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There is Still a Need for Recuperative Care Programs

By Kelly Bruno
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A recent news report citing a Las Vegas hospital's struggle to place homeless patients post discharge shows the issue is still significant for the health care industry. Public outcry highlighted a similar problem faced by hospitals in 2008. How do hospitals ensure homeless patients have access to the care and resources they need once they leave the acute-care setting?

According to the National Health Care for the Homeless Council, Inc., homeless patients are less likely to have coverage, and those who do have coverage face multiple barriers to accessing regular care. Consequently, many people experiencing homelessness have unmanaged, deteriorating health and are more likely than their housed counterparts to find themselves in emergency rooms because of a health crisis. It is estimated that patients are kept up to four extra days in the hospital due to insufficient availability of appropriate beds and lack of discharge options. These factors can add up to unnecessary care and higher costs for hospitals. A 2011 study by St. Michael's Hospital showed treating a homeless patient costs hospitals $2,500 more than the average patient.

Programs like the Recuperative Care Center administered by National Health Foundation (NHF) and their partner, Illumination Foundation, provide hospitals with an option for homeless patients who are not sick enough to remain in the hospital, but too sick for a shelter. Medical respite care fills a void in services for this vulnerable segment of the population with benefits to both hospitals and patients. In what becomes a collaborative relationship between hospitals and community providers, recuperative care offers a catalogue of much-needed services that can result in better outcomes.

The recuperative, or medical respite, care movement emerged soon after the Health Care for the Homeless program was established in 1983. The Robert Wood Johnson Foundation, the Pew Charitable Trust, and the U.S. Conference of Mayors together funded a $25 million, five-year effort to try new methods to deliver health care and social services to homeless patients. The Health Care for the Homeless initiative started in five cities, with Boston as the first with five beds set aside for patients. By 1988, the Health Care for the Homeless program expanded to 19 locations, some of which followed Boston's lead in setting aside beds for recuperating patients As of this year, there are 62 medical respite programs nationwide many still operating as part of Health Care for the Homeless projects. However, only 27 states currently have programs; California leads the way with 16 sites.

Over the years, funding has been a major concern for these centers. Often programs have to limit intake to ensure resources won't be overwhelmed. Currently, 19 receive money from the Health Resources and Services Administration; 30 from hospitals; 29 from private funds; 29 from local government; and 21 from foundation grants. Hospitals are the main source of funding for these programs.

Several models of care have evolved over almost 30 years since the program's inception. They include:

- Free-standing facility
- Shelter-based
- Nursing / medical component
- Motel rooms with medical monitoring
- Family respite motel/family shelter
- Contracted service in a board-and-care facility

Each option has advantages and disadvantages, e.g., ability to isolate patients with communicable diseases, ability to house families, 24-hour staffing, etc. For most sites, the core services include a quiet, stable recovery setting with medical oversight, healthy meals, laundry facilities, transportation, mental health support, medications, case management, and referral to specialty care.

Sabrina Edgington, program and policy specialist for National Health Care for the Homeless Council, Inc., sees medical respite care as vital to the delivery of health care to people experiencing homelessness.

"In medical respite programs, they get targeted attention and culturally sensitive, trauma informed takes on barriers being faced," Edgington said. "These centers also help implement better transitions and establish stronger health homes."

Though models may vary, the measures for success are similar. Successful programs reduce unnecessary and avoidable emergency room visits, lower length of stay, present safe discharge options with optimized health outcomes, engage in high utilization of ongoing care, and provide expert behavioral management. Recently the National Health Care for the Homeless Council, Inc., established a task force to determine benchmarks for these programs to maximize outcomes and standardize procedures. Guidelines will be available mid-2014.

In NHF's program, more than 1,500 homeless patients have been admitted to the program from private hospitals in Los Angeles and Orange counties; 44 percent were discharged to some form of housing option; and only 11 percent were readmitted to the hospital. Hospitals have so far saved more than $12 million. "There are 63 hospitals contracted to utilize the program and 20 beds at each site, however the program has not been at full capacity or had a need for a waiting list, " said Elizabeth Yang, Director of Recuperative Care Center. The program not only lowered the daily cost of care for homeless patients by almost 90 percent, but most get placement notification within four business hours and the length of stay is established up front, Ultimately, they are able to deliver services for less money, a goal of health care reform.

"Medical respite programs offer a wonderful and cost effective alternative to discharging to the streets; it allows patients to continue to receive necessary care, and reduces readmissions, many of which would likely occur within 30 days due to complications that arise from having to manage their health on the streets after leaving the hospital," Edgington said.

In this post-reform world, where better care, better health and lower costs is the mantra, hospitals continue to be challenged by post-discharge care of homeless patients. Respite care has a place in this new value-based landscape that demands effective collaboration among hospitals, community resources and patients.

Kelly Bruno is an experienced social service and health care executive, with over 15 years of service in the nonprofit industry. Currently COO for the National Health Foundation, Ms. Bruno has designed, developed and implemented programs that focus on health care system delivery change and insuring the uninsured. She is trained in both gerontology and early childhood education, has her master's degree in Social Work from California State Long Beach as well as a California Nursing Home Administrators license. For more information, please visit www.nhfca.org/Recup/Home.aspx.