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MEDICAL RESPITE FOR THE HOMELESS:  
BARRIERS AND FACILITATORS TO IMPLEMENTATION IN  
THE MUNICIPALITY OF ANCHORAGE

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## MEDICAL RESPITE BARRIERS AND FACILITATORS

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### Abstract

By bridging the gap between the discharge of a homeless individual from the hospital to a state of improved health, medical respite (MRs) programs have been shown to contribute to improved health outcomes and decreased healthcare costs. The question does not appear to be whether a MR program would benefit the Anchorage community, rather, what is the perceived need, how can we best implement this intervention, and what form would it take? The purpose of this project therefore was to explore answers to these questions through identification of barriers and facilitators to the implementation of MR services for the homeless in the Municipality of Anchorage. Data was collected through a series of semi-structured interviews with key informants. Reported barriers and facilitators were encompassed by 12 themes and classified according to the framework of Grol and Wensing (2004). The greatest number of barriers were identified within the social context level, while the most facilitators were perceived at the organizational context level. The process of reaching out to community leaders and key informants through the course of this project has contributed to an improved understanding of barriers and facilitators, provided recommendations for implementation, and has engaged key individuals in the MR discussion.

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### Medical Respite for the Homeless:

#### Barriers and Facilitators to Implementation in the Municipality of Anchorage

In comparison to the stably housed, those experiencing homelessness encounter many health disparities that not only have a negative impact on this vulnerable population, but a substantial impact on society as a whole. Elevated rates of physical and mental illness, frequent emergency department (ED) visits and hospitalizations, and increased mortality are common among this group of individuals (Hwang & Henderson, 2010). Although deemed appropriate for discharge from a hospital standpoint, homeless persons may remain ill and unable to care for themselves on the street or in a shelter. Even with the best-laid discharge plans given available resources, the homeless are frequently seen declining in health and returning to the ED for care. The absence of adequate options for discharge ultimately leads to lengthened overall hospital stays, increased costs, and poor health outcomes among this population.

### **Background**

#### **Health Disparities of the Homeless**

Rates of acute and chronic medical illness among the homeless frequently surpass those of the general population (Baggett, O'Connell, Singer, & Rigotti, 2010). Homeless individuals experience many complex challenges to health, including unpredictable environments; contagion exposure; unmet physical, psychological, and social needs; and increased exposure to violence (Fitzpatrick, La Gory, & Ritchey, 2003). Unreliable food and shelter are concerns unique to homelessness that often compete with addressing health needs until a crisis arises (Martins,

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2008). In addition to competing needs, the homeless often encounter decreased access to healthcare, which leads to a delayed clinical presentation, an increase in reliance on EDs, and elevated rates of hospitalization (Baggett et al., 2010).

In one large nationally representative quantitative study, 46% of homeless participants reported experiencing two or more medical conditions and 48% reported a history of mental illness (Baggett et al., 2010). Further, almost one third (32%) of the same study's participants reported an unmet need for medical or surgical care in the preceding year, and 21% reported an unmet need for mental health care or counseling. Rates of mental illness among the homeless are nearly double the estimated 26.2% of Americans ages 18 and older who suffer from a diagnosable mental disorder (Kessler, Chiu, Demler, & Walters, 2005).

### **Medical Respite**

Studies from both the U.S. and internationally identify an increased occurrence of physical and mental health problems among the homeless, and a number of interventions have been developed to address this understanding. One such intervention is medical respite (MR), which provides assistance to the homeless during one of their potentially most vulnerable periods: when recuperating from an illness or injury that required hospitalization. The National Health Care for the Homeless Council (NHCHC) (2012) defines MR as, “acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital” (p. 1). Medical respite addresses a period of increased vulnerability for susceptible homeless experiencing situations unlikely to be conducive to healing, such as unstable housing and unpredictable environments. The first MR was established in 1985 in Washington, D.C. with 63 MRs forming throughout the

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United States since. Medical respite programs continually emerge throughout the country; in Alaska the first and only program was implemented in Juneau in 2010.

Many MRs share common characteristics, but each program has been individually developed and has evolved to cater to the unique needs of the specific community served. Models employed by existing programs include apartment/motel room, assisted living facility/nursing home, homeless shelter, stand-alone facility, substance use treatment facility, or transitional housing (NHCHC, 2012). Funding is obtained from a variety of sources, primarily hospitals, private donations, local government, foundations, the Health Resources and Services Administration (HRSA), the Department of Housing and Urban Development (HUD), Medicaid, Medicare, religious organizations, and the United Way (NHCHC, 2012).

A number of successful program outcomes have been identified since implementation of the MR in Juneau, AK. These outcomes indicate the likely benefit of MR expansion to other Alaskan communities. Data from the Juneau MR pilot project, along with evidence from multiple studies, demonstrate associations between MR programs, decreased healthcare costs, and improved medical outcomes for the homeless (Buchanan, Doblin, Sai, & Garcia, 2006; Ciambor & Lovishchuk, 2013; Doran, Ragins, Gross, & Zerger, 2013; Kertesz et al., 2009; McMurray-Avila, 2009; Respite Care Providers' Network, 2008; Sadowski, Kee, VanderWeele, & Buchanan, 2009; Zerger, Doblin, & Thompson, 2009).

### **Relevance**

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA). With passage of this Act, the United States began a substantial overhaul of the healthcare system in an effort to increase the quality and affordability of health insurance, lower

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the rate of uninsured through expansion of public and private insurance coverage, and reduce the costs of healthcare for individuals and the government (U.S. Department of Health and Human Services, n.d.). The provision of comprehensive and continuous health care to patients by coordinating patient care across the gamut of healthcare settings is an important priority of the PPACA. Medical respite programs can potentially play a vital role in this effort and should be advocated for as an essential piece in a health care continuum for homeless patient populations (Klausner, 2011).

### **Literature Review**

#### **Health Service Use Patterns of the Homeless**

A meta-regression analysis of data from four nationally representative surveys revealed that more severe economic and housing instability was associated with poorer access to healthcare and increased rates of hospitalization in the general population (Reid et al., 2008). Rates of postponing medical care ranged from 6.5–11.6% of the general population compared to 24.6% of the actively homeless (Reid et al., 2008). Of those classified as low-income but not unstably housed or homeless, 7% reported postponing medications compared to 13.9% of the unstably housed and 32.2% of the actively homeless (Reid et al., 2008). In the general population, 7.3%-8.5% reported they had been hospitalized within the past 12 months in comparison to 10.6% of the unstably housed, and 23.6% of those actively homeless (Reid et al., 2008).

The National Health Interview Survey (NHIS) reported that less than 1% of Americans used the ED as their usual source of care (Walls, Rhodes, & Kennedy, 2002). In comparison, a study by Schanzer et al. (2007) found that more than one third of newly homeless reported using

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the ED for treatment. In a cross-sectional, secondary analysis of the 2005 National Hospital Ambulatory Medical Care Survey (NHAMCS), Oates et al. (2009) investigated national ED use patterns among homeless. An estimated 115,322,815 ED visits were made in the U.S. in 2005 and of these, 472,922 (4%) were made by patients reporting homelessness. The homeless population was found to be significantly more likely than the non-homeless to be uninsured and to arrive by ambulance despite similar triage need (Oates et al., 2009).

A Canadian study performed by Hwang et al. (2011) analyzed data for 90,345 housed patient admissions and 3,081 homeless patient admissions to compare hospitalization costs of the two types of patients. Homeless patient admissions were found to cost \$2559 (Canadian dollars) more than housed patient admissions after adjustment for age, gender, and resource intensity weight. The primary contributing factor identified in the study was that homeless patients on medical and surgical services remained hospitalized longer than housed patients (Hwang et al., 2011). The increased cost related to hospitalization of the homeless in Canada, despite the presence of universal healthcare, is notable as it indicates that health insurance coverage may not be the only solution for decreasing healthcare costs and improving access to care.

Schanzer et al. (2007) found that those who were newly homeless, not ever having experienced homelessness previously, experienced improvements in their health status and access to care during the 18 months following their entrance into a New York City shelter. This was largely attributed to the provision of primary care and mental health services on-site through clinics staffed by nurse practitioners, internists, psychiatrists, case workers and benefits counselors (Schanzer et al., 2007). Additionally, the New York City shelter system ensures that a person placed into a specific shelter remains in that shelter until he or she leaves the shelter

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system, which likely provides enough residential stability to enable a shift in focus to long-standing physical issues that they were unable to address while struggling with unstable housing (Schanzer et al., 2007). This study highlighted the hardships of residential instability and the considerable levels of physical disease and mental illness in those who are newly homeless, as well as the importance of access to primary care outside of EDs.

An absence of literature looking specifically at costs related to healthcare service utilization by the homeless makes it difficult to draw conclusions regarding the financial impact. Approximations of costs accrued by seemingly avoidable ED and ambulance usage, increased rates of hospitalization, and longer hospital stays have been made as a secondary finding of research investigating service use and outcomes, but no study has sought to evaluate these costs alone.

### **Barriers to Health and Healthcare**

A handful of qualitative research studies have endeavored to describe perceived healthcare needs associated with homelessness from the perspective of homeless individuals (Daiski, 2007; Martins, 2008; Nickasch & Marnocha, 2009). Common themes identified as barriers to health included scarcity of the resources necessary to meet basic needs of shelter, water, and food; limited financial resources; social stigma and lack of compassion for the homeless; and poor transportation (Daiski, 2007; Martins, 2008; Nickasch & Marnocha, 2009).

Daiski (2007) interviewed 24 homeless individuals and found the most commonly reported barriers to healthcare were the intersecting variables of addiction, mental health problems, and stress associated with fear for safety, as well as dehumanization and stigmatization by shelters and healthcare staff. Another qualitative study found similar



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conclusions; that the homeless frequently perceived being dehumanized and disrespected as barriers to health and healthcare (Martins, 2008). Nickasch and Marnocha (2009) interviewed nine homeless individuals about their healthcare experiences and found an overarching theme to be the belief that the circumstances of their life are controlled by external factors, such as fate or luck, or an external locus of control. An external locus of control is identified as a predominant theme in much of the qualitative and quantitative literature investigating healthcare barriers amongst the homeless (Hwang & Henderson, 2010; Morris & Strong, 2004; Nickasch & Marnocha, 2012;).

A lack of medical insurance is another factor commonly associated with homelessness and health disparities of the homeless (Hoshide, Manog, Noh, & Omori, 2010; Hwang et al., 2010; Schanzer et al., 2010). In a retrospective review of the 2003 Health Care for the Homeless User Survey (HCHU Survey), of 966 participants representative of a weighted population of 436,000 national Health Care for the Homeless (HCH) users 18 and older, 60% were uninsured (Baggett et al., 2010). More recent data revealed that these numbers have not changed substantially (DiPietro, Knopf, Artiga, & Arguello, 2011). The percent of uninsured homeless compared poorly against the 2012 U.S. Census report that 15.4% of the general U.S. population remains uninsured, not inclusive of those who are homeless (U.S. Census Bureau, 2012).

### **Homelessness and Health Service Use in Anchorage**

Between October 1, 2011 and September 30, 2012, an estimated 8,682 homeless were identified as residing in emergency shelters, transitional housing, and permanent supportive housing in the Municipality of Anchorage (Department of Housing and Urban Development [HUD], 2012). The Alaska Coalition on Housing and Homelessness' (ACHH) (2013) most

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recent yearly assessment of the Anchorage homeless population obtained through a point-in-time (PIT) homeless count found there to be 1,122 individuals on the night of January 29, 2013.

Alaska Natives and American Indians comprised 60% of the homeless surveyed.

A Vulnerability Index (VI) survey conducted by the ACHH (2011) of 355 homeless individuals performed over two days in September 2011 revealed a total of 225 inpatient hospitalizations in the past year, and 540 ER visits within the past three months. The top five individuals utilizing ED services had greater than 100 ED visits combined over the previous three months. Forty-nine percent of those surveyed (N = 171) reported having no insurance (ACHH, 2011).

Seven percent of the homeless from the VI survey reported illness or injury as the primary reason for homelessness (ACHH, 2011). Twenty-three percent reported physical disability as a condition affecting ability to retain housing. Chronic substance abuse was the only contributing factor identified by more participants (27%) than physical disability as the primary reason for homelessness (ACHH, 2011). These findings indicate that health issues may not only be exacerbated by homelessness, but may likely contribute to individuals becoming or remaining homeless. Whether homelessness is the cause of health disparity, or pre-existing health disparities are the cause of homelessness, it is evident that unstable housing is tied closely to disproportionately poor health outcomes.

Although some descriptive data helps to paint a picture of the homeless in Anchorage, little is known about perceived healthcare needs of this population; specifically, factors contributing to high rates of inpatient hospitalizations and ED usage, or even how high these rates truly are. Furthermore, literature reporting hospital readmission rates or unmet healthcare

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needs after discharge, either from the consumer or provider's perspective, is absent. Despite the presence of a number of studies describing the obstacles to obtaining a desired state of health among populations of homeless outside of Alaska, there remains a need for further description of health needs related to the homeless of Anchorage. Finally, there is little published data available to describe how and to what degree the homeless are utilizing available community resources.

### **Outcome Studies of Medical Respite for the Homeless**

In a systematic review of the literature synthesizing findings from 13 existing MR outcome studies, referral for MR upon discharge from hospitals was found to reduce future hospital admissions, reduce length of hospital stays, and reduce 90-day readmissions (Doran, Ragins, Gross, & Zerger, 2013). Homeless patients discharged to a MR experienced 50% fewer hospital readmissions at 90 days and 12 months of being discharged compared to patients discharged to usual care (Buchanan et al., 2006; Kertesz et al., 2009).

Homeless adults with chronic medical illnesses who were provided with case management and housing placement services upon hospital discharge have shown decreased hospitalizations, fewer hospital days, and fewer ED visits when compared to those who were not provided these services (Sadowski et al., 2009). A randomized control trial of 407 homeless adults showed that provision of case management and housing placement services to these individuals over 18 months resulted in a hospitalization reduction of 29% (95% CI, 10% to 44%), a 29% reduction in hospital days (95% CI, 8% to 45%), and a 24% reduction in ED visits (95% CI, 3% to 40%) (Sadowski et al., 2009). A retrospective review of computerized administrative data and hospital records over a 26-month period of time compared outcomes of patients that were eligible for a respite bed and did not receive one to those that were eligible and

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did receive one (Buchanan, Doblin, Sai, & Garcia, 2006). The group who was discharged to MR was hospitalized for 58% ( $p < 0.01$ ) fewer days and experienced a 49% reduction in hospital admissions ( $p < 0.01$ ) (Buchanan et al., 2006).

In summary, the available literature suggests that the provision of case management and housing for individuals experiencing homelessness leads to improvements in quantifiable healthcare outcomes, such as frequency and duration of hospitalization, as well as presentation to the ED. The prevalent limitation of many MR outcome studies is the absence of external validity. Available MR outcome studies primarily investigated a single sample of homeless and consequently there was an inability to make inferences regarding application of study findings to other homeless populations or be confident that positive effects were in fact due to MR. Although the health benefits of MR appear evident in a number of populations, the lack of more rigorous study methods makes quantifying the financial benefit less clear. From the existing literature on outcomes of MRs, conclusions cannot be made regarding cost effectiveness (Doran et al., 2013). However, it can be surmised that in comparison to the cost of hospitalization, MRs appear to be relatively inexpensive.

### **Project Objectives**

In view of the available literature describing patterns of health service use of the homeless, the extent of homelessness in the Anchorage community, known barriers to their healthcare, and the beneficial impact MR has been shown to have on costs and health outcomes, indications for the Anchorage implementation of MR have become evident. This project sought to better establish a) the perceived community need for MR, b) how stakeholders can best implement an MR program, and c) what a MR program in Anchorage should look like. Thus,

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these three questions drove the research and ultimately led to the tangible aim of the study: to identify barriers and facilitators to implementation of a MR for Anchorage.

The scope of this research is one component of the implementation process and an important step toward future program success and sustainability. Stakeholders equipped with a thorough understanding of implementation barriers and facilitators may be more prepared to anticipate and counteract the barriers, while focusing resources and efforts towards facilitators. Additionally, engaging in a community discourse through the process of data collection may increase community awareness of the MR topic.

### **Methods**

A Community-Based Participatory Research (CBPR) approach was used to guide the project methods. The CBPR approach to qualitative research is led by doctrines of social justice and social action in order to promote health and reduce health disparities (Minkler, 2010). This qualitative research approach aims at balancing research with action through community involvement and is defined as, “systematic inquiry, with the participation of those affected by the problem, for the purposes of education and action or affecting social change,” (Green et al., 1995, p. 2).

Before commencing research, preliminary conversations with community members helped shape the research goals. This initial step provided community members with the opportunity to participate in guiding the research that ultimately served to benefit them. Through preliminary discussion with key informants, the identification of barriers and facilitators arose as a promising means to achieve the research objectives. Although this study sought insight into

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barriers and facilitators, it also endeavored to achieve the secondary benefit of opening the lines of communication with community leaders.

### **Framework**

An abundance of evidence is available to demonstrate the clinical and cost-effectiveness of new and current ways of delivering and organizing healthcare. However, it is less clear how to translate this information into practice, or how to explain the factors that will promote or impede their implementation (May, 2013). GroL and Wensing (2004) identify the importance of a comprehensive understanding of barriers and facilitators to achieve change in practice.

Implementation strategies tailored to address barriers, while making use of the facilitators, can ultimately be more effective at meeting the unique needs of an individual community (GroL & Wensing, 2004). Six levels of evaluation are recommended for the identification of these impeding and promoting factors, including innovation (i.e. medical respite), the individual professional (i.e. key informants, stakeholders), the patient (i.e. the homeless individual), the social context (i.e. the Anchorage community), the organizational context (i.e. Anchorage hospitals and available resources), and the economic and political context (i.e. funding, policy) (GroL & Wensing, 2004, Appendix A). The proposed project employed a structure for data collection that was in alignment with these levels in an effort to outline MR implementation barriers and facilitators for the Municipality of Anchorage.

The value of establishing barriers and facilitators becomes more evident when the recommended steps for MR implementation are delineated. Ciambrone and Edgington (2009) identified ten steps for the planning and implementation of a MR program in any community (Appendix B). Steps include: 1) identifying the need, 2) identifying the stakeholders, 3) defining

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the scope of care and range of services, 4) identifying a model, 5) designing the program, 6) determining costs and identifying funding sources, 7) marketing the program, 8) implementing the program, 9) collecting data/outcomes, and 10) continuously evaluating, marketing, and refining the program. Understanding the barriers and facilitators serves to aid in carrying out these steps to implementation. In addition to the framework proposed by Grol and Wensing (2004), these steps were used as a guide for data collection.

### **Design**

The study was designed to be exploratory in nature to provide meaningful information to guide implementation and encourage further research. A CBPR approach was adopted to encourage the utility of the findings, to form community partnerships, and present the outcomes to individuals who may be able to carry out the MR implementation process. Community-Based Participatory Research aims to equally involve community members in order to generate a health-enhancing program well positioned for prepared adoption by the community (Faridi et al., 2007).

**Participants.** Study participants included well-connected and informed community experts who were knowledgeable about the subject of homelessness and/or provision of healthcare services to the homeless. All participants routinely worked with the homeless, whether in the healthcare setting, policy advocacy, or in the provision of any other supportive service (e.g. medical respite, transitional housing, emergency shelter, permanent supportive housing, case management). Participants were selected based upon the requirements that they reported a background in the subject(s) of homelessness and/or provision of healthcare services to the homeless; agreed to the specifics of the informed consent; represented a perspective that

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contributed to the goal of achieving a breadth of viewpoints; and were able to participate within the intended timeline for the study. The final sample size of seven was ultimately based on the availability of potential participants and their ability to consent within the desired three-week timeframe of the study.

The study sample included a purposive sample of five key informants, along with two key informants selected through snowball sampling based upon recommendations from the purposive sample. Participants were approached via email by the principal investigator (PI) to request participation. All participants agreed to be identified by name and the capacity in which they worked with the homeless. The following individuals were interviewed:

- **Susan Bomalaski**, Executive Director, Catholic Social Services, Anchorage, AK
- **Mary Beth Bragiel**, Deputy Director, Catholic Social Services, Anchorage, AK
- **Heidi Hurliman**, Advanced Nurse Practitioner; Program Coordinator, Brother Francis Shelter Caring Clinic, Anchorage, AK
- **Connie Markis**, Program Coordinator, Healthcare for the Homeless, Anchorage, AK
- **Scott Ciambor**, Planner, Alaska Mental Health Board; Chair, Alaska Coalition on Housing and Homelessness, Juneau, AK
- **Terri Simeck**, Hospital Case Manager, Anchorage, AK
- **Mariya Lovishchuk**, Vice Chair, Alaska Coalition on Housing and Homelessness; Executive Director, The Glory Hole (Emergency Shelter, Soup Kitchen, Care Center), Juneau, AK



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**Institutional Review Board.** This study was presented to the University of Alaska Anchorage (UAA) Institutional Review Board (IRB) and an exempt status was obtained. The potential risks of participation in the study were limited and were reviewed with participants.

**Data collection.** Semi-structured interviews are commonly utilized for healthcare related qualitative research. They provide a flexible structure for exploring perspectives, perceptions, experiences, understandings, interpretations, and interactions (Mason, 2004). Considering the exploratory nature of the study and the CBPR approach, this design was identified as complimentary to the goals of the study and was adopted for data collection.

Prior to participation, participants were provided with an informed consent (Appendix C) explaining the nature of the study and the risks and benefits involved. All participants were made aware of their right to decline to answer any or all questions and their ability to terminate their involvement at any time without repercussion. In advance of the interview, participants were given a MR policy brief for review to ensure familiarity with MR (Appendix D), as well as the interview topic guide (Appendix E).

Interviews were limited to a maximum of 60 minutes in consideration of the participant's time. Interviews ultimately ranged from 12 to 53 minutes and took place primarily at the participant's place of work, with one interview occurring at a private residence, and two others occurring over the phone. Data collection took place between May 5 and 22<sup>nd</sup> and was concluded upon obtaining an appropriate depth and breadth of interviewee perspectives.

Interviews were recorded with a digital audio voice recorder while the PI took supplementary field notes throughout the interviews. Professional transcription of the audio was

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obtained through the transcription service TranscribeMe. TranscribeMe signed a confidentiality agreement prior to utilization of their services (Appendix F).

Electronic data storage was utilized for rapid access to the data, low cost, and ease of archiving and removal. All notes or other physical pieces of data, including consents, were immediately transferred to an electronic format as well. The data was stored on the PI's personal, password protected laptop. The PI was solely responsible for maintaining and securing said data.

**Measures.** A topic guide consisting of open-ended questions (Appendix E) was used to provide a structure through which to explore experiences and attitudes of the participants (Al-Busaidi, 2008). The topic guide was composed of questions developed using frameworks proposed by Grol and Wensing (2004, Appendix A) and Ciambrone and Edgington (2009, Appendix B). The PI also used a visual aid composed of tables representing the proposed frameworks to guide further interview questions during interviews (Appendix G). The topic guide ensured that specific elements were addressed in all interviews, while the visual aid allowed for less structured, yet guided investigation into perspectives that may be unique to the specific participant.

**Data analysis.** Immediately after each interview, the PI reviewed field notes and expanded on initial impressions of the interview. Digital audio recordings of interviews were submitted to the transcription service (TranscribeMe) through a password protected online account. All data was entered into NVivo qualitative data analysis (QDA) software to store, organize, and analyze content from interviews. Raw data, including field notes and audio recordings, along with partially processed data, including transcripts and interviewer observations, was coded and analyzed for themes. Predetermined barriers and facilitators, as

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proposed in the framework of Grol and Wensing (2004, Table 1), were used as the initial codes.

If text could not be categorized within the predetermined barriers and facilitators proposed by Grol and Wensing, then a new code was created. After the coding process was complete, themes emerged and were subsequently categorized into levels as noted in Table 1.

Table 1

*Barriers to and Facilitators for Change at Different Levels of Healthcare*

| <b>Level</b>                   | <b>Barriers/Incentives</b>  |
|--------------------------------|---|
| Innovation                     | Advantages in practice, feasibility, credibility, accessibility, attractiveness |
| Individual professional        | Awareness, knowledge, attitude, motivation to change, behavioral routines       |
| Patient                        | Knowledge, skills, attitude, compliance   |
| Social context                 | Opinion of colleagues, culture of the network, collaboration, leadership        |
| Organizational context         | Organization of care processes, staff, capacities, resources, structures        |
| Economic and political context | Financial arrangements, regulations, policies                                   |

## Findings

### Barriers and Facilitators

All barriers and facilitators fell under one of 12 themes that emerged throughout the data analysis process. Overall, participants identified more concepts labeled as barriers than facilitators. The greatest number of barriers were identified within the social context level, while the most facilitators were perceived at the organizational context level. The findings are presented in Table 2 (see Appendix H for a full list of barriers and facilitators corresponding with each theme). Themes included ‘established efficacy,’ ‘perceived need,’ ‘comorbidities,’ ‘cultural considerations,’ ‘non-compliance,’ ‘collaboration,’ ‘attitudes towards the homeless,’

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‘leadership,’ ‘education,’ ‘available resources,’ ‘current policies/procedures,’ and ‘cost benefit.’

Each theme along with its specific barriers and facilitators will be reviewed.

Table 2

*Barrier and Facilitator Themes at Different Levels of Healthcare*

| <u>Level</u>                                 | <u>Barrier Theme</u>  | <u>Facilitator Theme</u>                        |
|--|---|---|
| Innovation<br>(medical<br>respite)           |   | Established efficacy                            |
| Individual<br>professional<br>(stakeholders) | Education   | Perceived need                                  |
| Patient<br>(homeless<br>individual)          | Comorbidities<br>Cultural Considerations<br>Non-compliance                | Comorbidities<br>Cultural Considerations        |
| Social context                               | Collaboration<br>Attitudes toward the homeless<br>Leadership<br>Education | Collaboration                                   |
| Organizational<br>context                    | Available resources   | Available resources                             |
| Economic and<br>political<br>context         | Current policies and procedures<br>Cost benefit                           | Current policies and procedures<br>Cost benefit |

**Innovation (medical respite).** ‘Established efficacy’ was the sole theme identified on the level of innovation. Only facilitators for the implementation of MR were recognized within this theme. All participants voiced a general understanding that MR has been successfully employed in other communities and inferred that a similar program could have a significant impact in the Anchorage community as well. This perceived potential for success was categorized as a facilitator for the recruitment of potential stakeholders and financers of a program. One participant noted the following: “If they (stakeholders) were told what other communities are

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doing, how it's being addressed, and the money or the efficiencies that are being saved, that would go a long way towards breaking down their, 'Oh, we can't do that.'”

**Individual professional.** Themes identified on the individual professional level included ‘perceived need’ and ‘education.’ ‘Perceived need’ emerged as a theme in each interview. All participants voiced the belief that MR would be a valuable program to implement for the homeless population in the Municipality of Anchorage. The belief was largely based on the anecdotal accounts of multiple deficits in the presently available interim, recuperative care for the homeless after hospitalization. Participants additionally supported their perception of need with accounts of Anchorage winter weather extremes posing a substantial danger to frail or ill homeless; ineffective public transportation (for obtaining medications and attending follow-up appointments); and references to data illustrating the extent of homelessness in Anchorage (including a Vulnerability Index survey from 2011 and yearly point in time counts).

This perceived need works as a strong facilitator for implementation. Ascertaining that multiple key individuals fundamental to implementation are supportive of such a program is an essential first step in the implementation process. The perception of need is illustrated in the following quote:

People can't stay in an acute care hospital forever, they have to be discharged somewhere. A lot of times they're discharged to their home of record, which often is a shelter. They end up on our door and we just can't care for them. There definitely needs to be some place for people to go when they're in that interim situation.

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‘Education’ was identified as a theme on the levels of both the individual professional and social context. Within both levels, education fell predominantly into the category of a barrier to implementation. Multiple participants voiced the need for more education due to a lack of knowledge of what MR is, or awareness that it even exists as an option. Medical professionals, hospital administrators, and leaders in local and state government were frequently identified as valuable professionals to receive such education. One participant noted the following: “I think it's a matter of getting representatives from all the different stakeholders in the conversation, to come together in educating.”

**Patient.** Within the patient level, themes identified included ‘comorbidities,’ ‘cultural considerations,’ and ‘non-compliance.’ The ‘comorbidity’ and ‘cultural consideration’ themes were viewed as contributing both barriers and facilitators, while ‘non-compliance’ produced only barriers.

Barriers falling under the ‘comorbidity’ theme revolved predominantly around the specific comorbidities of mental health conditions and substance abuse. Given the high prevalence of these conditions among the homeless, it was considered essential to be able to accommodate individuals in need of services addressing these issues. However, this was noted to be a challenging step without an obvious solution. These comorbidities have a disproportionate influence on one’s ability to care for oneself, comply with MR rules and expectations, and maintain stable housing. One participant noted, “I don't think that substance abuse and mental health issues are a quick fix. If you want to be a successful medical respite program, I would think that you would have to work with them on those issues.”

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Although the prevalence of mental health and substance abuse was identified as a barrier, the prospect of support and funding from agencies that are geared specifically towards aiding those who struggle with these conditions was considered a possible facilitator. As stated by one participant, “Having a body like the Mental Health Trust is unique. Their whole reason for being is supporting their beneficiaries.”

‘Cultural considerations’ arose as a theme with both barriers and facilitators. The cultural diversity of the Anchorage homeless population, including individuals from all over Alaska, the country, and the world, has potential to present a barrier. Considering the importance of recognizing cultural components of care in an MR, items such as language barriers and possible food restrictions may require immediate attention. Additionally, a program should also strive to encourage cultural competence in regards to customs, spirituality/religion, and health beliefs. However, these concerns were overall relatively small and were considered easily surmountable issues.

Cultural diversity, especially the large proportion of Alaskan Native homeless, was also considered a potential facilitator to MR implementation. One participant made the following observation: “I think one of the things that has to be taken into consideration is the huge proportion of Alaskan Natives that are among the homeless. At the Brother Francis Shelter it’s over 50%, it was 54% last year.” Taking into consideration the need for MR for this population alone, engaging the participation of those invested in the health outcomes of Alaskan Natives and American Indians was considered an important step, but ultimately an achievable goal.

However, the need for educating and engaging entities that have increased resources available for a specific population of individuals was identified as an existing barrier.

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Additionally, it was unclear how to equally distribute MR resources to all homeless individuals in need, regardless of cultural identity, or any other characteristic (e.g. homeless veterans, homeless Alaska Natives or American Indians, homeless with substance abuse or mental health comorbidities, etc.). With more substantial buy-in from certain organizations geared towards providing services to a uniquely qualified population of homeless, there is a risk for inadequate service provision to the entire spectrum of people experiencing homelessness.

‘Non-compliance’ was the final theme identified within the patient level and presented solely barriers to implementation. Concerns identified included non-compliance with rules of the MR; inability to provide the necessary oversight needed for certain models (namely the hotel model); and actions of MR participants bringing negative attention to the program, alarming the community, and interfering with community support. One participant voiced the following concern:

Make sure that they know the rules of the game so that they're not going into some place and trashing it, or having parties and drinking alcohol and all that, because those are always the things that you have to contend with.

**Social Context.** Themes identified within this level included ‘collaboration,’ ‘attitudes toward the homeless,’ ‘leadership,’ and ‘education.’ The greatest number of barriers within any one level was identified within the social context level.

The theme of ‘collaboration’ contained both barriers and facilitators. Given the relatively small community size in comparison to multiple other communities that have successfully implemented MR programs, this was largely recognized as a benefit as it would theoretically enable more successful collaborations. Collaboration between agencies in Anchorage was



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observed by participants as historically being successful and integral to implementation of a number of programs for the homeless and underserved populations.

In contrast, the existing and potential shortfalls of collaboration were also viewed as a barrier to implementation. Multiple participants identified lack of communication between various social service agencies, medical service providers, hospital administrators, and local government as an existing dilemma facing the progress of MR implementation. The importance of working collaboratively in order to achieve successful and sustainable MR was a prevalent theme noted in all interviews. As one participant commented, “It's a collaborative activity. So if one of the key partners isn't able to participate for one reason or another, then it might not get done.”

The theme of ‘attitude towards the homeless’ encompassed barriers such as stigmas held by professionals and by the general community. Assumptions are often made regarding who the homeless are, their ability to adopt a proactive role in their health, and the ability of the client to comply with the rules of a MR program. These barriers ultimately were believed to be counterproductive not only for obtaining funding and inspiring stakeholder interest in the project, but also in regards to gaining community support. One participant noted the following:

The issue of homelessness often is coming at having to fight down some negative stereotypes of nonworking, mentally ill, severely alcoholic. You kind of have to fight through some of those stereotypes and those concerns with the general public to get support and work towards a solution.

‘Leadership’ was a recurring theme that arose in all interviews and ultimately contained only barriers. Overall, a majority of participants perceived the need for, and the absence of, one

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or two key leaders to orchestrate implementation. A paid position for a primary organizer was thought to be optimal. Additionally, it was acknowledged that changes in leadership have already caused the MR discussion to be delayed in Anchorage. One participant voiced, “You have to have somebody who is a champion that is willing to move the conversation forward.” A second participant stated, “The leadership piece I think is key. Who has that staffing time to provide that little bit of admin to coordinate all these entities?”

‘Education’ was the final theme discussed within the social context. Lack of education and awareness of the varied faces of homelessness, absence of community understanding of what more can feasibly be done to mitigate homelessness, and the importance of increased education in order to gain community support were identified as essential pieces that presented potential barriers to MR implementation. As one individual stated, “I feel that with all programs that are new it is really educating the community and making sure that there's community support for the project.”

**Organizational context.** ‘Available resources’ was the single theme identified under the organizational context level. This theme contained a number of both barriers and facilitators. Barriers included funding and resources directed at MR supplanting resources for other programs; absence of hospital, local, and state government involvement; poor public transportation; and the concern for relying too heavily on volunteers for program implementation, operations, and sustainability.

Within the theme of ‘available resources,’ participants frequently recognized absence of local and state government involvement as a significant barrier. Although it was noted that the Mayor’s Task Force on Homelessness was assigned to implement a 10-year strategic plan to end

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homelessness in 2004, it was unclear how or whether this plan was formulated to address the complex health needs of a patient post discharge from the hospital, and the consequences this may have on an individual's ability to retain or obtain housing. It was observed by participants that this period post-discharge would be an opportune time to intervene not only with healthcare assistance for these homeless individuals, but also with linking the individual to services that may enable more permanent housing. Without local and state government awareness of the importance of the recuperative care step, it would be more difficult to implement a sustainable program.

Absence of hospital participation was viewed as a potential barrier in all interviews. It was generally believed that hospital participation would be achievable with improved collaboration and education. It was ultimately viewed as a facilitator to have a non-profit hospital in the community with a mission to serve the poor and vulnerable, as well as two additional hospitals that would likely have incentives to participate. It was believed that hospital involvement would be essential in the sustainability of a MR. One participant stated, "I think for something to be sustainable, it's going to have to go to the people that are already spending money on it. They need to see this as a different vehicle to more appropriately house the person, in a less restrictive and also less expensive setting."

Aside from area hospitals, participants identified an array of community resources with potential incentives for involvement: the Alaska Mental Health Trust, United Way of Anchorage, Department of Housing and Urban Development, Rasmuson Foundation, Alaska Native Corporations, local churches, charity organizations, private donations, and various grants. It was believed that volunteerism would play an important role, but could not be relied too heavily

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upon. If too greatly depended upon, there was concern with the ability to orchestrate an appropriate number of volunteers to fulfill the necessary services. Volunteer contributions were therefore identified as both a barrier and a facilitator under the theme of ‘available resources.’

**Economic and political context.** Themes identified within the economic and political context included ‘current policies and procedures’ and ‘cost benefit.’

Barriers within the theme of ‘current policies and procedures’ included the absence of hospital discharge policies for the homeless, as well as the potential for filling gaps in the discharge process with assisted living facilities (ALFs). Multiple professionals noted the absence of formal policy and procedure for discharging the homeless. Additionally, it was noted that the current available discharge options don’t adequately meet the needs of the homeless, particularly those with a large degree of independence who do not need much in the way of specialized care, simply a safe, clean, consistent place to stay.

Assisted living facilities (ALFs) are presently an available solution for the homeless individual in need of recuperative care. Discharge planners are able to apply for funding (e.g. Alaska General Relief) to cover the expense of an ALF stay, but ALFs must be amenable to accepting a reduced rate of pay for their service. This discharge option functions both as a barrier and a facilitator. The ALF option serves as a barrier in that it lessens the immediate necessity of MR, but dually functions as a facilitator in that it further reveals the need for MR. Although ALF works for some, it often includes a level of care and supervision that make it an unsuitable fit for many homeless individuals upon discharge. Additionally, it potentially misapplies funds that may be more effectively used for a program, such as MR, that would more adequately meet the specific needs of the homeless individual requiring recuperative care. One individual noted,

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“Certainly ALF has its role, but I think we're being asked to place a lot of people in ALF that aren't appropriate.”

‘Cost benefit’ was the final theme identified within the economic and political context. The majority of interview participants reported the potential cost benefit of MR as an important facilitator. Overall, it was considered to be in the best interest, particularly for area hospitals and for the city, to have mechanisms in place to ensure safe, appropriate discharge of the homeless. Due to the changes in health care payment mechanisms and financial incentives for avoidable readmissions and improved quality outcomes, the opportunity to involve area hospitals was established as a clear facilitator. Due to the potential to prevent avoidable trips to the ER via ambulance, the municipality would also likely experience a cost benefit. Simply stated by one participant, “In addition to this being the right thing to do, it's also the cost effective thing to do.” High Anchorage area housing costs were viewed as a barrier as this may increase the cost of MR and lead to a reduced cost benefit.

### **Recommendations**

All participants unanimously believed that establishing a medical respite program for the homeless is a needed intervention for the Municipality of Anchorage. Although it was believed that some of the needs of the Anchorage area homeless are unique in comparison to other communities (e.g. weather extremes, housing costs), adopting elements of MRs implemented in other cities, especially ones sharing similar characteristics (e.g. population size, climate, etc.), would be an appropriate first step. Ultimately, clear recommendations and guidelines advising the implementation of MR are available through a number of sources, namely the National Health Care for the Homeless Council (NHCHC) (Jaco, 2011; NHCHC, 2012). Although these

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documents are not specifically tailored to the Anchorage community, there was a belief among participants that there should not be a ‘reinvention of the wheel.’

The initial program was collectively envisioned as launching with a relatively small capacity while utilizing existing facilities and community resources. Throughout time, the program could be further tailored and expanded to address specific needs of the community as they emerge and become further delineated via ongoing data collection, experience, and increasing community and stakeholder awareness of program benefits. Given the considerable perceived need for MR, it was recognized that a fledgling program would initially be unable to comprehensively accommodate the entirety of the community’s needs, including all the barriers and facilitators emerging from this study. However, the general belief was that beginning with a small program would be better than no program at all, and that this would open the doors for development of a MR that eventually could more adequately address the needs of the community.

Collaboration between agencies was believed to be essential for cost effectiveness and sustainability of a MR. With shared ‘buy-in’ amongst stakeholders, the burden would be unlikely to exhaust one agency’s resources, would be more likely to provide the spectrum of necessary services, as well as more likely to prevent preference and bias when admitting individuals to a program (e.g., if a hospital has more resources invested, may cause preferential admission of patients from said hospital).

In order to avoid preferential admission of one category of homeless individual (e.g. single male vs. single females, mental health or substance abuse comorbidities, discharge from a specific hospital, disabled, elderly, unemployed vs. employed, etc.) and to equalize buy-in from

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all area hospitals, it was suggested that adopting a program model that sources funds from hospitals in the form of a flat rate per patient referred, regardless of needs or estimated duration of stay, has potential. However, given the small scale that a new MR might initially adopt and in the interest of simplicity, it seemed acceptable to partner with a single hospital initially in order to facilitate more rapid implementation, with the goal of further demonstrating the need and eventually gaining support and achieving collaboration with other hospitals.

Ideally, the program would be established in close proximity to resources, including food, shelter, healthcare services, oversight/supervision, and transportation. Multiple participants noted the potential for the Brother Francis Shelter (BFS) to be a viable location to initiate a program while also providing the desirable central, convenient location. However, additional funding and collaboration of service providers would be essential for BFS to be capable of hosting a small MR program.

Brother Francis Shelter provides temporary, emergency shelter for men and women, an evening meal, use of shower and laundry facilities, case management services, advocacy, job readiness, and referrals for employment, permanent housing, mental health issues, and treatment options for alcohol and substance abuse, as well as on-site basic medical services through the Caring Clinic (Catholic Social Services, n.d.). This array of services, in addition to the central location close to public transportation and Bean's Café, a soup kitchen serving breakfast and lunch, make BFS a practical option for MR. Given the belief of a number of participants that a MR facility would function best if utilizing previously established resources in a central location, the BFS emerged in multiple interviews as a promising location for a MR program.

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Government and hospital involvement emerged as a potential means to overcome many of the barriers and was viewed as important for implementation. When MR is placed within the larger context of the effort to end homelessness, as well as the effort to reduce costs of healthcare, the implementation of MR likely becomes more pertinent to stakeholders on the government level. Additionally, it is important to educate and engage hospital administrators and discharge planners so they understand the costs and poor health outcomes associated with current discharge practices. Education and community outreach were identified as a means to acquire hospital and government support, as well as to achieve support from other stakeholders and the community. Community education was identified as important in order to mitigate community backlash or assumptions in regards to the potential negative community impact.

Although it was believed to be a feasible intervention to implement, MR was largely understood to be more readily achievable if a minimum of one person were able to take the lead on implementation and continued operation. Although possible for a volunteer to step into this role, the funds for a paid position for a program coordinator role would be preferable. This would aid in addressing issues that arise when individuals become overrun by other responsibilities and are unable to adequately fulfill their secondary role of MR coordinator. Ultimately, before any other step can be taken towards implementation, the emergence of a leader was considered essential.

### **Discussion**

This project sought to address several gaps in the literature, including: a) the perceived need for MR in Anchorage, b) how to best implement this intervention, and c) the best form MR could take to adequately meet the needs of the Anchorage community. In order to better



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understand and organize these concepts, barriers and facilitators were placed within the context of a framework proposed by Grol and Wensing (2004), which identified barriers to and incentives for change at different levels of healthcare. Throughout the process of identifying barriers and facilitators to MR implementation, suggested answers to the research questions emerged, as well as opportunities for further research.

All participants acknowledged a firm professional belief in the need for medical respite. Overall, participants identified more concepts labeled as barriers than facilitators. All barriers and facilitators could be classified into a total of 12 themes. The greatest number of barriers were identified within the social context level, while the most facilitators were perceived at the organizational context level. This finding draws attention to both the social and organizational levels of change in the process of MR implementation.

According to Grol and Wensing (2004), social context includes barriers and facilitators such as the opinion of colleagues, culture of the network, collaboration, and leadership. These barriers and facilitators proposed within this level correspond with an idea relayed by a majority of participants: that the absence of a collaborative community effort guided by a leader seemed to be a significant barrier to implementation, and potentially explains the predominance of barriers found at the social context level.

Furthermore, participants largely believed that the necessary organizational aspects were available given the appropriate collaboration and leadership. Within the organizational context, Grol and Wensing (2004) identified organization of care processes, staff, capacities, resources, and structures as potential barriers and facilitators. This level contained the most facilitators for

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implementation, potentially indicating that a strong number of positive organizational aspects are present that may function as facilitators if properly accounted for and utilized.

The themes identified throughout the course of this study encompass a number of barriers and facilitators that have a direct application to multiple steps of the MR implementation process. Although the identified barriers and facilitators don't exhaustively address all steps in implementation as proposed by Ciambrone and Edgington (2009, Appendix B), the findings have, at a minimum, identified a strong perceived need; recognized multiple stakeholders; generated recommendations for a feasible model; and established elements of program design and potential funding sources.

No study has previously been performed to outline the barriers and facilitators to MR implementation in Anchorage, or in any other community. Findings presented in this fashion are unique to this study. However, the themes resulting from this study are themes that have emerged in the MR implementation literature, specifically comorbidities, leadership, collaboration, and cost benefit (Ciambrone & Edgington, 2009). The only finding identified as being unique to Anchorage was the prevalence of Alaska Natives and American Indians amongst the homeless.

### **Strengths and Limitations**

The strengths of this study included the purposive sampling technique. Through this method, the researcher was able to select individuals from a breadth of backgrounds with the depth of understanding desired. Although small, the sample of participants represented a variety of experiences and perspectives. Additional strengths of this study included the systematic

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approach to data analysis through use of NVivo QDA software and the use of a recognized theoretical implementation model by Grol and Wensing (2004).

Study limitations included the small sample size. Due to this, the opinions of participants may not comprehensively reflect the perspective of the entire community of key informants. However, due to the exploratory nature of this research, the sample was appropriately small and generalization was not initially intended outside the study focus area of Anchorage. The study would benefit from additional perspectives of care providers, hospital administrators, and leaders in local and state government. Additionally, the perspectives of homeless individuals residing in Anchorage was not included within the scope of this project, but would be of great value.

### **Dissemination Plan**

The findings will be presented at a general membership meeting of the Alaska Coalition on Housing and Homelessness (ACHH). If representatives of The United Way of Anchorage, Catholic Social Services, The Municipality of Anchorage Department Health and Human Services, Providence Hospital, Alaska Regional Hospital, Anchorage Neighborhood Health Center, and Brother Francis Caring Clinic are not present at the general membership meeting of ACHH, research findings will be discussed with representatives of these organizations on an individual basis, if desired.

### **Conclusion**

This CBPR project emerged as a result of community feedback and was shaped in response to interest in the possibility of MR for Anchorage. Through the identification of barriers and facilitators and a summary of recommendations addressing the research questions, this study has potential to give direction to the MR discussion. The process of reaching out to community

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leaders and key informants through the course of this project has not only contributed to an improved understanding of barriers and facilitators and provided recommendations for implementation, but it has engaged key individuals in the MR discussion. By approaching community leaders and key informants, the MR conversation has received a degree of publicity and potentially a rejuvenated interest among stakeholders. Those unversed in the concept of MR were made familiar with this model, and those already familiar were asked to critically think about the barriers and facilitators to action in Anchorage, as well as contemplate their potential role in implementation.

Opportunities for further research on this topic include improved and continued data collection on the homeless, implementation of a MR pilot program with ongoing outcome assessment, focus group based research to encourage discourse between potential stakeholders (particularly hospital representatives), or a needs assessment from the consumer (homeless) perspective.

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## MEDICAL RESPITE BARRIERS AND FACILITATORS

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## MEDICAL RESPITE BARRIERS AND FACILITATORS

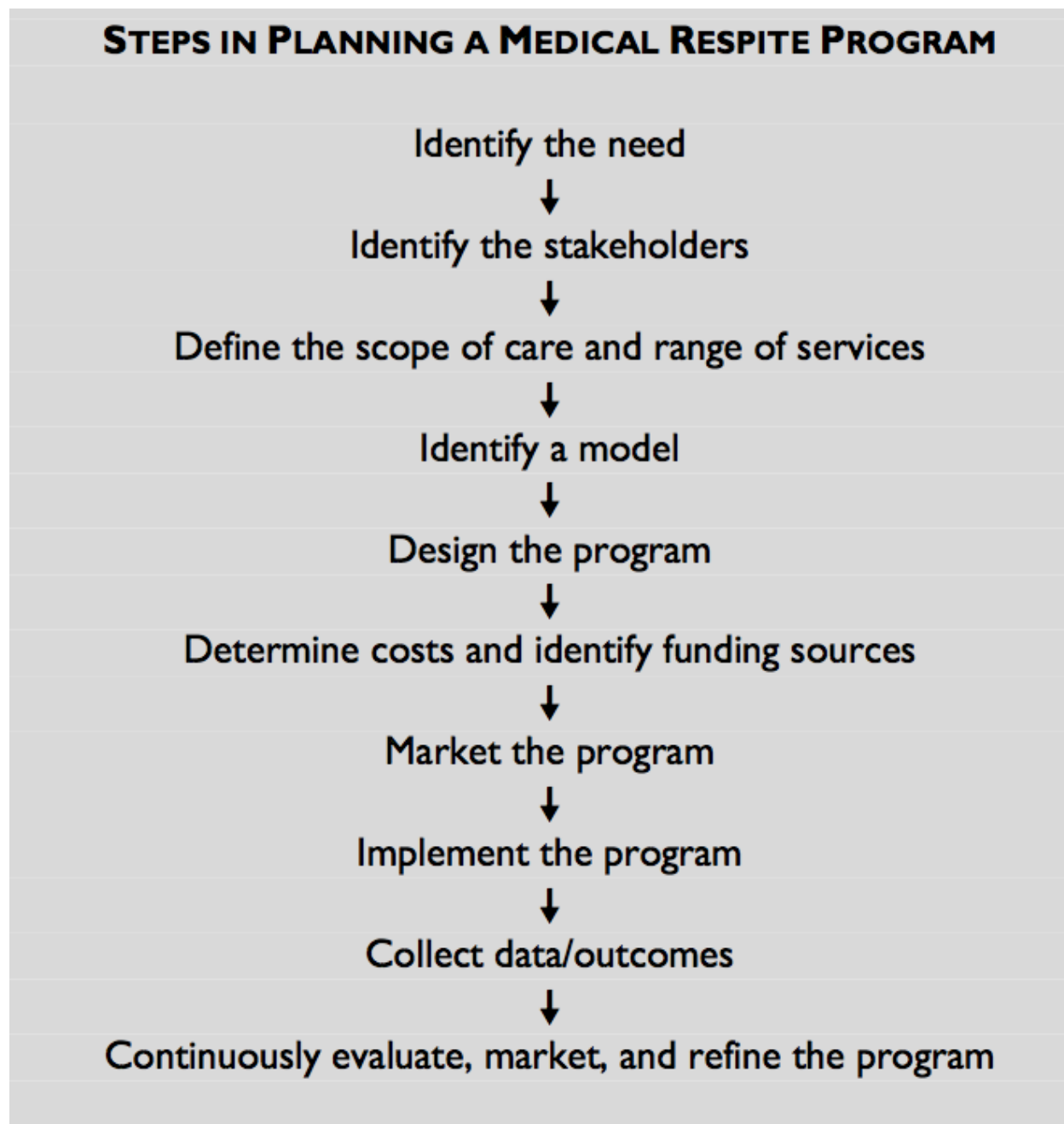
**Appendix A***Barriers to and Incentives for Change at Different Levels of Healthcare*

| <b>Level</b>                   | <b>Barriers/Incentives</b>  |
|--------------------------------|---|
| Innovation                     | Advantages in practice, feasibility, credibility, accessibility, attractiveness |
| Individual professional        | Awareness, knowledge, attitude, motivation to change, behavioral routines       |
| Patient                        | Knowledge, skills, attitude, compliance   |
| Social context                 | Opinion of colleagues, culture of the network, collaboration, leadership        |
| Organizational context         | Organization of care processes, staff, capacities, resources, structures        |
| Economic and political context | Financial arrangements, regulations, policies                                   |

MEDICAL RESPITE BARRIERS AND FACILITATORS

**Appendix B**

## MEDICAL RESPITE BARRIERS AND FACILITATORS



## MEDICAL RESPITE BARRIERS AND FACILITATORS

### Appendix C

#### Consent Form

**Title of Study: MEDICAL RESPITE SERVICES FOR THE HOMELESS:  
BARRIERS AND FACILITATORS TO IMPLEMENTATION IN  
THE MUNICIPALITY OF ANCHORAGE**

**Principal Investigator:**

Beatriz E. Dietrick  
Family Nurse Practitioner Student  
University of Alaska Anchorage  
(907) 321-5614  
bedietrick@uaa.edu

**Background:**

You are being invited to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

Medical respite is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. The purpose of this study is to identify barriers and facilitators for implementing a medical respite program for the homeless of Anchorage.

**Study Procedure:**

You are being asked to attend a one-on-one semi-structured interview exploring your experiences with homeless patients and information that may be valuable for implementation of a medical respite for the homeless of Anchorage. Interviews will be limited to 60 minutes in duration.

**Risks:**

The risks of this study are minimal. These risks are similar to those you experience when disclosing work-related information to others. The topics in the survey may upset some respondents. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

**Benefits:**

There will be no direct benefit to you for your participation in this study. However, we hope that the information obtained from this study may ultimately aid in implementation of a medical respite program and improved health outcomes for this vulnerable population.

## MEDICAL RESPITE BARRIERS AND FACILITATORS

### Appendix C, Continued

#### **Confidentiality:**

For the purposes of this research project your comments will remain anonymous if you so choose. If you wish to permit disclosure of your name, title, and/or nature of work, you will be given the option at the end of this agreement. If you wish to preserve confidentiality, every effort will be made by the researcher to preserve your confidentiality including the following:

- (a) Notes, interview transcriptions, and transcribed notes and any other identifying participant information will be kept on a password protected computer in personal possession of the researcher. When no longer necessary for research, all materials will be destroyed.
- (c) A non-disclosure agreement with the transcription service, TranscribeMe, ensures confidentiality and security of audio and transcripts.
- (d) The researcher and the members of the researcher's committee will review the researcher's collected data. Information from this research will be used solely for the purpose of this study and any publications that may result from this study. If the participant desires, any final publication will ensure that all participants involved in this study will not be identified and their anonymity will be maintained.
- (e) Each participant has the opportunity to obtain an audio recording of their interview. Participants should inform the researcher if a copy of the interview is desired.

Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

#### **Person To Contact:**

Should you have any questions about the research or any related matters, please contact the principal investigator at (907) 321-5614, or [bedietrick@alaska.edu](mailto:bedietrick@alaska.edu)

#### **Institutional Review Board:**

If you have questions regarding your rights as a research subject, or if problems arise which you do not feel you can discuss with the Investigator, please contact Dr. Dianne Toebe, Compliance Officer, at (907) 786-1099

#### **Voluntary Participation:**

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you do decide to take part in this study, you will be asked to sign a consent form. If you decide to take part in this study, you are still free to withdraw at any time and without giving a reason. You are free to not answer any question or questions if you choose. This will not affect the relationship you have with the researcher.

#### **Consent:**



## MEDICAL RESPITE BARRIERS AND FACILITATORS

By signing this consent form, I confirm that I have read and understood the information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that disclosure of my name, title, and/or nature of work is voluntary. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

**Appendix C, Continued**

Please circle which of the following may be disclosed in the final manuscript:

My Name

My Title

The Nature of My Work

If you circled any or all of the above, please state the name or terms you wish to be used:

Name – \_\_\_\_\_

Title – \_\_\_\_\_

Nature of Work - \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_

## MEDICAL RESPITE BARRIERS AND FACILITATORS

## Appendix D

## MEDICAL RESPITE CARE: REDUCING COSTS AND IMPROVING CARE

POLICY BRIEF

APRIL 2011

### What is medical respite care?

Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Unlike “respite” for caregivers, “medical respite” is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. These programs are housed in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. Medical respite care meets the post-hospital recuperative care needs for people who are homeless while reducing public costs associated with frequent hospital utilization.

**Homeless patients discharged to a medical respite program experience 50 percent fewer hospital readmissions within 90 days of being discharged compared to patients discharged to their own care.**

### Why do we need medical respite care?

People experiencing homelessness have high rates of physical and mental illness, increased mortality, and frequent emergency department visits and hospitalizations. Indeed, homeless persons are three to four times more likely to die prematurely than are their housed counterparts. These deaths are most often associated with acute and chronic medical conditions exacerbated by life on the streets or in shelters. Frequently, people who are homeless are discharged from hospitals with care instructions that are difficult to follow while living on the streets; moreover, their lack of a stable home environment diminishes the effectiveness of their hospital care. Homelessness exacerbates health problems, complicates treatment, and disrupts continuity of care. Medical respite care is an alternative to discharging patients to the streets while continuing hospital-recommended care, and has been shown to reduce inpatient length of stay, emergency department visits, and outpatient clinic visits (see Figure 1).

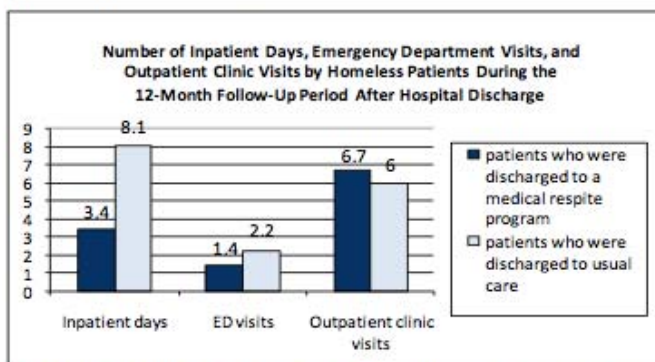


Figure 1: Hospital and clinic utilization before and after medical respite program participation

Source: Buchanan, D., Doblin, B., Sai, T., & Garcia, P. (2006). The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health, 96*(7), 1278–1281.

## MEDICAL RESPITE BARRIERS AND FACILITATORS

## Appendix D, Continued

POLICY BRIEF

APRIL 2011

## Demonstrated cost avoidance for hospitals partnering with medical respite programs

- Los Angeles, CA      \$3 million total annual cost avoidance for hospitals<sup>1</sup>
- Portland, OR      \$3.5 million total cost avoidance over three years for one hospital<sup>2</sup>
- Cincinnati, OH      \$6.2 million total annual cost avoidance for three hospitals and the community<sup>3</sup>
- San Diego, CA      \$800,000 total annual cost avoidance for 20 patients studied over the course of a year<sup>4</sup>
- Atlanta, GA      \$185,000 total cost avoidance based on length of stay reductions for 154 patients<sup>5</sup>
- Sacramento, CA      \$1.07 million total annual cost avoidance for 119 patients<sup>6</sup>
- Richmond, VA      \$11.2 million total cost avoidance over 2 years for 3 health systems<sup>7</sup>
- Salt Lake City, UT      \$5.5 million total annual cost avoidance<sup>8</sup>

Figure 2: Demonstrated cost avoidance for hospitals partnering with medical respite programs

## Hospital stays contribute to costs

Nationwide, the average hospital stay for most patients is 4.6 days, but those facing homelessness average a stay nearly twice as long.<sup>9, 10</sup> Certainly these averages reflect a wide variance in the needs of many different patient groups, but a lack of safe and appropriate discharge options (due to lack of housing) and a dearth of community resources for medically recommended recuperation will lengthen overall stays. The costs associated with these increased lengths of inpatient stays can be substantive for both hospitals and the larger health care system, but medical respite care can offset the impact of these expenditures (see Figures 2 and 3). In addition to the reduced length of stay upon referral, studies find that homeless patients discharged to a medical respite program experienced 50 percent fewer hospital readmissions at 90 days and 12 months of being discharged compared to patients discharged to their own care.<sup>11, 12</sup>

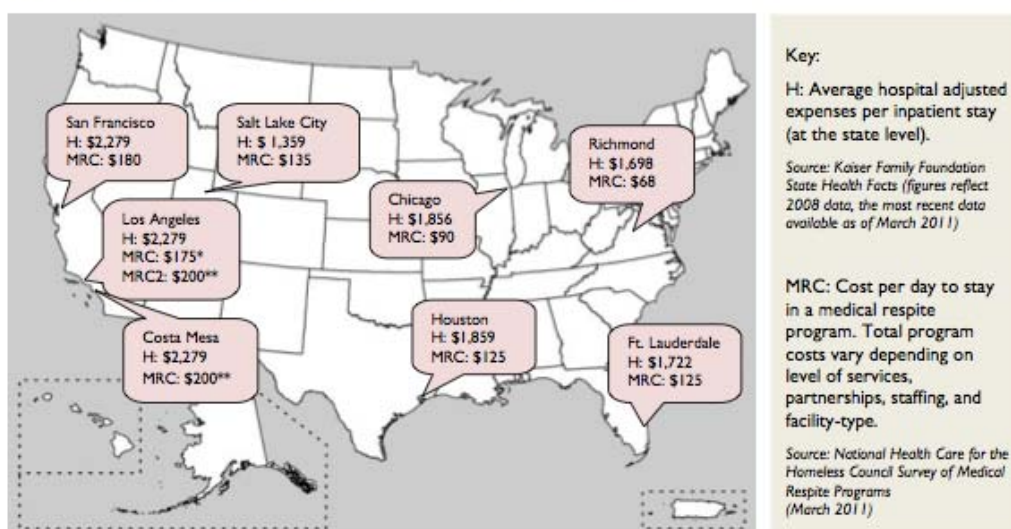


Figure 3: Average daily hospital inpatient cost for select states compared to the daily cost in a medical respite program in that state



## MEDICAL RESPITE BARRIERS AND FACILITATORS

### Appendix D, Continued

#### POLICY BRIEF

APRIL 2011

#### Medical respite care and health reform

The changes contained within the health reform law encourage the system to shift toward a more coordinated service delivery model, which is expected to increase quality of care and decrease overall costs. As such, incentives are available to health care providers to implement innovative models of care such as health homes, expanded home and community-based services, and discharge planning programs that provide 24-hour care management and support during transition in care settings.

#### *Health homes*

Health homes link primary and behavioral care and community supports in order to address the "whole person."<sup>13</sup> Health Homes can be a team of providers within the same facility or within partnering facilities working together to coordinate care. The provisions of the Patient Protection and Affordable Care Act (PPACA) establish a number of criteria for health homes including:

- Comprehensive care management,
- Care coordination and health promotion,
- Comprehensive transitional care from inpatient to other settings, including appropriate follow up,
- Individual and family support, which includes authorized representatives, and
- Referral to community and social support services, if relevant.

Medical respite programs are ideally suited to meet these criteria. The average length of stay for medical respite programs is two weeks, which provides ample time for comprehensive care management, care coordination, health promotion, and comprehensive transitional care. Partnerships with medical respite programs will increase primary health care providers' ability to meet health home criteria for their patients who are experiencing homelessness.

#### *Home and community-based services*

The provisions of PPACA also provide states with more flexibility to offer home and community-based services to people who might otherwise utilize more costly institutional care (e.g., inpatient hospitalizations). The 1915(i) Home and Community-Based Services (HCBS) Program allows states to amend their state Medicaid plan to include services and supports to low-income individuals before they need institutional care. It can also be a mechanism for states to provide services to people who have mental health and substance use disorders.<sup>14</sup> States can target benefit packages to specific populations – for example – one 1915(i) HCBS benefit package could be created for people facing homelessness and in need of medical respite care. States can also propose that additional services be covered beyond the traditional set of Medicaid home and community-based services (i.e., case management, homemaker/home health aide, personal care, adult day health, habilitation, and caregiver respite), or create a new Medicaid eligibility category for people who become eligible for the 1915(i) program, which would not only allow uninsured individuals to receive 1915(i) services but would also make them eligible for the full Medicaid package.

#### *Comprehensive discharge planning*

PPACA includes a number of provisions to improve discharge planning programs at hospitals. For example, insurers will be required to report on coverage benefits and reimbursement structures for comprehensive programs for hospital discharge that prevent hospital readmission.<sup>15</sup> Beginning January 1, 2015, qualified insurers who offer a plan through a state Exchange can only contract with a hospital that has more than 50 beds if the hospital implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that

## MEDICAL RESPITE BARRIERS AND FACILITATORS

## Appendix D, Continued

POLICY BRIEF

APRIL 2011

## Recommendations &amp; conclusions

- People facing homelessness have longer hospital lengths of stay compared to their housed counterparts; this is primarily due to lack of housing or other appropriate discharge options.
- Medical respite programs are proven to reduce future hospital readmissions by half.
- Hospitals should be investing in medical respite programs as part of health home initiatives for patients who are facing homelessness.
- States have a number of options to receive a federal match for the provision of medical respite care. These options include reimbursement for medical respite services provided by Federally Qualified Health Centers and implementation of an 1115 demonstration waiver. The Patient Protection and Affordable Care Act adds another state option, the 1915(i) Home and Community-Based Services Program, which allows states to expand the set of traditional home and community-based services and target specific low-income populations who may be at risk of institutional care, including those at risk of costly in-patient hospitalizations.
- Hospitals should be integrating medical respite care into comprehensive discharge planning programs for people facing homelessness.
- Insurers need to assess the comprehensiveness of hospital discharge planning programs by evaluating whether appropriate discharge options, such as medical respite care, are offered to people facing homelessness.

## REFERENCES

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- <sup>5</sup> Andrews, T. Mercy Care Services Recuperative Care Program. (personal communication, March 23, 2011). Based on a year-long assessment, from November 2008 to November 2009, of the impact of the Recuperative Care Program on the Grady Health System.
- <sup>6</sup> Salazar, A. Interim Care Program at the Effort. (personal communication, March 21, 2011). Based on avoided inpatient days for 119 patients participating in the medical respite program in 2009. Average inpatient days per client 6 months pre MRC was 6.9 days; average inpatient days per client 6 months post MRC was 1.3 days.
- <sup>7</sup> Neal, M. The Daily Planet Medical Respite. (personal communication, March 18, 2011). Based on a 2-year pilot, 5,840 bed days averted.
- <sup>8</sup> Hanks, M. Fourth Street Respite Care. (personal communication, March 18, 2011). Based on 546 patients participating in the medical respite program in 2009.
- <sup>9</sup> Agency for Healthcare Research and Quality. (2008). National and regional estimates on hospital use for all patients from the HCUP Nationwide Inpatient Sample (NIS). Accessed April 8, 2011 at: <http://hcupnet.ahrq.gov/HCUPnet.jsp>.
- <sup>10</sup> Salit SA, Kuhn EM, Hartz AJ, Vu JM, Mosso AL. (1998). Hospitalization costs associated with homelessness in New York City. *New England Journal of Medicine*, 338(24): 1734-40.
- <sup>11</sup> Kertesz, S. G., Posner, M. A., O'Connell, J. J., Swain, S., Mullins, A. N., Shwartz, M., & Ash, A. S. (2009). Post-hospital medical respite care and hospital readmission of homeless persons. *Journal of Prevention & Intervention in the Community*, 37(2), 129-142.
- <sup>12</sup> Buchanan, D., Doblin, B., Sai, T., & Garcia, P. (2006). The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health*, 96(7), 1278-1281.

## MEDICAL RESPITE BARRIERS AND FACILITATORS

### **Appendix E**

#### **Key Informant Interview Topic Guide**

1. Do you see a need for a respite care facility for the homeless in Anchorage? Can you explain your reasons for believing there is/is not?
2. What do you believe to be resources of the Anchorage community that will facilitate implementation of a successful and sustainable medical respite?
3. What do you see as factors that may prevent implementation?
4. What are your thoughts on possible ways to address and overcome factors that may prevent implementation?
5. How can we best utilize resources that will aid implementation of a successful medical respite?
6. Are there any other considerations we need to take into account, such as relationships with other facilities or political considerations?

## MEDICAL RESPITE BARRIERS AND FACILITATORS

7. Can you describe a MR program that you think would work for the Anchorage community in regards to location, design, funding, etc.?
8. Do you believe the medical respite needs of Anchorage area homeless are unique in comparison to other communities with medical respite programs? Why or why not? If so, do you believe that these unique aspects impede or facilitate implementation?
9. To whom should I speak with for further insight into facilitators and barriers to medical respite?
10. Thank you for participation in the interview. All responses will be kept confidential.

### **Appendix F**

#### Confidentiality Agreement for Transcription Services

TranscribeMe, and all those employed by said company, hereby agrees to maintain full confidentiality in regards to any and all audiotapes, videotapes, and oral or written documentation received from Beatriz E. Dietrick related to her research study titled **MEDICAL RESPITE SERVICES FOR THE HOMELESS: BARRIERS AND FACILITATORS TO IMPLEMENTATION IN THE MUNICIPALITY OF ANCHORAGE**

Furthermore, we agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped or live oral interviews, or in any associated documents;
2. To not disclose any information received for profit, gain, or otherwise;
3. To not make copies of any audiotapes, videotapes, or computerized files of the transcribed interview texts, unless specifically requested to do so by Beatriz E. Dietrick
4. To store all study-related audiotapes, videotapes and materials in a safe, secure location as long as they are in our possession;

## MEDICAL RESPITE BARRIERS AND FACILITATORS

5. To return all audiotapes, videotapes and study-related documents to Beatriz E. Dietrick in a complete and timely manner.

Please provide the following contact information for the researcher and the transcriber and/or translator:

For Transcription service:

Address:

2150 Shattuck Ave, Suite 250

Berkeley, CA 94704

Telephone: 1-415-800-3317

For Researcher:

Address:

PO Box 1543

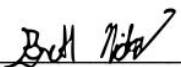
Girdwood, AK 99587

Telephone: (907) 321-5614



**Appendix F, Continued**

TranscribeMe is aware of the potential to be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals upon disclosure of identifiable information contained in the audio recordings, video recordings and/or documents to which access is provided. TranscribeMe is further aware that if any breach of confidentiality occurs, we will be fully subject to the laws of the State of Alaska.

Representative signature: 

Name of Representative: Brett Nichols

Title: Project Manager

Name of Transcription Business: TranscribeMe Inc.

Date May 2<sup>nd</sup>, 2014



**Appendix H**

*Barrier and Facilitator Themes at Different Levels of Healthcare*

| <b>Level</b>  | <b>Barriers</b>   | <b>Facilitators</b>   |
|---|---|---|
| <p><b>Innovation</b><br/>(medical respite)</p>  |   | <p><u>Theme: Established efficacy</u><br/>                     -MR employed successfully in multiple communities<br/>                     -Inferences can be made that a similar program would conceivably be beneficial for Anchorage<br/>                     -Clear benefits easily visible to potential stakeholders and financiers of a program</p>  |
| <p><b>Individual professional</b><br/>(study participants, all professionals involved with service provision to the homeless, stakeholders)</p> | <p><u>Theme: Education</u><br/>                     -Lack of awareness and understanding of MR<br/>                     -Need for more education among professionals, namely medical professionals, hospital administrators, and leaders in local and state government<br/>                     - Need for more accessibility to data delineating specific MR needs</p> | <p><u>Theme: Perceived need</u><br/>                     -Multiple community leaders in support of MR<br/>                     -Recognition of deficits in presently available interim, recuperative care for the homeless after hospitalization<br/>                     -Recognition of Anchorage weather extremes posing increased concern for frail or ill homeless<br/>                     -Generally understood as feasible and prudent to implement MR in Anchorage<br/>                     - Available data illustrating need, including vulnerability index surveys, point in time counts, and potential for hospitals to generate reports of homeless treated<br/>                     -Anecdotes aid in clarifying patient characteristics and breadth of services ideal for MR, bolster perception of need, and work to disband negative stereotypes and assumptions regarding the individuals who may benefit from MR services</p> |

**Appendix H, Continued**

|   |   |  |
|---|---|--|
| <p><b>Patient</b><br/>(Homeless individual)</p> | <p><u>Theme: Comorbidities</u><br/>                     -High prevalence of mental health and substance abuse may interfere with program compliance<br/>                     -No simple solution for addressing mental health and substance abuse<br/>                     -Important to be able to accommodate individuals in need of mental health and substance abuse services<br/>                     -Necessary to address mental health and substance abuse co-morbidities in order to address other health concerns, enable compliance with MR rules, and maintain stable housing</p> <p><u>Theme: Cultural Considerations</u><br/>                     -Culturally diverse community of homeless creates the challenge of developing a culturally competent program (i.e. one that addresses aspects such as language barriers and possible food restriction)<br/>                     -Important to engage those invested in health outcomes of Alaskan Natives and American Indians</p> <p><u>Theme: Non-compliance</u><br/>                     -Perceived risk of non-compliance with rules of the MR<br/>                     -Inability to provide the necessary oversight needed for certain models (namely the hotel model)<br/>                     -Actions of MR participants alarming the community and interfering with community support</p> | <p><u>Theme: Comorbidities</u><br/>                     -Possibility of support and funding from agencies that are geared specifically at aiding those who struggle with mental health conditions and substance abuse</p> <p><u>Theme: Cultural Considerations</u><br/>                     -Large proportion of Alaskan Native homeless may increase likelihood of funding from a number of entities specifically invested in improving health outcomes of this specific population</p> |
|---|---|--|

**Appendix H, Continued**

|                              |  |  |
|------------------------------|--|--|
| <p><b>Social context</b></p> | <p><u>Theme: Collaboration</u><br/>                 -Lack of communication between various social service agencies; medical service providers; hospital administrators; and local and state government<br/>                 -Risk for unequal distribution of MR resources to all homeless individuals in need, regardless of specific demographic characteristics (i.e. comorbidities, cultural identity, gender, etc.)</p> <p><u>Theme: Attitudes toward the homeless</u><br/>                 -Stigma held by professionals and the general community<br/>                 -Assumptions made about who the homeless are<br/>                 -Assumptions made about the ability of the homeless individual to adopt a proactive role in their health<br/>                 -Assumptions made regarding the ability of the homeless individual to comply with the rules of a medical respite program</p> <p><u>Theme: Leadership</u><br/>                 -Absence of a current leader directing the implementation of MR<br/>                 -Perceived need one or two key leaders to orchestrate implementation<br/>                 -Perceived need for a paid position for a primary organizer<br/>                 -Changing leadership/lack of continuity of leadership has caused delays in MR progress</p> | <p><u>Theme: Collaboration</u><br/>                 -Relatively small community size in comparison to multiple other communities who have successfully collaborated for MR implementation<br/>                 -Historically inter-professional collaboration has been successful in providing for homeless and underserved populations in Anchorage</p> |
|------------------------------|--|--|

**Appendix H, Continued**

|   |  |   |
|---|--|---|
| <p><b>Social context, continued</b></p> | <p><u>Theme: Education</u><br/>                 -Lack of community education and awareness of the varied faces of homelessness<br/>                 -Lack of community understanding of what more can feasibly be done to mitigate homelessness<br/>                 -Need for improved education to gain support of the community</p>   |   |
| <p><b>Organizational context</b></p>    | <p><u>Theme: Available resources</u><br/>                 -Funding and resources directed at MR supplanting other programs<br/>                 -Absence of involvement of local and state government<br/>                 -Absence of local hospital involvement<br/>                 -Concern for relying too heavily on volunteers for program implementation and sustainability (overextending volunteer resources)<br/>                 -Need for further data collection in order to adequately shape program to meet need</p> | <p><u>Theme: Available resources</u><br/>                 - Potential for MR to operate through use of resources and services at existing facilities and organizations<br/>                 - Recognized poor transportation further establishes a need<br/>                 -Availability of volunteers to function in multiple roles<br/>                 -Multiple potential financial resources identified: three area hospitals (Providence, Alaska Native Medical Center, and Alaska Regional Hospital), Alaska Mental Health Trust, United Way of Anchorage, Department of Housing and Urban Development, Rasmuson Foundation, Alaska Native corporations, in-kind service provision, local churches, charity organizations, private donations, and various grants<br/>                 -Presence of a non-profit hospital with a mission to serve the poor and vulnerable</p> |

**Appendix H, Continued**

|  |   |  |
|--|---|--|
| <p><b>Economic and political context</b></p> | <p><u>Theme: Current policies and procedures</u><br/>                 -Absence of discharge policies for the homeless<br/>                 -Availability of assisted living facilities for recuperative care of the homeless</p> <p><u>Theme: Cost benefit</u><br/>                 -Uncertainty of cost benefit<br/>                 -High cost of housing</p> | <p><u>Theme: Current policies and procedures</u><br/>                 -Absence of consistent, reliable discharge process for those who are homeless and in need of recuperative care<br/>                 -Assisted living facilities ineffectually filling gaps in needs for recuperative care of the homeless<br/>                 -Hospital personnel recognize a need for improving the discharge process and available resources for the homeless</p> <p><u>Theme: Cost benefit</u><br/>                 -Cost benefit demonstrated in multiple other MR programs throughout the US<br/>                 -Multiple entities serve to benefit fiscally</p> |
|--|---|--|