Medical Respite Care as a Response to the Health Needs of People Experiencing Homelessness

A Literature Review
for the Sherbourne Health Centre Infirmary Program
Toronto, Canada

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Purpose Statement

The initial purpose of this literature review was to provide background information for the 2014 Program Evaluation of the Sherbourne Health Centre Infirmary Program, a medical respite program in Toronto, Canada. Joyette Consulting Services conducted this Program Evaluation.

This literature review is also highly applicable to other agencies or professionals who are interested in learning about medical respite care, designing medical respite programs, or improving existing ones.

The Program Evaluation of the Sherbourne Health Centre Infirmary is an internal document that can be requested by contacting the Program Director, Melanie Oda, at moda@sherbourne.on.ca.

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Introduction

Homeless individuals suffer from disproportionately poorer health, and they use acute care health services more frequently than the general population. Hospitals are increasingly discharging patients sooner and providing treatment and services on an outpatient basis, and safe recuperation options are scare for homeless people. The medical respite care model addresses this aspect of the homeless individual's health care needs. The Sherbourne Health Centre Infirmary Program (SHCIP) is one such medical respite care program.

Defining Homelessness

The current definition of homelessness is when an individual or family is without stable, permanent, appropriate housing. This definition includes those who are unsheltered, in emergency shelters, provisionally accommodated, or at risk of homelessness, and it reflects both the states of literal homelessness and housing vulnerability (Gaetz, Donaldson, Richter, & Gulliver, 2013).

Homelessness in Toronto

The number of homeless people in Toronto in 2013 was estimated at 5,253 people. This figure has remained stable since 2009 when accounting for population growth. According to the most accurate counts, males make up 2/3 of the homeless population, and this is consistent since 2009. People identifying as Aboriginal are overrepresented in the homeless population compared to the general population, and the percentage of homeless Aboriginal individuals who sleep outdoors is increasing. The most dramatic trend in the homeless population of Toronto is that it is aging. Since 2009 the number of homeless people over the age of 60 has doubled (City of Toronto, 2013).

Homelessness and Health

The literature consistently reports that homeless individuals have poorer health outcomes than the general population. The most commonly reported health impacts of homelessness and housing vulnerability relate to chronic disease, mental illness, substance use, infectious diseases, assault and injury, disability, and mortality. This population also faces greater barriers to accessing health care services including not having identification or a health card, being unable to make or keep medical appointments due to lack of transportation or a telephone, competing priorities of basic day to day needs, limited drug coverage, and poor coordination or transition of care from

hospital to the community. This often leads individuals to delay seeking care when they need it.

Homeless individuals are found to have higher frequency of emergency department visits, more frequent hospitalizations, longer length of stay during hospitalizations and therefore, higher health care costs than the general population.

Medical Respite Care

Medical respite care is an important part of the continuum of care for individuals experiencing homelessness. Medical respite care refers to recuperative or convalescent care for those who are not ill enough to require hospitalization, but are too sick or vulnerable to be discharged to the streets, an emergency shelter, or unsafe housing. Medical respite care allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services (Bauer, Moughamian, Viloria, & Schneidermann, 2012; Donovan, Dee, Thompson, Post, & Zerger, 2007; NHCHC, 2010a; Zerger, 2006). This type of care also represents a critical window to engage patients and help them make connections to community-based medical care, social services, and housing so that they can better manage their health upon discharge (Bauer et al., 2012; NHCHC, 2012; Zerger, 2006).

Medical Respite Care Delivery Models

The four main service models for medical respite care are: care facility-based, shelter-based, free-standing, and apartment-style. The SHCIP is a hybrid model, straddling the free-standing and care-facility based medical respite models. Benefits of this are that the SHCIP has the flexibility and freedom to deliver its own nursing, administrative, and social services, and it also has the benefit of sharing medical, laboratory, administrative, housekeeping, security, and meal services with the rest of the Sherbourne Health Centre.

Impacts of Medical Respite Care

Medical respite care has been demonstrated to reduce future hospital re-admission, reduce future hospital inpatient days, lead to improvements in housing status (Kertesz et al., 2009; Buchanan, Doblin, Sai, & Garcia, 2006; Doran, Ragins, Gross, & Zerger, 2013), increase access to financial resources, improve severity of primary medical diagnoses, increase connection to community primary health care (Mcmurray-Avila, Ciambrone, & Edgington, 2009), potentially decrease emergency department use, and provide health services at a reduced cost when compared to hospitalization (Buchanan et al. 2006; Kertesz et al. 2009).

Best Practices and Guidelines

There are no best practice guidelines established for medical respite care, however there are several recommendations contained in the literature. These range from the ideal service delivery model, the types of services that should be on-site, how to market the program and maintain relationships with partner agencies and referral sources, and what data programs should collect on an ongoing basis.

Challenges and Lessons Learned

Some themes that were uncovered in the literature included challenges with not having enough bed capacity, prioritizing clients due to ethical issues, dealing with referrals that do not meet the criteria but have no where else to go, relationships with hospitals and other referring agencies, and staff retention and training issues.

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ACRONYMS

ADL Activities of Daily Living. Includes self care activities such as getting dressed, bathing, ambulating, toileting, and eating.

ALC Alternative Level of Care. When a patient in a hospital is determined to be ready for discharge because they do not require acute care services, but they can't be discharged because there is no safe place for them to go, they remain in hospital labeled as ALC patients.

AMA Against Medical Advice. Refers to when a patient chooses to leave a medical program before their care providers feel they are medically stable enough. In this case the staff are aware the patient is leaving and sometimes they are asked to sign a release of liability form (AMA form).

AWOL Absent Without Leave. Refers to when a patient leaves and does not return to a medical program. In this case it is done without the patient informing staff.

BHCHP Boston Health Care for the Homeless Program. A health care service in Boston, US.

CCAC Community Care Access Centres. Agencies in Ontario that are run by the Ministries of Health to coordinate public access to government funded home and community services.

CHW Community Health Worker. Unlicensed health workers who assist clients in case management, care coordination, housing and sometimes personal care activities.

CW Case Worker. A client resource worker who may be unlicensed or a registered social worker. Provides case management and other social services to clients.

FHT Family Health Team. A primary health care service delivery model that includes physicians, NPs, RNs, social workers, dieticians, and other professionals.

FMD Family Medical Doctor. A physician who provides ongoing primary health care to clients in the community.

HCH Health Care for the Homeless. A network of health care programs in the US that provides primary health care to homeless individuals.

IV Intravenous. A method of administering medications such as antibiotics that requires the supervision of a nurse.

LGBTQ Refers to individuals who identify as Lesbian, Gay, Bisexual, Trans, Queer or Questioning

LHIN	Local Health Integration Network. The health authorities responsible for regional administration of publicly health care services in Ontario.
MD	Medical Doctor. A physician, a medical professional who helps clients achieve overall health primarily through overseeing medical intervention.
NHCHC	National Health Care for the Homeless Council. An American homeless health care organization.
NP	Nurse Practitioner. An Extended class of RNs who are authorized to autonomously perform activities that RNs cannot, such as prescribing medication, diagnosis, and treatment plan orders.
OICH	Ottawa Inner City Health. A health care organization in Ottawa, Canada.
OT	Occupational Therapy. Allied health professional that helps clients achieve overall health primary by focusing on the daily occupations of life.
PA	Physician Assistant. Health care professionals who work with and are supervised by physicians, more commonly used in the US health care system, but also in Canada.
PSW	Personal Support Worker, historically known as health care aide, personal attendant. Completed a certificate program with a focus to help clients with personal care, safely mobilize and transport clients with mobility issues and provide support.
PT	Physiotherapist. Allied health professional that helps clients achieve overall health primarily through movement and exercise.
RN	Registered Nurse. A registered professional who helps clients achieve overall health through primarily medical intervention.
SCU	Special Care Unit. A medical respite facility in Ottawa, Canada. There is an SCU for men, and an SCU for women located in 2 different facilities.
SHC	Sherbourne Health Centre. A health center in Toronto, Canada where the SHCIP is located.
SHCIP	Sherbourne Health Centre Infirmary Program. A medical respite care facility in Toronto, Canada, located in the SHC.
SMH	St. Michael's Hospital. An inner city acute care hospital in Toronto, Canada that has a focus on serving homeless individuals and marginalized populations.
SNA	Toronto Street Needs Assessment
US	United States of America

INTRODUCTION

Homelessness is a multifaceted public health challenge. The pathways in and out of homelessness reflect a complex interaction between structural factors, system failures, and individual circumstances (Gaetz et al., 2013). Competing priorities related to the daily struggle for safe shelter and food, and barriers to routine medical care all challenge homeless individuals' ability to maintain a healthy lifestyle and adhere to medical treatment regimes. This continues to result in homeless and vulnerably housed populations suffering from disproportionately poorer health, and they are consistently associated with more frequent use of hospitals and longer hospital stays (Bauer et al., 2012). Complicating matters, services, treatments, and procedures are increasingly being provided on an outpatient basis and hospital stays are becoming shorter (Zerger, 2006). While these individuals may not be ill enough for hospitalization, safe recuperation alternatives are rare.

The medical respite care model addresses this aspect of the homeless individual's health care needs, filling a gap between hospital and community care. Programs that implement this model provide temporary shelter and post-acute medical care for individuals who are not ill enough to be in hospital, but are too ill or frail to safely recover from a physical illness or injury on the streets or in a homeless shelter (Bauer et al., 2012). The Sherbourne Health Centre Infirmary Program (SHCIP) is one example of this type of care.

An extensive search of scholarly and grey literature was performed, including a review of research, toolkits, practice guidelines, and internal documents from the SHCIP. This literature review: presents important literature on homelessness and how homelessness affects health, uncovers the trends of homelessness in Toronto, defines the concepts related to medical respite care, explores and compares service delivery model components, presents the impacts of medical respite care, identifies best practices, and lastly, discusses the challenges of providing medical respite care. The literature gathered encompasses studies from various countries including Canada, the US, the Netherlands, and Australia.

Challenges and Limitations

While efforts have been made to find all articles and publications related to homelessness in Canada and medical respite care worldwide, this literature review does not claim to be a comprehensive review of all information potentially available internationally. While the US has a well-developed hub for medical respite programs and services through the National Health Care for the Homeless Council, other countries that offer these services do not appear to have any such centralization of information. Therefore it is possible that more medical respite programs exist that this literature was able to find, perhaps due to use of different terminology, languages, or a lack

publication. This limitation highlights the need for all medical respite programs to share information in order to learn from each others' expertise, experience, and challenges.

PART 1: HOMELESSNESS AND HEALTH

This report uses the most current definition of homelessness released by the Canadian Homelessness Research Network (2012): when an individual or family is without stable, permanent, appropriate housing, or the immediate means and ability of acquiring it. This definition includes individuals who are unsheltered, staying in emergency shelter, provisionally accommodated, and at risk of homelessness, therefore reflecting both the states of literal homelessness and housing vulnerability. This is shown in Figure 1. Including all of these subgroups of individuals in the definition of homelessness is important because vulnerably housed individuals have been demonstrated to spend almost as much time without a place to sleep as absolutely homeless people do over a period of 2 years (Holton, Gogosis, & Hwang, 2010; Gaetz et al., 2013), illustrating the fluidity of the transitions between homelessness and unstable housing.

Figure 1. *Definition of Homelessness*

Sleeping Rough (Unsheltered)	• public spaces, makeshift shelter (e.g. tents), buildings and spaces not designed for habitation (e.g. car, buses, squatting)
Emergency Sheltered	emergency shelters, including violence against women and children shelters
Provisionally Accomodated	• transitional housing, couch surfing, hotel/motel, institutionalized with no fixed address (e.g. hospital, jail, mental health facility)
At Risk of Homelessness	• facing eviction, living with violence/abuse, spending 30% or more of before-tax income on rent plus below standard quality of space

(Canadian Homelessness Research Network, 2012)

1.1.   Homelessness in Toronto

This section presents relevant data on homelessness in Toronto. The goal was to identify the current make up of the homeless population in Toronto and how it has changed since the SHCIP's establishment in 2007.

For the purposes of this literature review the Toronto Street Needs Assessments (SNA) conducted in 2006, 2009, and 2013 were be used. These point-in-time homelessness studies provide an excellent comparison of trends in homelessness over time, as the methodology has remained consistent for all three surveys. Volunteers conducted face-to-face surveys on one specific night of the year. These surveys took place outdoors, and in the shelter system, hospitals, treatment centres, and correctional facilities (City of Toronto, 2013). As a result, data was captured from all of the subgroups in the homeless definition with the exception of many provisionally accommodated individuals. (To date, no studies have been found that provide data on all subgroups in the definition). Some compelling trends from the 2013 SNA are presented in Figure 2.

In 2013, there were an estimated 5,253 people experiencing homelessness in Toronto (City of Toronto, 2013). In addition, on any given night in Toronto there are 23 people living with housing vulnerability for every one person sleeping in a shelter (Holton et al., 2010). Lastly, 13.2% of Toronto's households are in severe housing need (paying more than 50% of their income on housing), and this rate is the highest of all the Canadian census metropolitan cities (Gaetz et al., 2013).

Figure 2. *Highlights from SNA 2013 report*

The number of homeless individuals has been stable since 2009. There were an estimated 5,253 people who were homeless in Toronto on the night of April 17, 2013 including those with and without shelter, which is stable when accounting for population growth from 2009-2013.

Males represent 2/3 of the homeless population. This is consistent with previous years.

People identifying as Aboriginal continue to be overrepresented in the homeless population. While 1% of the population of Toronto identified as Aboriginal, 16% of the homeless population identified as Aboriginal. In 2013, compared to 2009, the proportion of Aboriginal homeless people who sleep outdoors has increased by 4%.

One in five homeless youth identified as LGBTQ. This is the first year the SNA asked about LGBTQ identity.

The homeless population is aging. The percentage of homeless individuals who are over age 60 more than doubled from 2009-2013.

Respondents who say they need help addressing their health needs has increased by 6% since 2006.

Respondents who said they have used the emergency department or health clinic in the last 6 months in 2013 had decreased slightly from 2006.

(City of Toronto, 2013)

1.2.   Homelessness and Health

Whether looking at local, national, or international research, the results are the same: homelessness and housing vulnerability negatively affect health. The relationship between homelessness and health is generally assumed to be bidirectional, whereby sick people become homeless, and homeless people become sick (Hwang, 2002; Wellesley Institute, 2010). This section provides an overview of the literature that explores the impacts of homelessness on health and how this relates to the health care services that homeless individuals utilize and require.

General Overview

Permanent shelter is a fundamental need for optimal health. Health problems for individuals experiencing homelessness stem from or are worsened by: overexposure to environmental elements like extreme temperatures, rain, snow, and sun; exposure to communicable diseases; inadequate access to safe drinking water and nutritious food; victimization, crime, and violence; chronic stress; criminalization; and coping mechanisms such as alcohol, drugs, or tobacco. These social circumstances can convert a medical condition that is manageable in a safe home with rest and care from supports such as friends, family, or community members into a condition requiring hospitalization (Gaetz, 2004; HCH Clinicians Network, 2010; Holton et al., 2010; Neate & Dent, 1999; Zerger, 2006). Meanwhile, the health care delivery system, which has traditionally struggled to adapt to this population's complex needs, faces both budgetary constraints and an aging population with increasingly complex and chronic illnesses (Zerger, 2006). In an effort to manage constrained resources and still provide care for everyone, services and procedures are being provided more frequently on an outpatient basis, hospital stays are becoming shorter, and community hospital beds are disappearing (Zerger, Doblin, & Thompson, 2009; Zerger, 2006). This creates a cycle between homelessness, health, and quality of life. The most commonly reported health impacts of homelessness and housing vulnerability are: chronic disease, mental illness, substance use, infectious diseases, assault and injury, disability, and mortality.

Chronic Disease. Homeless and vulnerably housed individuals suffer from high rates of a wide range of chronic medical conditions (often poorly controlled) including: arthritis (33%), asthma (23%), high blood pressure (18%), chronic obstructive pulmonary disease (18%), ulcers (9%), diabetes (8%), heart disease (8%), cirrhosis (6%), cancer (5%), epilepsy (4%), and poor dental health (Frankish, Hwang, & Quantz, 2005; Holton et al., 2010; Gaetz, 2004). Regardless of whether individuals are homeless or vulnerably housed, Hwang and colleagues (2011a) found that over 85% have at least one chronic health condition.

Mental Illness. Prevalence of mental illness is much higher in homeless individuals than the general population. Experience of mental illness ranges in severity and includes: depression, trauma, schizophrenia, anxiety, and mood disorders (Gaetz, 2004). The most commonly uncovered mental illnesses in the homeless population are affective disorders such as depression, anxiety, and bipolar disorders, with a lifetime prevalence of 20-40% (Frankish et al., 2005). In another study, 52% of vulnerably housed and homeless participants reported a past diagnosis of a mental health problem (Holton et al., 2010; Hwang et al., 2011a). As a subgroup of homeless and vulnerably housed individuals, single women have a higher prevalence of mental illness than single men or women with children (Hwang & Henderson, 2010).

Substance Use. Prevalence of substance use is higher among homeless individuals than the general population, including injection drug use and the associated health risks (Gaetz, 2004). One study demonstrated that homeless men have a lifetime prevalence of 60% for alcohol misuse (Frankish et al., 2005), and another found that 48% of participants considered themselves to have had a drug or alcohol problem in the past year (Kushel, Vittinghoff, & Haas, 2001). Substance use is linked to several important sequelae: leaving against medical advice (AMA) from hospitals, incomplete therapy or treatment, and high rates of emergency department use and re-hospitalization (Rachalis, Kerr, Montaner, & Wood, 2009). Leaving AMA from a hospital significantly raises the risk of re-hospitalization (Bauer et al, 2012).

Infectious Diseases. Homeless individuals are at an increased risk of tuberculosis, and prevalence among homeless populations in 1997 was ten times higher than the general population (Gaetz, 2004). Compared to the general population, homeless and vulnerably housed individuals also have higher rates of HIV (6%), particularly homeless youth, (Frankish et al., 2005; Gaetz, 2004), and higher rates of Hepatitis B and C (up to 30%) (Gaetz, 2004; Holton et al., 2010).

Assault and Injury. Homeless individuals are at high risk for assault and injuries. A shocking study from 1993 demonstrated that in the past year 40% of Toronto homeless participants had been assaulted, and 21% of female participants had been raped (Frankish et al., 2005). More recently, Holton and colleagues (2010) found that 38% of homeless and vulnerably housed individuals had been beaten up or attacked in the past year.

Disability. Homeless people in their 40s and 50s often develop health disabilities that are commonly seen in persons who are decades older (Frankish et al., 2005). Over 25% of homeless and vulnerably housed individuals reported difficulty walking or other problems with mobility, and 61% reported having had a traumatic brain injury at some point in their life (Holton et al., 2010).

Mortality. Individuals experiencing homelessness face an increased risk of death compared to the general population, particularly for youth and women (Frankish et al., 2005; Gaetz, 2004). A study from Toronto demonstrates that males using the emergency shelter system are twice as likely to die from murder or suicide than the general population (Hwang, 2002).

The options for these sick homeless and vulnerably housed individuals are limited, and as the research presented in the next section will demonstrate, the burden of these clients on the health care system is high.

Barriers to Health Care

Even in Canada where there is universal health insurance, homeless people face many barriers that impair their access to health services including not having identification or a health card, being unable to make or keep medical appointments due to lack of transportation or a telephone, competing priorities of basic day to day needs, limited drug coverage, and poor coordination or transition of care from hospital to the community (Frankish et al., 2005; Greysen, Allen, Lucas, Wang, & Rosenthal, 2012; HCH Clinicians Network, 2010).

Past experience and/or anticipation of barriers to care can cause homeless and vulnerably housed individuals to delay seeking care. Greysen et al. (2012) found that 60% of those studied said they delayed seeking care because they were concerned they wouldn't get the care they needed, or they were concerned they wouldn't have shelter once they were discharged. Participants stressed that discharge planners from hospitals often don't think about whether people have a safe place to stay, only that their medical needs have been met (Greysen et al., 2012; Hwang et al., 2001). The top reported barriers to accessing care are being refused services, not 'feeling up to' seeking care, not having a health card, not knowing where to go to get their needs met, and waiting too long for an appointment (Holton et al., 2010).

Health Care Utilization

Despite the research that has shown that homeless individuals seek care less than they may require it, there is a large amount of research illustrating that this population still uses health care services far more than the general population. The most commonly measured outcomes for health care utilization are emergency department visits and hospitalizations.

Emergency Department. Emergency department use is an important marker of systemic problems, as it can reflect poor access to nonemergency health care services (Kushel, Perry, Bangberg, Clark, & Moss, 2002). Homeless individuals have been shown to have much higher rates of emergency department visits than the general population (Kushel et al., 2002; Frankish et al., 2005; Greysen et al., 2012; Hwang & Henderson, 2010; Kushel et al., 2001). When compared to controls, emergency department visits were 9 times higher in homeless single men, and 12 times higher in homeless single women (Hwang & Henderson, 2010). Fifty percent of homeless and vulnerably housed individuals visited the emergency department at least once in the past year (Holton et al., 2010), and almost half of the users of the emergency department stated they used it as their only source of health care (Kushel et al., 2002). Kushel et al. (2002) found that of all the homeless people who participated in their study on health care utilization, only 8% of the homeless participants accounted for the majority of the emergency department visits in the group. This suggests that health service efforts need to be

targeted to those homeless and vulnerably housed individuals who are most chronically ill and mentally unstable.

Hospitalizations. Homeless people are hospitalized up to five times more often than the general population, and they stay in the hospital longer than a housed, low-income comparison group (Frankish et al., 2005; Greysen et al., 2012; Hwang & Henderson, 2010; Kushel et al., 2002). Twenty-five percent of homeless and vulnerably housed individuals studied stayed overnight in hospital at least once in the past year (not including nights in the emergency department) (Holton et al., 2010). A study that compared homeless men and women to a control group found that homeless men were hospitalized 8.5 times more often, and homeless women were hospitalized 4.6 times more often (Hwang & Henderson, 2010). The longer length of hospitalization for homeless patients is often attributed to not having a safe place to recuperate after a hospital stay, and therefore is of particular relevance to the medical respite care discussion.

Related Costs

Hospitalization and emergency department use are expensive ways to provide care, and there is a great deal of literature demonstrating that the cost impacts of homelessness are significant.

In Toronto, homeless individuals were found to have an annual average cost $1,464 per person per year from emergency department use. Emergency department costs for housed persons were found to be only 13% of this figure. In the same study, average annual costs for homeless persons' hospitalizations was $2,495, but for the housed group it was only 21% of this figure (Hwang & Henderson, 2010). This is consistent with the literature that demonstrated more and longer hospitalizations, and more emergency department use by homeless individuals.

A study conducted in New York City in the early 1990s uncovered that homeless patients cost $2,414 more per hospital admission on average. This was found to be even more dramatic for homeless psychiatric patients, whose admissions cost $4,094 more (Salit, Kuhn, Hartz, Vu, & Mosso, 1998). Twelve years later, a similar study conducted in Toronto found that, compared to housed patients, medical admissions to hospital for homeless patient's cost $2,559 more, and psychiatric admissions to hospital cost $1,058 more for homeless patients. A substantial proportion of these differences were found to be due to far more alternative level of care (ALC) days in the homeless group. These costs were adjusted for age and gender (Hwang, Weaver, Aubry, & Hoch, 2011b). The increased number of ALC days has important implications for this review, because it suggests that these ALC days could potentially be avoided through medical respite care.

PART 2: MEDICAL RESPITE CARE AS A SOLUTION

As demonstrated in the previous section, homeless and vulnerably housed individuals have poorer health, utilize more acute care resources than the general population, and face significant challenges to safe recuperation after an acute medical illness or injury. Shelters often require clients to leave the premises during the daylight hours, making medical recommendations such as elevating an infected leg, medication and/or special diet adherence, attending follow-up appointments, wound care, mobility restrictions, and bed rest difficult to adhere to. This is also true when individuals have housing if it is unsafe, unclean, or inaccessible, or if they have limited social supports (Kertesz et al., 2009). One possible solution to this public health issue is medical respite care. This section provides a definition of medical respite care, illustrates the various models of medical respite care, highlights the impacts of medical respite care, and presents best practices, guidelines, challenges, and lessons learned.

Of note, though much of the literature is from the US, this is very relevant to the Toronto context. Henderson and Hwang (2010) support the comparison between homelessness in Toronto and the US as a whole by discussing how the contributors to this public health issue are similar. First, deinstitutionalization of people with mental illness occurred almost at the same time in the US and Canada, which contributed greatly to homelessness. Second, the economy and labor market of Canada is closely linked to that of the US, and full-time employment for unskilled workers has declined in both countries. Lastly, public funding for the social safety net as a percentage of the GDP are similar between the US and Canada (15% and 18% respectively) (Hwang & Henderson, 2010).

2.1.   Defining Medical Respite Care

While SHCIP is called an 'infirmary', the majority of the literature available on this type of service provision uses the term 'medical respite care'. Medical respite care refers to recuperative or convalescent care for those who are not ill enough to require hospitalization, but are to too sick or vulnerable to be discharged to the streets, an emergency shelter, or in some cases unsafe housing. Medical respite care allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services (Bauer et al., 2012; Donovan et al., 2007; NHCHC, 2010a; Zerger, 2006). Other less commonly used terms include 'recuperative care', 'convalescence for homeless adults', or 'interim care' (NHCHC, 2012).

> "Respite care offers a unique opportunity to offer important services to homeless individuals who may not have encountered the healthcare system for years, except in emergencies. The respite team can often build rapport and trust with homeless clients, successfully engage them in critically needed medical and behavioural healthcare, and help them achieve stability through supportive housing. This is especially important for individuals who have experienced prolonged homelessness."
>
> (Donovan et al., 2007, p. 2)

The focus of medical respite care is not just to stabilize the physical health of clients. This type of care also represents a critical window to engage homeless patients and help them make connections to community-based medical care, social services, and housing so that they can better manage their health upon discharge (Bauer et al., 2012; NHCHC, 2012; Zerger, 2006). Figure 3 contains the defining features of a medical respite program according to the Respite Care Providers Network in the US. These characteristics are consistent with the characteristics of the SHCIP.

History

The first medical respite facilities in the US started emerging in the mid 1980s, while in Canada, the need for respite services was not formally articulated until well into the 1990s. Since then, systemic trends including the decentralization of mental health services, defunding of social services, and changes leading to health systems discharging people quicker have led to rapid proliferation of medical respite services particularly in the US (Zerger et al., 2006). In 2000, the US federal government funded a pilot initiative for 10 emerging medical respite programs. By 2006, there were 32 programs known to be actively providing medical respite services in the US (Zerger, Doblin, & Thompson, 2009). To date, as far as this literature search can deduce, there are 3 medical respite programs in Canada (1 in Ottawa, and 2 in Toronto including the SHCIP), 63 in the US, 1 in Melbourne, Australia, and 1 in Amsterdam, the Netherlands. As previously noted, it is very likely that there are many more such programs in the world, and likely in Canada, that were not discovered through the search strategy for this review.

In 1999, a group of respite care providers in the US met and formalized their collaboration, creating the Respite Care Providers' Network. This network supports new and existing medical respite programs through education, client advocacy, networking, and research (NHCHC, 2012; Zerger et al., 2009). This review has been unable to uncover any such initiatives in Canada. In fact, there is very little publically available information about the limited number of medical respite programs in Canada. In the experience of the author, both as a medical respite professional and a researcher who has contacted professionals in this field, these programs have no formal means of

communicating and sharing information with each other, and in many cases they are not even aware that each other exists.

Figure 3. *Defining Characteristics of Medical Respite Care*

• A short term specialized program focused on homeless persons who have a medical injury/illness and may also have mental illness or substance abuse issues

• Comprehensive residential care providing residents the opportunity to rest while enabling access to hospitality, medical and supportive services that assist in completing their recuperation

• Length of stay restricted to the period of time required to complete medical recovery and to access community services

• Whole person care through collaboration with other local providers who offer a variety of services to residents during their stay in respite care and also provide continuity of care when the resident moves into the community

• Active participation by residents in the process of their recuperation and discharge planning

• A bridge that closes the gap between acute medical services currently provided in hospitals/emergency rooms, homeless shelters that do not have the capacity to provide needed recuperative care, and more permanent housing options

• Low cost, high quality and innovative recuperative services which result in significant savings to communities

• Various service delivery models incorporating the basic characteristics of a respite care program developed to meet the needs of local homeless populations and resources available in local communities

• An integral component of the continuum of care for homeless services in any community

(HCH Clinician's Network, 2007)

2.2.   Medical Respite Care Delivery Models

There are many different respite care delivery models. During the process of this literature review, descriptive information was available for several medical respite programs: 63 from the US, 3 from Canada, 1 from Australia, and 1 from the Netherlands. Data from the US was incredibly useful in analyzing different frameworks, because there were a few publications that compared and contrasted different models. Important findings from these articles are summarized in this section including the types of service

models, eligibility criteria, referral sources, staffing and services, capacity, length of stay, harm reduction policies, and partnerships. This is important as it sets the stage for the following section which attempts to uncover which program aspects are most effective.

Service Models

There are four main models for medical respite care services described in the literature. Listed by frequency of occurrence (according to Zerger's 2006 descriptive analysis of 10 medical respite programs), the four main service models are: care facility-based, shelter-based, free-standing, and apartment-style. There are an additional two alternative models: combination models, and the motel/hotel voucher model (Mcmurray-Avila et al., 2009; Zerger, 2006; NHCHC, 2012). Figure 4 provides a description of these models. Following this, Table 1 presents the benefits and challenges of each model.

The SHCIP can be categorized as a hybrid model, straddling the free-standing and care-facility based medical respite models. By being a separate program within an outpatient health centre, SHCIP has the flexibility and freedom to deliver its own nursing, administrative, and social work services, but it has the benefit of sharing medical, laboratory, administrative, housekeeping, security, and meal services with the rest of the Sherbourne Health Centre (SHC).

Figure 4*. Medical Respite Care Service Models*

Care-Facility Based
- These programs exist in a variety of facilities like nursing homes, substance abuse treatment programs, or board and care facilities. Usually the facilities already have 24-hour health care staff in place, plus other services like administration, housekeeping, and meal preparation. Generally the respite program rents a number of beds used for respite care, which covers the cost for these services, and then the respite program provides the medical supervision and daily clinical visits.

Shelter-Based
- These respite programs are in collaboration with one or more homeless shelters in their community. Respite beds are usually separate from the general shelter population. In general, health providers visit the respite patients daily and provide "on-call" medical supervision at night, relying on shelter staff to supervise respite patients overnight. Services like administration, housekeeping, and meal preparation already exist in the building.

Free-Standing
- In this model the respite program exists it its own facility, and has complete control and responsibility over the facility and the medical care.

Apartment
- This model uses apartments in the community to house respite clients. Administration needs such as security, housekeeping and food preparation, are handled through community organizations, and medical supervision and case management are provided by the respite program.

Combination
- Some medical respite facilities combine these above models. This is used if, for example, there are not enough beds to meet the community's needs. Some medical respite programs will complement their respite beds in stand alone facilities with respite beds in a shelter. Another example is when free-standing models combine with care-facility models, where the medical respite program has control over the medical care provided in the unit, but not necessarily the facility services such as housekeeping.

Motel/Hotel Voucher
- This is similar to the apartment model. These programs either directly rent the rooms or collaborate with other organizations in operating voucher programs. Health and social service staff make 'home' visits to the hotel/motel, and arrange transportation for clients needing to go to a clinic or hospital. Arrangements are made for meals, or cooking facilities are available.

(Zerger, 2006; Mcmurray-Avila et al., 2009)

Table 1. *Benefits and Challenges of the Different Service Models*

Service Model	Benefits	Challenges
Care Facility-Based	– efficient use of existing resources and services (e.g. beds, food preparation, transportation, pastoral support, cleaning, classes, 24h staffing, security, connections to transitional housing) – resources provided tend to be comprehensive (e.g. medical providers and social services on site, more dietary options, more flexible rules), works well for clients with complex needs – tend to be connected with broader systems of care (e.g. mental health, hospital, primary care partnerships) – cost effective	– limited control of existing resources – difficult to control certain policies (e.g. harm reduction) – usually have capacity to accommodate dietary restrictions
Shelter-Based	– efficient use of existing resources and services: beds, food preparation, transportation, pastoral support, cleaning, classes, 24h staffing, security, connections to transitional housing – cost effective	– limited control of existing resources – difficult to control certain policies (e.g. harm reduction) – difficult to control for dietary requirements – difficult to accommodate clients with mobility restrictions – health and safety issues of the shelter environment
Free-Standing	– full control over services, staff, rules and regulations – generally able to accommodate clients with far greater medical and/or psychosocial needs	– this model is the most costly – securing funding can be challenging – must fund 24/7 staff and provide all services related to administration and ancillary services (e.g. food preparation, cleaning staff, laundry, etc.)

Apartment	– allows families to stay together – private, restful environment – effective for isolating for infectious diseases	– limited number of people can be served – high level of independence is required – 24/7 care not available – proximity to other services may be limited – cannot guarantee safe environment
Combination	– provides safe discharge/additional recovery from stand-alone facilities – step-down level of care	– tensions between philosophies of care, policies, and control of the beds at different sites – prioritization and triage to different sites can be challenging
Motel/Hotel Voucher	– relatively low cost – easy to start up – families can stay together – effective at isolating infectious disease	– high level of independence is required – 24/7 care not available – proximity to other services may be limited – cannot guarantee safe environment

(Zerger, 2006; Mcmurray-Avila et al., 2009)

Zerger (2006) presents how effective these models are at serving the needs of the community, albeit based on self-report by the program coordinators. On a scale of 1-10 (1=not at all effective; 10=extremely effective), all models were rated 8.5-9/10 except for the apartment model, which was rated 7/10.

Though these models seem to be straightforward, the reality is that programs rarely act alone. Reading through the 66 program descriptions in the *Medical Respite Program Directory* (NHCHC, 2012), it is clear that many programs adopt a combination or hybrid model, and most rely heavily on partnerships with community health and social agencies to provide a wide range of medical and social services to their clients. Each facility acts creatively within the resources they have, and tries to serve the population by making partnerships to share the burden of caring for these high needs clients in a system with low resources.

Eligibility Criteria

All medical respite programs reviewed by Doran et al. (2013) have eligibility criteria that require clients to be homeless, and in some cases they can be unstably housed or at risk for homelessness. Almost all required a medical issue necessitating respite care; some required that the medical issue be acute and time limited (e.g. surgical

recuperation or antibiotic therapy for infection), others accepted patients who had acute exacerbations of chronic illness (e.g. poorly controlled diabetes) (Zerger, 2006; Doran et al., 2013). This is consistent with the SHCIP.

Most programs require clients to be independent with self care and medication administration, although some facilities, especially those in care facilities, are better able to accommodate clients who are not ambulatory, need oxygen therapy, and some assistance with personal care (Zerger, 2006). Facilities with 24/7 nursing support (and sometimes those with nurses only 40 hours per week) offer medication storage and administration (NHCHC, 2012). The SHCIP requires clients to be ambulatory and independent with self care, and nurses store and administer medication.

Referrals

More than half of referrals for medical respite programs come from hospitals (53-61%), which include both inpatient units and the emergency department (Zerger, 2006; Respite Research Task Force, 2008; Zerger et al., 2009). Approximately 20-24% are from health clinics or other programs servicing the homeless population, approximately 10% are from non-homelessness programs, and finally about 8% are from other sources (including self-referrals) (Zerger et al., 2009; Zerger, 2006). Current research shows that an average of 60% of referrals are admitted to medical respite programs (Zerger et al., 2009). SHCIP's referrals are accepted from the community, hospitals, and self-referrals. At the time of this review there were no data available about what proportion of referrals are from each of these sources.

Staff and Services

As indicated above, different models provide various intensities of medical care. Each program varies according to local needs, service model, and funding (Nashville & Edgington, 2011; Kertesz et al., 2009).

Services commonly provided in medical respite facilities include medical services (nurses, physicians, nurse practitioners), case management and service coordination (social workers, case workers, community health workers), meals, transportation to medical appointments, medication administration and/or dispensing and/or storage, substance use services, mental health services, and housing referrals (Zerger, 2006; Bauer et al., 2012**;** Kertesz et al., 2009; Buchanan et al., 2006; NHCHC, 2012*).*

Regardless of services provided, all programs evaluated by Zerger (2006) had emergency on-call plans; some included medical staff on-call, while others had arrangements made with hospitals and emergency departments. It is not very common for programs to have 24/7 nursing care on site, though a handful of the bigger programs do have this. This is an interesting fact, given that the SHCIP has this. Figure 5 and 6 demonstrate some of the clinical and social services provided in 66 medical respite
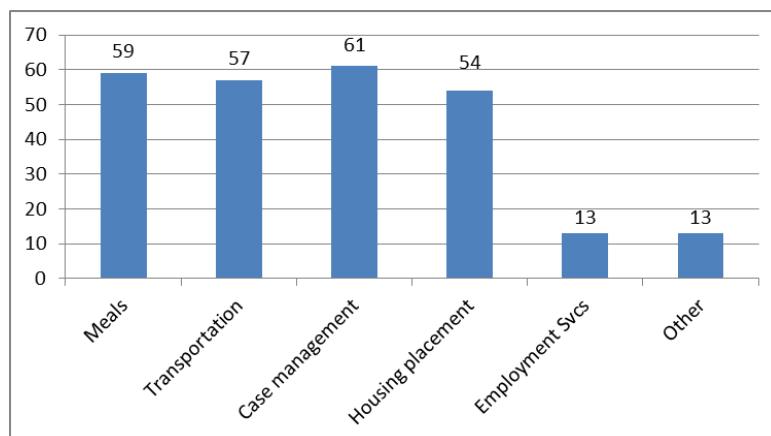
programs across the US and Canada as of 2012. The SHCIP offers all of the most commonly offered services, more details are provided in Appendix A.

Figure 5. *Number of medical respite programs by clinical services provided*
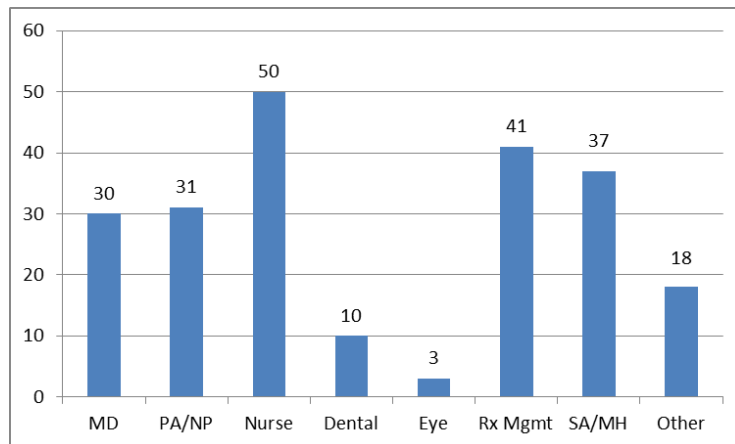
(NHCHC, 2012)

**Figure 6**. *Number of medical respite programs by support services provided*

(NHCHC, 2012)

Capacity

Bed capacity varies greatly across programs. Across the 25 programs studied by Zerger et al. (2009), the median number of beds is 13. In the directory that looks at all 66 programs in the US and Canada, the most common number of beds was 1-10, followed by 11-20 as shown in Figure 7. The largest program is the Barbara McInnis House in Boston, which has 104 beds. The SHCIP, at 10 beds, is consistent with the majority of other medical respite programs. Interestingly, it is the only program with a capacity of 10-20 beds that has 24/7 nursing care; all other programs with this level of nursing care have higher bed capacities.

Figure 7. Number of medical respite programs by beds available (program capacity).
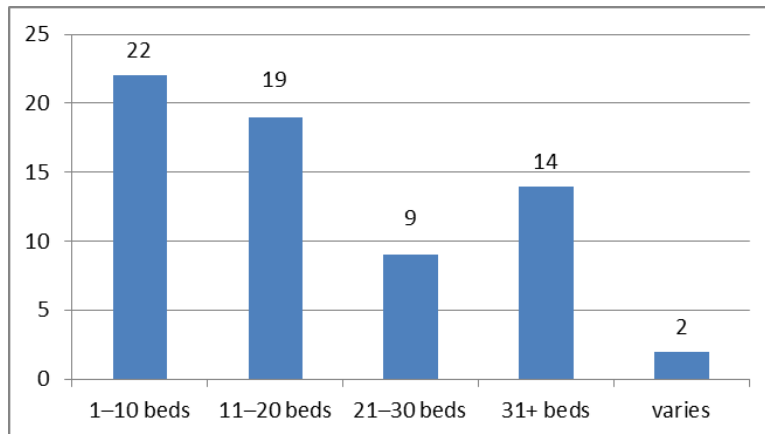
(NHCHC, 2012)

Length of Stay

Some studies reported length of stay as a median, and others reported it as a mean. Across all 66 medical respite programs described, the mean was 35 days and the median was 24 days (NHCHC, 2012). Boston's medial respite program's mean length of stay was 31.3 days (Kertesz et al., 2009). It is important to note that both of these measures are affected greatly by outliers, for example those who leave before treatment is completed, and those who stay in the program for an exceptional length of time. The SHCIP's target length of stay is maximum 21 days, which is shorter than these findings. However, median and mean length of stay data for the SCHIP were not available.

While all programs studied had an ideal length of stay in mind, almost all 26 facilities that Zerger (2006) studied were flexible and determined discharge dates on a case-by-case basis. This flexibility was exercised particularly for health conditions that were unpredictable during screening, or for connecting clients with additional services (e.g. housing, substance abuse services, or primary care). Flexibility in length of stay is also practiced to some degree at the SHCIP.

Harm Reduction

Harm reduction is an approach to providing care that aims to reduce the adverse health, social, and economic consequences associated with the use of psychoactive drugs in people unable or unwilling to abstain (International Harm Reduction Association, 2010). Harm reduction is an important component of medical respite programs because substance use is a significant risk factor for leaving medical respite programs early, and substance-using patients are more likely to be readmitted to hospital than other medical respite patients (Bauer et al., 2012).

In the medical respite setting, harm reduction policies vary across programs. Some have strict sobriety policies (e.g. many programs using the shelter-based models), while others operate under a harm reduction model and continue to work with clients to help reduce the health and safety risks related to their substance use while they are admitted to the medical respite program (e.g. the SHCIP) (Bauer et al., 2012; Nashville & Edgington, 2011). Notably, programs that do not follow harm reduction principles tend to have higher rates of clients leaving the program before completing their treatment plan (Nashville & Edgington, 2011). Of the programs evaluated by Zerger (2006), 90% required that clients not be actively using alcohol or other drugs, a finding which is inconsistent with SHCIP's harm reduction paradigm. While there were acknowledgements in the literature that harm reduction frameworks or policies do exist in medical respite programs, there was little information provided about what these policies include and how they are implemented in different medical respite settings.

Partnerships

While no literature specifically investigates partnerships, it is apparent that medical respite services are never provided without a great deal of collaboration with community agencies and other health care providers. Many programs have formalized partnerships with hospitals or primary health care centres. In the US, health centres that provide primary care exclusively to homeless individuals seem to be the most common partnership with medical respite programs, often providing the medical portion of the care (physician, nurse practitioner, or physician assistant). In most cases at least some nursing care is provided by home health care agencies (in Canada, this is the Community Care Access Centres (CCAC)), and these agencies often provide personal support, physiotherapy, and occupational therapy as well. Community social service agencies often collaborate to provide support with finding housing, income, and connecting clients with other community supports upon discharge. The SHCIP relies on several partnerships to provide holistic services to clients, these are described in more detail in Appendix A.

Medical Respite Program Profiles

In an effort to illustrate how the service delivery components above are implemented in practice, four medical respite programs including the SHCIP are profiled and presented in the Appendix A.

To conclude this section, Figure 8 summarizes the characteristics of the SHCIP that differ from the majority of other medical respite programs.

***Figure 8**. Characteristics that make the SHCIP unique*

24/7 nursing care combined with a capacity less than 20 beds

Harm reduction paradigm

2.3.   Impacts of Medical Respite Programs

The available literature that presents the impacts of medical respite care is fairly limited. The information that is available is presented in this section. First, a summary of impacts of medical respite services is provided, followed by a description of medical respite service users, and the cost of medical respite care. For readers who are interested in more detailed information about the impact studies, this is provided in Appendix B.

Summary of Impacts of Medical Respite Care

In general, medical respite programs are shown to reduce hospital re-admission, reduce future hospital inpatient days, improve housing status (Kertesz et al., 2009; Buchanan et al., 2006; Doran et al., 2013), increase access to financial resources, improve severity of primary medical diagnoses, increase connection to community primary health care (Mcmurray-Avila et al., 2009), potentially decrease emergency department use, and provide health services at a reduced cost when compared to hospitalization (Buchanan et al., 2006; Kertesz et al. 2009). These findings are presented in Figure 8.

While these findings are relevant, the information available does not tell us a great deal about which aspects of which models work better than others in which circumstances. Therefore, a supplementary in-depth description of the impact studies is provided in Appendix B. This includes a detailed description of the services available at the medical respite care study sites, the study methodology, and the specific outcomes presented.

Figure 8. *Summary of Impacts*

> Reduced future hospital admission and hospital days (Buchanan et al., 2006; Doran et al., 2013)
>
> Reduced 90-day hospital readmissions (Kertesz et al., 2009; Doran et al., 2013)
>
> Reduced hospital length of stay (Buchanan et al., 2006; Doran et al., 2013)
>
> Improvements in housing status (Zerger et al., 2006)
>
> Trends toward reduced emergency department use (Doran et al., 2013)
>
> Reduced cost (medical respite was reported generally as inexpensive, particularly when compared with the cost of hospitalization, but definitive conclusions about the cost effectiveness of medical respite programs from the existing literature cannot be made as per Doran et al. 2013))
>
> Increased connection with ongoing primary care in the community (from 33% to 50%) (Zerger, 2006)
>
> Significantly reduced severity of primary diagnoses (by 25%) (Zerger, 2006)
>
> Improved access to income resources (Zerger et al., 2006)

Demographics of Medical Respite Users

Zerger's (2006) descriptive analysis of 10 medical units provided some interesting demographic information of the clients who used these services. This majority of clients were male (78%), and the average client was 48 years old. The average age is similar to the average age of homeless people in Toronto (42 years old) (City of Toronto, 2013). What is particularly interesting about this is that 2/3 of the homeless population is male, while almost 4/5 of medical respite users are male. This provokes questions of why women are underrepresented by this service.
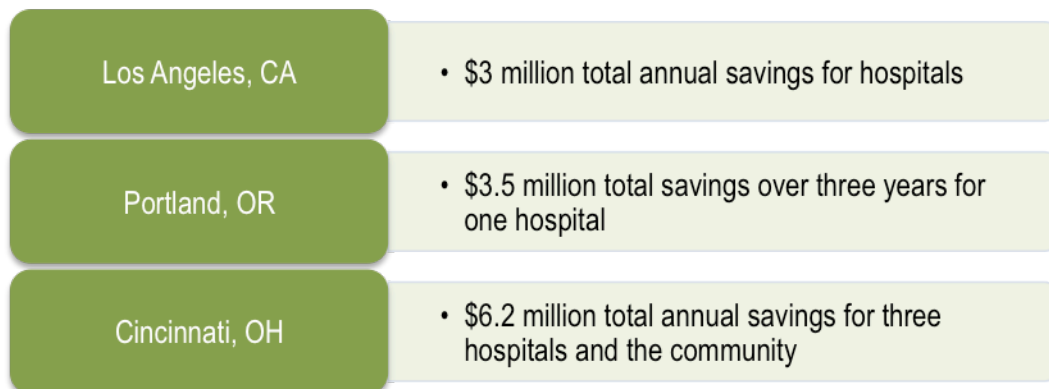
Most medical respite clients have long histories of homelessness, with 43% having been homeless for 1 or more years prior to coming, and only 12% having been homeless less than one month. In terms of health needs, most respite clients have multiple, severe, and complex needs. Seventy-five percent of clients had admitting diagnoses rated as 'poorly controlled, needing frequent adjustment in treatment and dose monitoring', and 70% of clients had at least one other diagnosis, most commonly a mental health issue. In general the psychosocial needs of clients are great, as most clients are without any social or family supports. Two-thirds had no access to a source of primary health care, half had no income, half had documented or suspected psychiatric problems, 62% had alcohol use issues, and 56% had other substance use issues (Zerger, 2006).

Cost of Medical Respite Care

It was discussed in Part 1 that homeless individuals cost the health care system more, particularly when measuring emergency department use and hospital length of stay. Hwang and Henderson's study (2010) reports that the estimated cost of one ALC day at St. Michael's Hospital (an inner city hospital in Toronto with a focus on serving homeless patients) is $368 for medical patients, and $845 for surgical patients. While the study does not provide exact costs of medical respite care, authors concluded that "respite care facilities, which consume far fewer resources per patient day than acute care hospitals, have the potential to reduce overall health care costs for homeless individuals" (Hwang & Henderson, 2010, p. 353).

A Fact Sheet from the NHCHC in 2010(a) published some significant figures that demonstrate cost savings from medical respite programs in three US cities: Los Angeles, Portland, and Cincinnati. These are presented in Figure 9. However, interpretation of these figures warrants caution, because the references provided were personal communications with the Chief Medical Officers of hospitals (Los Angeles and Portland), and with the Centre for Respite Care's Executive Director (Cincinnati).

Figure 9. Estimated Cost Savings from Medical Respite Programs in 3 US Cities

Los Angeles, CA	• $3 million total annual savings for hospitals
Portland, OR	• $3.5 million total savings over three years for one hospital
Cincinnati, OH	• $6.2 million total annual savings for three hospitals and the community

(NHCHC, 2010)

Basu, Kee, Buchanan, & Sadowski (2012) conducted a study where hospitalized homeless individuals were randomized into a usual care group, and a group that was given a series of interventions: medical respite after hospital discharge, case management, and stable housing. Participants were followed for 18 months. The results demonstrated cost savings of annual service use per person in the intervention group (measured in hospital days, emergency department visits, outpatient clinic visits, substance use treatment centres, nursing home stays, prisons and jails, days in medical respite, and other social costs related to housing such as shelters, and case management). However, this was not considered statistically significant. Having said that, there is a difference between statistical significance and clinical significance.

Clinically, this study demonstrates that medical respite is part of a continuum of care that can have dramatic impact on cost savings for homeless patients (Basu et al., 2012).

2.4.   Best Practices and Guidelines

There are a few resources that provide guidance on how to deliver medical respite programs and services, mainly coming from the Medical Respite Care Providers Network in the US. This section provides a summary of these recommendations.

Service Model

According to the Medical Respite Care Providers Network, the free-standing medical respite unit is the ideal care model. Using this model, the facility is designed specifically for medical respite services and therefore creates the most appropriate environment for delivering services. In this model the medical respite organization can control the admission guidelines, length of stay, harm reduction policies, and can adapt the program to the needs of the homeless clients in that particular community (Mcmurray-Avila et al., 2009).

Services

Medical respite programs are most effective when the services provided are interdisciplinary, comprehensive, continuous, and individualized, and when they simultaneously addressing clients' medical and psychosocial needs. The level of services provided is ultimately based on the availability of financial resources, which will determine the range of patient conditions that can safely and successfully be treated. At minimum, basic nursing should be made available (there no specific guidelines on how many hours per day this should occur) (Mcmurray-Avila et al., 2009). If clients with mental illness and/or addiction issues are admitted, mental health expertise and substance use services should be made available (Mcmurray-Avila et al., 2009; Zerger, 2006). Other highly recommended services include social services or case management either on site or through appropriate referrals (Mcmurray-Avila et al., 2009). Lastly, all services targeting individuals experiencing homelessness should ideally also be involved in advocacy work (HCH Clinicians Network, 2010).

Admission Guidelines

Admission criteria should be clearly outlined in a policy that is accessible to all stakeholders. Programs should be flexible enough to make exceptions for individuals who do not exactly fit the criteria but have no other safe recovery options (Mcmurray-Avila et al., 2009).

Program Marketing and Outreach

Ongoing marketing is crucial to the success of a medical respite program. There is a need to continually clarify admissions criteria and improve relationships with the programs that refer clients and accept them after discharge. Program administrators should consider meeting regularly with care coordinators and discharge planners in hospitals, emergency departments, nursing homes, substance use treatment programs, referring clinics, shelters, and relevant community agencies. Good quality relationships with these stakeholders are described as mutually beneficial (Mcmurray-Avila et al., 2009). Figure 10 provides highlights from this section.

Training

Medical respite programs should strive to support ongoing training and professional development for medical respite care coordinators and staff. This should include training around ethical issues that exist in this type of care in order to acknowledge the dilemmas staff face when screening referrals, harm reduction strategies, and other relevant topics (Zerger, 2006).

Harm Reduction

Harm reduction-informed addiction treatment should be provided in all medical respite care facilities. When possible, partnerships should be made with agencies and professionals specializing in substance abuse (Nashville & Edginton, 2011).

Measurement and Outcomes

Ongoing collection of data and outcomes is important in order to support evaluation of the efforts of medical respite programs over time. Staff should be trained on how to track data correctly, and the consequences of not tracking it. Outcomes should be measured using validated and standardized tools. Some examples of what data should be collected are: changes in client health and ability to function, resolution of acute health conditions, successful linkages to services (e.g. primary care, mental health, substance use, housing), avoided hospital stays as a result of respite care, and general demographic data (e.g. gender, age, active substance use, medical and psychiatric diagnoses, income sources, length of time homeless, drug coverage, community supports, use of health services in the last year).

Collecting data and measuring outcomes can be burdensome to medical respite program staff. In the absence of experienced staff to conduct research, programs administrators should develop a strategy to track outcomes. Partnerships with academic agencies or community agencies that do research can help alleviate this burden. (Mcmurray-Avila et al., 2009).

Figure 10. *Highlights of the Guidelines for Medical Respite Care*

The free-standing medical respite unit is the ideal model
Services should be interdisciplinary, comprehensive, continuous, and individualized; they should simultaneously address clients' medical and psychosocial needs, and be informed by harm reduction principles
Clearly outline admission criteria in a policy
Engage in ongoing efforts to market the program and work on relationships with referees and partners
Collect program data on a regular basis
Develop and support training and professional development opportunities for coordinators and staff

(Mcmurray-Avila et al., 2009; Zerger, 2006; Nashville & Edginton, 2009)

2.5.   Challenges and Lessons Learned

This section illustrates some of the compelling remarks made throughout the medical respite literature that highlight the challenges of providing this service.

Capacity, Referrals, and Prioritization

Of particular importance is the fact that despite having 63 respite programs in the US, and 3 in Canada, "the need for respite is vast, and remains largely unmet" (Zerger, 2006, p. 5). All the programs evaluated by this literature review are facing a growing need for their services, meanwhile resources are already limited and many programs are concurrently facing funding cuts or threats of funding cuts. Approximately 2/3 of the individuals referred to the larger programs reviewed by Zerger (2006) such as Seattle, Washington, and Denver were unable to be admitted because of lack of bed capacity. Furthermore, the screening of referrals is charged with ethical dilemmas related to prioritizations, and challenges with what to do with clients whose needs don't fit the program criteria but don't have any other place to go (Zerger, 2006). "Many respite staff report not only more clients being referred, but sicker ones as well." (Zerger, 2006, p. 29). Some program coordinators reported being frustrated by restrictive timing of admissions (e.g. not being able to accommodate admission in evenings or weekend). These restrictions limit access for clients needing short term respite (Zerger, 2006).

Admitting clients into medical respite programs who present medically different than what the referral forms suggests is also challenging (e.g. when referees do not disclose that a client has medical or personal care needs that are beyond the scope of the medical respite setting). Having clear goals for admission from the beginning, including clients in the goal planning, and doing referral assessments face to face are ways to mitigate these challenges (Zerger, 2006).

Relationships with Hospitals and Other Agencies

As already mentioned, the relationships that medical respite programs have with hospitals and other referring sources are crucial. There will always be frustrations, the demand for respite beds is high, and meeting the needs of referring agencies is challenging. Hospital discharge planners are under a lot of pressure, and they can get frustrated when respite beds are not available immediately. Medical respite staff need to communicate well with hospital medical staff to ensure appropriate coordination of services (Mcmurray-Avila et al., 2009).

A report based on a national survey of 28 respite program's relationships with the hospitals in their communities recommended that presentations be given to the hospital discharge planning staff on respite care eligibility criteria, and the expectations of the clients. Giving tours to discharge planners from hospitals, and developing clear memorandums of understanding for partnerships were also helpful. "Hospital funders are mostly concerned with shortened hospital stays and reduction in repeat emergency department visits, but hospital staff see our biggest assets as ease of accessibility to the program, making their day and job easier" (Respite Research Task Force, 2008, p. 13). Successful strategies for working together include: keeping notes of cases that went well and did not go well, holding frequent meetings with hospital staff and working on relationship building, and educating hospital staff about homelessness issues. Lastly, medical respite programs must be flexible but have clear boundaries (Respite Research Task Force, 2008).

The NHCHC recommends that medical respite programs enter into written contracts with hospitals, stating that these serve as a point of reference to resolve contested issues or renegotiate future agreements. See NHCHC, 2010b for specific examples of what a formal partnership agreement should include.

Harm Reduction

Given the high prevalence of substance use among homeless individuals already described, the subject of harm reduction in medical respite care is important. Unfortunately, there is very little guidance provided in the literature related to harm reduction practices and policies in such settings. Adequate pain control is one important issue, as it is not unusual for clients to be treated with high doses of opioids in hospital

and then discharged on much lower doses. This leaves patients at a much higher risk for illicit drug use and leaving medical respite care if pain is not treated appropriately. There is a role for medical respite staff to advocate for adequate pain control, and appropriate tapering of narcotic medication as indicated (Nashville & Edginton, 2011). The use of harm reduction policies and practice in medical respite care is an area requiring further research.

Administrative Challenges

Recruiting, training, and retaining staff is challenging, and high turnover is common. More than half of the programs surveyed had changed respite coordinators during the course of the evaluation (a 2.5-year period) (Zerger, 2006). No strategies were provided to mitigate these risks specifically for medical respite care.

2.6.   Gaps in the Literature

While there is a substantial amount of descriptive information regarding medical respite care from the US, there are significant gaps in both descriptive data from other countries and impact literature of medical respite programs as a whole. There are four main gaps identified in this review, they are highlighted in this section.

Impacts of Specific Program Components

As previously described, studies of the impacts of medical respite care provide limited information. Several questions came up during the course of this review that remain unanswered.

What is the impact of 24/7 nursing support, medication storage and administration?
What is the impact of having psychiatry on site?
What is the impact of having a harm reduction model, framework, or policy?
What is the impact of the various service delivery models?
What is the impact of various community partnerships?
Which partnership structures/frameworks are most effective?

Relationships between Medical Respite Care Providers

One of the biggest challenges of this literature review was finding up to date information on similar services in Canada and internationally. The US has a centralized Medical Respite Care Providers Network that provides support, training, resources, and some recommendations, and keeps an up to date record of medical respite programs in the country. Canada has no such centralized site. Terminology is used differently, and some programs are very small with a few beds here and there in shelters, making it difficult to find information about them. Knowledge exchange needs to become a part of medical respite care efforts so that programs can learn from each other's evaluations and

planning strategies. Furthermore, Canadian medical respite care providers would benefit from either becoming part of the US Respite Care Providers Network, or developing their own network in order to facilitate collaboration on research and advocacy efforts.

Best Practice Guidelines for Medical Respite Care

There was only one document that specifically addressed guidelines for developing a medical respite program. However, the missing information about the impacts of specific components of service delivery makes it difficult to develop or improve upon existing programs based on best practice. Arguably, reluctance of care providers to establish this type of service as a best practice may be in part due to it being a 'band aid' solution to a much greater systemic social issue that ultimately needs to change (Zerger, 2008). Either way, medical respite care in Canada needs to move away from a culture of 'piecing together the resources we can' toward a culture of collaboration and service provision based on research.

Cost Analysis

The literature is severely lacking in cost analysis when it comes to demonstrating the effects of medical respite care on the system as a whole.

CONCLUSION

People experiencing homelessness suffer disproportionately poorer health than the general population. The individual impacts of this are significant, as so are the effects on our already strained health care system. Medical respite care fills a gap between hospital and community care that is holistic and less costly.

This review has presented the available literature on medical respite care in a way that is relevant to both service providers and those interested in developing new or improving existing medical respite programs. The needs of the homeless population in Toronto, Canada have been presented, followed by in-depth description and analysis of the various components of medical respite care service delivery, impacts, best practices, guidelines, challenges, and lessons learned.

Medical respite care is an important part of the continuum of care for homeless and vulnerably housed individuals.

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APPENDIX A
Medical Respite Program Profiles

Four medical respite program profiles are presented in this Appendix. The most up to date information as of 2014 is used to provide context and comparison of the diverse types of services and facilities that fall under the medical respite care umbrella.

Recall that this literature review was conducted to complement and inform a program evaluation of the Sherbourne Health Centre Infirmary Program (SHCIP). As such, the programs were selected based on comparability to the SHCIP. The first profile presented is the SHCIP. The next two programs are Canadian, selected because they exist within the same health care structure and constraints (Seaton House Infirmary, Toronto, and Special Care Unit, Ottawa). Lastly, the Barbara McInnis House in Boston, US was selected because it is the largest and most comprehensive medical respite program the author found, and it has a similar model of care to the SHCIP in that they are both free-standing facilities with strong partnerships with a health clinic.

Information was collected through a variety of methods: websites, referral packages, research publications, personal communication with program directors and intake coordinators, and site tours. Where gaps occur, information was not available.

Profile 1: Sherbourne Health Centre Infirmary Program, Toronto, Canada

Service Model	Hybrid of free-standing and care-facility models. It is operated by the SHC, which is an outpatient health centre consisting of 3 FHTs. The SHCIP is on the 3rd floor of this building. Floors 1 and 2 are FHTs. The FHTs operate Mon-Fri 9am-5pm, with some evening and Saturday clinics. The Infirmary is the only program in the SHC that operates 24/7.

Eligibility Criteria	Homeless, recovering from an acute medical illness or injury or surgical procedure. Must be over 16, medically and psychiatrically stable to be in a community facility, not in need of rehabilitation or long-term care, independent with transferring, mobility, and ADLs. Assistive devices are acceptable. Must be willing to develop a safe discharge plan, which may include transfer to a shelter. Unable to accept clients in need of withdrawal management or mental health crisis services. Marginally housed individuals are considered when there is a clear barrier to required health care due to their housing situation. Exceptions can be made for clients who need some assistance with ADLs in partnership with CCAC, extra PSW support can be arranged. There are also a growing number of clients served who are homeless or vulnerably housed and undergoing chemotherapy or radiation for cancer.
Referrals Process	Referrals come from hospitals, community agencies, self-referrals, and the SHC primary care team. The majority of referrals come from hospitals and the SHC. Intake is based on need, not on date of referral, though this is considered. Priority is given to clients sleeping outdoors with few community supports.
Staff and Services	*CHW*: 1 on duty 24/7. Helps with intakes, social support, meeting client's basic needs on the unit (meals, orientation, recreation, laundry etc.), some basic ADLs, accompaniment to appointments. *MD*: 1 part time physician, on the unit Mon-Fri for about 3 hours per day. Clinical rounds Tues and Thurs. Staff from SHC FHT. *RN*: 1 on duty 24/7 for care of the inpatients. 1 additional intake RN 40 hours/week. *On-call*: Physician on-call 24/7 when staff MD is not working, staffed by SHC FHT. Administrator on-call 24/7. *CW*: 1 caseworker 40 hours/week. Primary responsibility is discharge planning and service coordination. *Admin*: Unit manager, 30 hours per week. 1 administrative assistant, 40 hours/week: duties include managing supplies and stock, budgetary processes, scheduling, and some care coordination. *Other*: housekeeping, 24/7 security, laundry and laboratory service contracts, transportation, meals, recreational equipment, library, computer, internet access, chaplaincy services, access to dental bus, diabetes education, primary care, and counseling.
Capacity	8-10 beds, census is determined by patient acuity
Length of Stay	Short-term. Stays range from a few days to maximum of 3 weeks. In some cases this can be extended if there are clear goals (e.g. IV antibiotics have been extended past planned stop date, client has secured housing available 1 week from planned discharge date).

Nursing Capacity	The RN on duty is in charge of the unit. They oversee all care plans and physician orders, including: management and administration of medications, care coordination with other community health providers, ongoing physical assessment, and intervention. Wound care and IV medication administration is provided by CCAC RNs that visit the unit, as they would if the client were housed.
Harm Reduction	Although there is no formal harm reduction policy, the SHCIP embraces a harm reduction approach. Clients are not required to abstain from substance use. However clients are not allowed to use illicit substances on site. If clients are caught using on site, the team discusses the circumstances and, depending on the severity of the occurrence, clients are given a warning or discharged to a safe location. Clients are asked to be open about drug use and efforts are made to develop a mutually agreed upon harm reduction plan to promote safety with medication interactions and adherence to care plan. Clients on methadone and other opioid replacement therapies are accepted into the program. These therapies must be prescribed by an authorized physician in the community and can be administered on site by RNs. RNs who administer medications assess clients who are suspected to be under the influence for potential medication interaction, and use their discretion to determine plan of action with the assistance of other team members, as necessary.
Partnership	A local pharmacy fills a large number of prescriptions for SHCIP clients Mon-Fri between 10am-6pm. Deliveries included. Some clients continue with their regular pharmacy. Services shared with the rest of SHC include: staff physician and on-call physicians, housekeeping, 24/7 security, some administrative staff including human resources and senior management, building maintenance, IT services, and laboratory. CCAC provides PSW, RN, PT, and OT services to eligible clients on a case by case basis. Other community partners include: St. Michael's Hospital, Fife House, McEwan Housing and Support Services, Fred Victor Housing, PASAN, Toronto Public Health, Princess Margaret Hospital.

Operations	Admission decisions are made in collaboration with the intake RN and the rest of the multidisciplinary team. Admissions take place Mon-Thurs 10:30am-4:30pm. Upon arrival, infection control procedures are followed and clients are oriented to the facility by CHW. Intake RN completes the admission assessment including infection control risks and physical assessment, reconciles all medications and arranges for delivery from pharmacy when required, and develops a care plan in collaboration with team MD. Subsequent nursing care during the admission is managed by the duty RN. CHWs go over policies and procedures with clients, and complete a social history. Clients meet with the CW 24-48 hours after admission and as needed. Care plans and discharge planning are reviewed and updated by the entire team twice weekly during clinical rounds. Clients can come and go from the facility throughout the day, provided that they follow the mutually agreed upon medical care plan, respect the roles and responsibilities, and return for 11pm curfew. Fresh meals are provided daily.
Impacts	Program Evaluation 2014. Internal document, may be available upon request.
Program Origins	Established 2007.
Funding	Funded by the Toronto Central LHIN.

(NHCHC, 2012; Sherbourne Health Centre, 2010)

Profile 2: Seaton House Infirmary, Toronto, Canada

Service Model	Shelter-based. Based within a city shelter that has 543 beds. Operations are shared between Seaton House and SMH.
Eligibility Criteria	The Infirmary is for men only. Clients must have health care needs that cannot be met as an outpatient, that require frequent physician/nurse care and/or rehab, and meet one of the following criteria: peri-operative care, wound care, multisystem medical issues, chronic alcohol or substance use, severe and persistent mental health issue, uncontrolled or poorly controlled chronic illness, frequent ER visits, complex care plan to be developed, terminal illness requiring palliation.
Referrals Process	Referrals are received from local hospitals, community agencies, and the shelter, however most are received from local hospitals, especially SMH.

Staff and Services	The Infirmary Program is located within the Annex Program, a harm reduction program within Seaton House that provides a managed alcohol program. Though these programs are described as separate by staff, they share a great deal of staffing resources and, as such, are difficult to separate for the purpose of this description. *CHW*: Seaton house shelter staff fill this role, staffing ratios unclear. Administration of medication is done by CHWs, as delegated by RNs. *MD:* Physician 24 hours per week and on-call. Physicians come from a number of SMH partner sites including 410 Sherbourne FHT and 69 Queen St. FHT. University of Toronto residents also rotate through the Infirmary and are supervised by SMH staff physicians. *RN:* There is 1 RN for the Infirmary. Their responsibilities are unclear, but may include: admissions, intakes, assessments, and medications. There are other RNs that rotate through the rest of the shelter and assist with Infirmary clients. Staffing ratios are unclear. *CW*: Case management services are offered, unclear client ratios and role. *Other services*: Substance use/mental health services (unspecified), connection to primary health care provider, Psychiatrist (unspecified roles, hours), meals, transportation, housing referrals, job training and placement, and education.
Capacity	There are 28 Infirmary beds. 23-24 beds are typically filled (rationale not available).
Length of Stay	4 weeks to 4 months.
Nursing Capacity	In this setting, the role of the RN is unclear. There is only 1 full time RN who works Mon-Fri. There may be RN coverage overnight; on-call services are unclear. Medication administration is delegated to the CHWs. Visiting RNs from the CCAC provide wound care and other complex medication administration. There is currently no capacity for 24/7 nursing care, though staff identified this as something that the program and clients would benefit from.
Harm Reduction	Seaton House Infirmary acknowledges that many of their clients are unable or unwilling to stop using substances and uses a harm reduction approach, though there does not seem to be a formal policy. Staff distribute alcohol on the premises as part of the Annex alcohol management program, but not methadone. RNs control the narcotics, however it is unclear what happens when they are not on shift. RNs do assessments, and the team tries to be aware when clients are using other substances to monitor interactions with their prescribed medications. Clients are not permitted to keep controlled drugs in their rooms, and using on site is prohibited. The process for violations is unclear.

Partnership	The primary partnership mentioned by staff is SMH, including the hospital itself and affiliated FHTs. Another primary partner is the CCAC, which is very involved in providing RNs and PSWs.
Operations	Admission hours and process are unclear. There are daily rounds at 9am with the RN and the care team. Referrals mainly come from hospitals. If required, medications that are not covered will be paid for by Seaton House.
Impacts	No formal evaluation is known.
Program Origins	Established in 1999.
Funding	At least partially City of Toronto, details unavailable.

(personal communication with anonymous staff member, Jan 20, 2014; Kertesz et al., 2009).

Profile 3: Special Care Unit, Ottawa, Canada

Service Model	Shelter-based. There are 2 sites: the SCU for men in the Salvation Army shelter, and the SCU for women in the Good Hope shelter. The structure of the two units is the same in terms of staffing, services, intake, length of stay, and operations. The SCUs are operated by OICH.
Eligibility Criteria	Eligibility criteria for the two sites are the same. Clients must be homeless, eligible for a shelter bed, and have complex health needs that cannot be met in a general shelter. Priority is given to clients with mental health and substance use challenges, hospital discharges, and those with the fewest supports. Clients don't necessarily have to have a medical issue if a mental health or substance use issue is present, but there must be goals set for the admission. People must be mostly independent with ADLs, but some support is provided (e.g. occasional incontinence care, one-person transfers). Assistive devices are acceptable.
Referrals Process	Decisions for admissions are made in collaboration between the Admissions RN and the shelter staff (shelter considers previous contact and conflict). Referrals come from shelter, police, hospital, CMHA, community workers, and self-referral. The majority of referrals come from hospitals and shelters.

Staff and Services	*PSW:* The SCU for men is staffed 24/7 by Care-For staff, who are PSWs that are trained on the SCU. There are 2 PSWs on the day shift Mon-Fri, and 1 PSW on the night shift and on weekend day shifts. These staff administer medications to clients. *MD:* There is 1 MD from Ottawa Inner City Health who does rounds 1-2 times per week for clients in the SCU who do not have a FMD. If they have a FMD, this person oversees their care and provides all medical orders. Clients are required to see their FMD (if they have one) for all prescriptions. *RN:* There is 1 RN for the SCU for men, and 1 RN for the SCU for women. These RNs work 40 hours/week. There is no RN on site outside of Mon-Fri business hours. *NP:* There is an NP who works at OICH who can see clients during the day. *Psychiatry:* There is a psychiatrist at OICH 1 day per week that can see SCU clients. There is also 1 psychiatric RN for all of OICH that works 40 hours per week who can see SCU clients. *On-call:* There is an RN on-call for all OICH clients each night (this is over 200 clients across several different programs), as an emergency back up there is also an MD on-call. RNs work under several medical directives. *CW:* 1 CW assists clients with housing applications and discharge planning in each SCU. This person works 40 hours/week. *Other:* Meals, transportation. *Admin:* no information available.
Capacity	SCU for men: 30 beds. SCU for women: 15 beds.
Length of Stay	The target is for clients to stay maximum of 3 months, however they will not discharge clients if they don't have a stable place to go. This goal is met in the majority of admissions; however, there have been cases where clients have stayed over a year (provided that they are working on goals).
Nursing Capacity	Each RN is responsible for overseeing all the nursing-related functions of their SCU, including: processing and prioritizing all referrals, doing admission assessments and designing care plans, double-checking medications as they arrive from pharmacy in docets or blister-packs, preparing medications for PSW staff to administer. The RN does not administer medication and the RN does not perform daily physical assessment or intervention. Wound care and IV medication administration are provided by CCAC RNs that visit the unit, as they would if the client were housed.

Harm Reduction	There is no official harm reduction policy. Clients are not required to abstain from using drugs or alcohol to receive care. However, use is strictly prohibited on site. If use on site occurs, there is a progressive reconciliation process starting with short time outs that may lead to overnight time outs away from the unit (safe plans are established where possible). Methadone is not prescribed on site, but clients on methadone are accepted into the program. If PSWs who are administering medications have concerns about intoxication, they will call the RN on-call, who will come and assess them.
Partnership	The SCU is run by OICH, which funds the RN, and the MD. All other staff are partners. PSWs are contracted through the CCAC. The CCAC funds these staff partially, and the other portion is funded through OICH (which is funded by the LHIN). CCAC will sometimes provide extra hours to support high-needs clients with ADLs, but only in certain circumstances. Another support that CCAC provides is RNs who provide IV antibiotics and wound care. A local pharmacy provides all medications in blister-pack form. The SCU recently started a new partnership with police and ambulance services to target those who live predominantly outside who rarely have contact with health professionals. Since then, referrals from these groups have increased. The psychiatrist and the psychiatric RN both work for and are funded by the Royal Ottawa Centre for Mental Health. The OICH also works collaboratively with medical schools, and medical students and residents often work in the SCU providing support to the RN and MD. If clients have community workers, the SCU works with them to assist with discharge planning. The shelters provide the case manager, housekeeping, security, meal preparation and building administrative staff. During night shift and weekends when there is 1 PSW staffing the SCU, shelter staff are sometimes called upon to assist as situations arise. There are 3 frontline shelter staff in the building (in addition to the PSW in the SCU) on each shift. This is for a total of 190 beds, or up to 219 on cold winter nights.
Operations	Eligibility criteria for the two sites are the same, however they tend to serve slightly different demographics. The SCU for men tends to serve an older population, while the SCU for women tends to serve women who are much younger, with more mental health issues and substance use issues. This reflects different needs in the homeless population. Clients will meet with the admission RN within their first 24 hours. Often people come for just a medical issue, and then mental health issues arise or are uncovered. In this case, clients will stay until they have the chance to see the psychiatry team and a plan can be initiated. Follow up care is provided at OICH for clients who do not have a FMD.

Impacts	A program evaluation was conducted by OICH in December 2012. Relevant results are presented in the Impacts section of this literature review.
Program Origins	SCU for men was established in 2003. SCU for women was established in 2009.
Funding	Funded by the Champlain LHIN, budget shared with other 7 OICH programs.

(NHCHC, 2012; personal communication Lynn Bernett, RN, November 25, 2013; Ottawa Inner City Health, n.d.)

Profile 4: Barbara McInnis House, Boston, United States of America

Service Model	Free-standing facility, occupies the top 3 floors of a building that is also occupied by a dental program, an ambulatory primary care clinic, and administration offices (all part of BHCHP).
Eligibility Criteria	Primary issues must be medical. Clients must be: homeless, psychiatrically stable, independent with ADLs, and in need of short term recuperative care. Infectious diseases must be disclosed. In practice, exceptions are made for those who have nowhere else to go who need: medical detox (from alcohol but not opioids), some help with ADLs, palliative care, support with cognitive issues.
Referrals Process	The admissions office has 4 RNs who work Mon-Fri. All referrals are screened by these RNs. Admissions mostly happen during these hours, but can also happen on evenings and weekends by the nursing supervisor. Referrals come from hospitals, community agencies and health care providers, shelters, and self-referrals.

Staff and Services	*Teams*: There are 8 teams that care for clients on the units, each team has 13 clients. *PSW:* There are care aides 24/7; 1 care aide per 2 teams during the day, and 2 care aides for all 8 teams overnight. *MD*: There is 1 MD who oversees all the clients and does rounds, works 40 hours/week. *NP*: There are 2 NPs that care for all 8 teams, they work 40 hours/week. The NPs and MDs also provide care in the BHCHP shelters in the area and are not on the unit all day. *RN:* During the day, there is 1 RN per team; at night, there is 1 RN for 2 teams. The admissions office also has 4 RNs. *CW:* There is 1 case manager per 2 teams. Duties include discharge planning. *Admin*: There is a medical director and nursing supervisor dedicated to Barbara McInnis House. Information about administrative assistants is not available. *Other:* meals, transportation to medical appointments, housing referrals, laundry, security, pastoral care, and volunteers for recreational support. Clients also have access to the dental, podiatry, pharmacy, eye care, and primary care in the building.
Capacity	104 beds
Length of Stay	Average length of stay is 11 days. Some are just a few days, others up to 60 days. Exceptions are often made for people who have nowhere else to go and need 4-6 weeks of treatment.
Nursing Capacity	In this setting, the RNs on the teams do nursing related activities, including: admission assessments, care planning, medication management, and administration. They also do all the IV medication administration, and wound care. No outside agencies are contracted to perform nursing activities.
Harm Reduction	Follows harm reduction principles, provides connection to treatment programs when applicable. Further details about the harm reduction principles were not available.
Partnership	BHCHC is the main partnership. Services shared include dental, podiatry, pharmacy, eye care, and primary care in the building. Security and house keeping staff are shared.

Operations	An average of 10 patients are admitted each day. The intake RNs do the pre-intake assessment over the phone. When clients come in, processing the admission (assessment, care plan development, medication reconciliation) is the responsibility of the teams. Intake RNs provide no direct services to inpatients. Teams also do all the discharge planning. Case managers send intake RNs email updates to keep them informed of discharges for the following day. For the most part, clients in hospital are not guaranteed beds, must wait for discharges. Exceptions are made for scheduled procedures like colonoscopy prep or post-op care, and a maximum of 2 admissions per day can be pre-booked this way.
Impacts	Kertesz et al., 2009
Program Origins	Established in 1998 as part of the BHCHP. It started as a 25-bed shelter-based program.
Funding	Information not available.

(NHCHC, 2012; personal communication Emily RN, Dec 3, 2013; Kertesz et al., 2009).

APPENDIX B
Impacts of Medical Respite Care: Description of Studies

Four individual studies evaluating the impact of medical respite programs are described in detail, including a description of the study methodology, the study site, and the outcomes.

1. (Buchanan et al., 2006; Buchanan, Doblin, & Garcia, 2003)

These two articles present the same prospective cohort study that was conducted in a 64-bed medical respite program in Chicago, US, called Interfaith House. It was the first published study that measured impacts of medical respite services on health outcomes. Clients who received care were compared over a 2-year period with a control group of individuals who were denied respite care due to lack of bed availability. This medical respite care facility was located within a transitional housing facility. Services provided at this respite facility included: post-acute care services by volunteer health providers, medication organization, counselling for substance abuse, case management, and referrals to permanent housing. There was no skilled nursing on site and clients who needed this were not accepted. To be eligible for the program, clients must have had an acute medical illness, been able to perform activities of daily living (ADLs) with minimal assistance, and be able to function in an environment that is alcohol and drug free (the control group consisted of individuals who met this criteria as well, but were not accepted due to bed availability).

Findings. Discharge from hospital to this medical respite program was associated with significantly fewer days of hospital care during the subsequent 12 months, compared to controls: 3.4 inpatient days compared to 8.1 respectively. Emergency department visits had a 'trend towards' reduction, however the analysis was not considered statistically significant. The average length of respite stay was 42 days.

Limitations noted include generalizability to programs that do not require clients to be sober (as this one does), or to individuals with complex mental health issues. This program differs from the SHCIP in that it does not provide on-site nursing care. The results of this study are certainly relevant to the SHCIP, however consideration must be given to the programmatic differences. It might be hypothesized that since the SHCIP has more services on site, and can accommodate clients with potentially higher medical acuity, the positive impacts would be amplified.

2. (Kertesz et al., 2009)

This is the next published study that formally measured impacts of medical respite programs. It is a retrospective cohort study conducted at the Barbara McInnis House in

Boston, US which at the time was a 90-bed facility. The study compared homeless clients discharged from hospital to the respite program with homeless clients discharged to other locations over a 2-year period. Authors measured hospital readmission rates within 90 days of discharge from hospital, and financial costs for each participant. The Boston program differed greatly from the Chicago program in the previous study in the level of services provided. At the time of the study, the Barbara McInnis House had 24/7 nursing care, on site physicians including psychiatrists, nurse practitioners, physician assistants, case workers, a dental team, interventions for other illnesses (not just the primary diagnosis for referral), primary care connections,12-step meetings, spiritual care, assistance with identification procurement, and transportation to medical appointments. The bed capacity at Barbara McInnis House was much greater as well. As such, this program is able to accommodate more medically complex clients than the Chicago program. This program did not require clients to remain sober during their stay, and 90% of admitted clients had active substance used disorders. The model of care was a care-facility based, which is the model that is considered to be able to provide the best services and result in the best health outcomes (Mcmurray-Avila et al., 2009).

Findings. Compared to individuals discharged to 'own care' (streets and shelters), respite individuals were 50% less likely to be readmitted to hospital within 90 days (rates were appropriately adjusted for characteristics like burden of illness and substance use). The cost comparison across study groups was unfortunately not considered relevant given that it merely demonstrated that respite costs were significantly higher than the cost of being discharged to 'own care'. This was because data was not available on the public cost of those discharged to 'own care' (ambulance, shelters, jails, and emergency departments other than the one at the specific hospital of study). The mean charges for a respite stay per patient were reported as $7,929 for mean length of stay of 31.3 days. This program is similar in service delivery and intake eligibility to the SHCIP, and while the capacity is 10 times greater, staffing ratios are similar to the SHCIP. One could suggest that this impact study reflects most closely the impacts of the SHCIP.

3. (Bauer et al., 2012)

This is a retrospective study in a 45-bed medical respite care unit in San Francisco, US that compared outcomes for clients who left medical respite before completion of treatment with those who stayed for full treatment. The study site facility 24/7 medical staff (24/7 on-call RNs, advanced practice RNs, physicians assistants, a part-time physician, a nurse practitioner, a case worker 80 hours per week, and community health workers who were supervised by social workers), and it followed a harm reduction model. This program is a free-standing facility, operated by the San Francisco Department of Public Health in collaboration with Community Awareness and Treatment Inc. Eligible clients must be too frail to return to the streets but not require skilled nursing facility care, they must be mostly independent with ADLs, and if they are on methadone they must be part of a methadone maintenance program. Clients are excluded if they are incontinent, need IV antibiotic administration more than once daily, have acute rehab

needs, or are psychiatrically unstable. Storage and administration of medications, meals, case management, housing referrals, connection to primary health care, and transportation to medical appointments are all provided (Health Care for the Homeless, 2012). The eligibility criteria reflect that of SHCIP quite well. While the services provided appear to be quite similar, staffing ratios are unclear from the information available, and one might predict that the SHCIP staffing ratios for both RN and case management are much lower given the bed capacity. They also do not have 24/7 RN support on site, which may or may not have an effect on outcomes.

Findings. Clients who left the program before completion of their care plan were placed into two categories: (a) AMA, and (b) AWOL (absent without official leave). These two variables were measured and reported separately. Female clients of any age, male clients under 50, and those living outside prior to admission were more likely to leave AMA or AWOL. Substance use was significantly associated with leaving AWOL, but not AMA. Those who left AMA or AWOL were less likely to be connected to community based medical, mental health, substance treatment services as well as supportive housing applications, but this was not significant when it was adjusted for length of stay.

Clients who left AMA were 1.8 times as likely to go to the ED within the next 90 days, but they were not more likely to be admitted to hospital. Interestingly, those who left AWOL had much different outcomes. They were 2.1 times as likely to go to the ED within the next 90 days, and 3.0 times as likely to be admitted to hospital when compared to those who completed their medical care plans. These numbers however were not significant when adjusted for substance use, and this is consistent with other literature that links substance use with re-hospitalization. What makes these findings relevant, however, is that they suggest that completing medical respite treatment may not have the same benefit for substance using clients as for other clients.

4. (Muckle, 2012)

This document is an unpublished program evaluation of the Special Care Unit for Men in Ottawa, Canada. This program is described in detail in Appendix A. The evaluation was based on a staff online survey (n=13, representing 100% of program staff), a stakeholder online survey (n=6, representing 43% of stakeholder organizations), semi-structured interviews with clients (n=14), brief analysis of discharge data compiled by staff nurses, and quarterly outcomes data provided by the caseworker. The small sample sizes and descriptive nature of the data make applying the results to the SHCIP and other medical respite programs challenging.

Findings. The staff survey demonstrated that only 50% of all staff felt they were able to handle their work load, though details were not provided about why this was. It was reported in this section that 'staff members felt that they were providing a consistent standard of care to clients', but data were not provided to support this claim. Challenges with team dynamics were identified with 75% reporting they did not express themselves

at least some of the time, however 85% felt that the team maintained a positive relationship with the clients.

The stakeholder survey demonstrated that 66% of respondents felt that the program was adequately staffed, and 83% felt that it would be inappropriate to apply stricter rules to the 3-month length of stay target. All respondents of the stakeholder survey felt that the stakeholders who currently engaged with the SCU were the appropriate ones, and no opportunities for new partnerships were identified. Areas for improvement that were identified by stakeholders included: a greater bed capacity, better communication between staff conducting outreach and case workers, improved access to a psychiatrist, and further training for staff in concurrent disorders.

From the client semi-structured interviews, 88% reported their health care needs were being met, and 88% felt there were enough staff for the program, 88% felt that staff were adequately trained, 61% of clients had their chronic physical conditions stabilized during their stay, and 46% had mental health issues stabilized. All clients interviewed felt that their access to 'other' services had improved since coming to the SCU ('other' was not defined). Some relevant concerns identified by clients were safety on the property related to drugs, concerns of not having 24/7 staff available for health-related concerns, having to wait a long time to get their medication, and a dislike for the mandatory mental health assessment for housing approval. Clients identified that increased social activities, improved standard of food, internet access, and life-skills courses would greatly improve the program.