RECOVERATIVE CARE
(YEAR 6)

Medically Fragile and Homeless...

...Finding A Pathway To Care.

FRONT STEPS
THE CENTRAL TEXAS 
RECUPERATIVE CARE PROGRAM (RCP)

There are approximately 35 recuperative care centers across the nation, ranging from 105 bed stand-alone facilities to rented beds at nursing homes to a few reserved mats in homeless shelters. The Central Texas RCP currently consists of 4 beds leased from Monte Siesta Nursing and Rehabilitation, a local nursing facility.

Too well for the hospital, too sick for the street.

a hospital setting but still need skilled nursing care, and are not safe to be discharged to the streets. The nursing home provides medical care, and RCP provides program coordination, intensive case management, weekly drug/alcohol/mental health counseling and eventually, a pathway to housing. Utilizing the Health Care for the Homeless practice model, Front Steps assists clients by facilitating access to primary medical care, social services, behavioral health, addiction services, vision and dental benefits. RCP ensures that patients receive education regarding chronic disease management and post-discharge self-care which includes the identification of a primary care clinic for ongoing health care needs.

Ideally, clients move into permanent or transitional housing following program completion, with ongoing intensive case management support to assist them in maintaining housing and maintaining their health. Despite long periods of homelessness and lack of involvement with social services prior to entering RCP, clients have demonstrated great success in achieving goals, such as obtaining government disability benefits, becoming clean and sober, re-establishing contact with family and even returning to school or work.

Research indicates that homeless people stay 4.5 days longer in hospitals than non-homeless people. They are 10 times as likely to present to the ER as a low income, housed patient. A study conducted by David Buchanan and published in the American Journal of Public Health revealed that respite care after hospital discharge reduces homeless patients’ future hospitalizations (3.7 vs. 8.3 days). An article in the Journal of the AMA reports that housing and case management provided to a population of homeless adults with chronic medical illnesses results in fewer hospital days and emergency department visits compared with the usual care**.

Respite care reduces future hospitalizations

** Laura S. Sadowski, MD, MPH; Romina A. Kee, MD, MPH; Tyler J. VanderWeele, PhD; David Buchanan, MD, MS JAMA 2009; 301(17):1771-1778.

RCP is providing an unduplicated service for MAP patients. No other program in the city provides this type of intense wrap-around care. RCP is a key player in assisting Central Health with achieving its goal of creating a rational and effective approach to health care delivery for the underserved and ensuring a single standard of care for all eligible residents. Front Steps has made a commitment to continue to house RCP patients with funding from the RCAH (Religious Coalition to Assist the Homeless), the First Steps Program and our own development efforts.
ABOUT RECUPERATIVE CARE

RCP GOALS:

- Improve patient health outcomes
- Decrease hospital recidivism (using Emergency Department as Primary Care and avoiding inpatient stays)
- Connection with primary care home
- Establish a means for self sufficiency
- Break the Cycle of Homelessness

PURCHASED SERVICES:

- 24-hour onsite medical staff: registered nurses (RNs), licensed practical nurses/licensed vocational nurses (LPNs/ LVNs), and nurses' aides (CNAs)
- Supervision by the Medical Director, Dr. James Chudleigh and his Nurse Practitioners
- Resident evaluation and care planning
- Lab draws
- Medication management
- Personal care items
- A clean, furnished, shared room
- Dietary services: nutritious meals and snacks, in accordance with medical requirements
- Housekeeping, laundry and linen service
- Personal care (including incontinence care)
- Therapy Services: Physical, Occupational, Speech
- PICC line care
- Wound care
- Feeds when swallowing is temporarily not possible
- Resident activities and events

RCP SERVICES:

- Identifying and linking to PCP, attending primary and specialty care appointments with clients, patient education regarding disease management and post discharge self care, hospice referrals, working with clients on how and when to properly access emergency services
- Assistance with transportation, obtaining ID, birth certificates, social security card, voter’s registration, MAP cards, clothing, personal care items
- Emotional support, reunification with family, a sense of belonging
- Assistance with financial and insurance benefits, including but not limited to SSI, SSDI, VA, Food Stamps, MAP and Medicaid/Medicare and Obamacare
- Weekly individual counseling for substance abuse and mental health issues, referrals to inpatient and outpatient treatment facilities
- Resolving outstanding warrants with both the city and community courts and attorneys
- Detailed assessment of housing barriers and resources, housing placement whenever possible, shelter placement (when housing placement isn’t possible), ongoing transitional case management for up to two years or until permanent housing is located
- Program Coordination
- Linkage to other resources for specialized services, i.e. ATCIC for Psychiatric care, Goodwill for job placement
- Assistance with USCIS and obtaining replacement green cards
- Working with consulates and embassies to resolve citizenship issues when necessary
The chart above shows the sources of all referrals to Recuperative Care. The vast majority of the referrals come from University Medical Center Brackenridge (108 referrals). St. David’s South Austin Hospital referred 8 patients, Seton Main referred 8 patients, St. David’s Main Campus referred 7 patients, St. David’s North Austin Medical Center referred 6 patients and Seton Northwest referred 3 patients. Seton Williamson, Shoal Creek, Lakeway Regional Medical Center and the ARCH Clinic each referred one patient.
Jeff’s Story

Jeff is quite a survivor. In the past few years, he’s lost his marriage, his relationships with his kids, his home, his leg and hip from cancer, and very nearly lost his life. He lost his home, marriage and children due to drug addiction and job loss. After becoming homeless, he was diagnosed with cancer. He received treatment, but developed vascular necrosis (dead tissue from lack of blood supply) in his hip and that had to be amputated along with his leg. He then developed a bone infection that lead to sepsis. Luckily, he was staying in the ARCH that night and help was within reach. He was septic and almost died before the hospital brought the infection under control. He ended up spending a couple of months in the hospital and subsequent rehab. Then, he came to Recuperative Care. He states that he was restless at first, because he did not know what to do with himself. This stopped when he received his prosthesis. He said he realized there was still hope even in the face of all his losses. He worked diligently to learn how to work on his prosthetic leg. He also reached out to Narcotics Anonymous, the American Cancer Society, the Amputee Coalition and NAMI (National Alliance on Mental Illness) and started making valuable connections in the community. He also applied for permanent housing and was accepted. Now he is living in his own apartment, making new connections in his building, and looking into going to Austin Community College. He hopes to transfer to University of Texas at Austin after 2 years at ACC. Of the Recuperative Care Program, he says, “If it weren’t for Tejas, I might not be alive today. I definitely would not be in supported housing.” He describes himself as, “rising from the ashes, like a phoenix.” We are very proud of Jeff and the strides he’s made to make a better life for himself.

If it weren’t for Tejas, I might not be alive today.
RECUPERATIVE OUTCOMES (Year 6)

Of those leaving RCP, housing was located for 56% of patients. Another 22% left AMA (whereabouts unknown), 3% died and 19% returned to homelessness after completing their stay.

33% of patients received ongoing case management from RCP post-discharge. 14% were followed by social work via another program, 22% left AMA, 3% died and 28% discharged with no need for further case management.

For Fiscal Year 6, 144 homeless adults were referred by area hospitals to RCP, only 36 unduplicated clients were admitted due to limited staffing capacity.

Average length of stay was 47.36 days.

RCP patients carry an average of 13 ICD-9 Diagnoses.

Of 36 patients admitted during the designated time period, 19 did not apply for Social Security benefits because they had no permanent disabling condition, or were ineligible due to citizenship status. 11 were approved for benefits due to an application submitted by RCP and 6 were still pending a decision when they finished their stay.

68% of RCP admissions have been identified as “Frequent Service Users” *

68% of all patients served in year six reduced their ER and inpatient stays during the 12 months following their stay in RCP.

RCP provided 1705 occupied bed days in FY 2013-2014.

* Frequent Service Users refer to patients who have received care from RCP multiple times in a given fiscal year.
Mr. Jones does not have a long history of being homeless. At age 44, Mr. Jones was working and living in his own place, but was having increasing medical problems. The problems he was having led to open heart surgery and the placement of a pacemaker. After his surgery, he was unable to return to full time employment, which led to going into debt. Soon, he was unable to pay his rent every month. This led to his being evicted from his apartment. Luckily, people from his church agreed to help him move. On the day he was moving out, he fell down the stairs at the apartment complex and broke his ankle in 3 places. Because of this accident, he landed in the hospital, and was then referred to Recuperative Care. Mr. Jones underwent surgery for his broken ankle, and ended up with a bone infection, which required IV antibiotics. Because of the bone infection, the broken ankle, and all the other medical problems he has, Mr. Jones stayed in Recuperative Care for about 6 months. At the end of that time, he moved into our transitional living house, where he promptly began looking for permanent housing. He stayed in the transitional living house for about 4 months before an opening became available at Capital Studios. Recuperative Care staff were successful in getting Mr. Jones on the waiting list for an apartment while he underwent yet another stay in the hospital. When Capital Studios opened for business, they interviewed Mr. Jones. Unfortunately, an eviction he had on his record was enough to prevent him from moving in. However, the BSS+ Program, also through Front Steps, paid his rental arrears so the eviction could be resolved. This final step allowed Mr. Jones to qualify for Capital Studios. With the help of his fellow church members, he moved in very shortly after the Christmas holidays. He is thrilled with his new apartment, the location, the on-site amenities and the proximity of Capital Studios to his church. He says the other tenants are friendly, tidy, quiet, and seem to appreciate the property and all it has to offer. Mr. Jones says that Recuperative Care was a God-send and a life saver. He says of himself, “I am the epitome of what the program can do.” We are very proud of Mr. Jones and all that he has accomplished.

I am the epitome of what this program can do!
Key program staff currently includes:

Leah Huddleston, LCSW, Recuperative Care Program Coordinator, Master of Science in Social Work, Administrative Concentration from Hunter College in New York City, Bachelor of Arts in Psychology from University of Texas at Austin

Brad Lindgren, Transitional Living Case Manager and State Certified Trainer on HIV, TB, Hepatitis, STDs, Motivational Interviewing, Cultural Competency, Ethics, Overdose Prevention, Addiction, and many other topics

John Ruben, LMSW, Front Steps Counselor, Master of Science in Social Work, Clinical concentration from Indiana University, Bachelor of Social Work from Indiana University

Greg McCormack, M.Ed., Director of Programs, Master of Education, Texas State University, Counseling Concentration, Bachelor of Science in Psychology, Texas State University

**“Frequent Service Users” defined as averaging at least 2 ER visits per year for a minimum of three years in a row

OR having at least 3 ER/Inpatient visits in the 12 months prior to admission to RCP.

**Laura S. Sadowski, MD, MPH; Romina A. Kee, MD, MPH; Tyler J. VanderWeele, PhD; David Buchanan, MD, MS  J.A.M.A

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