoft Excel** spreadsheet, which should be emailed to the Evaluation Team at one of the email address listed in the About tab. This spreadsheet will be integrated into the primary Respite Database.

Each quarter is defined according to following **discharge** dates:

**Q1** January 1 - March 31
**Q2** April 1 - June 30
**Q3** July 1 - September 30
**Q4** October 1 - December 31

When you press any of the export quarterly data buttons, you will be prompted to enter the **year** for which you would like quarterly data. You must enter a four-digit year (i.e., 2000).

| Button | Function |
|---|---|
| Export Q1 Data | Exports Q1 data to a Microsoft Excel spreadsheet |
| Export Q2 Data | Exports Q2 data to a Microsoft Excel spreadsheet |
| Export Q3 Data | Exports Q3 data to a Microsoft Excel spreadsheet |
| Export Q4 Data | Exports Q4 data to a Microsoft Excel spreadsheet |

## Database Web Site

# www.nhchc.org/Respite/