Medically Fragile and Homeless...

...Finding A Pathway To Care.
THE CENTRAL TEXAS  
RECUPERATIVE CARE PROGRAM (RCP)

Approximately 35 recuperative care centers exist across the nation, ranging from 105 bed stand-alone facilities to rented beds at nursing homes to a few reserved mats in homeless shelters. One of those centers is The Central Texas Recuperative Care Program (RCP) in Austin, Texas which was created and is managed by Front Steps. The Austin RCP center 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.

RCP provides care to homeless clients who may no longer need 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, transitional and permanent 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.

Following program completion, clients move into permanent or transitional housing whenever possible, 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.

Respite care reduces future hospitalizations

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**.

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, HUD and our own development efforts.
RCP GOALS:

- Improve patient health outcomes
- Decrease hospital recidivism (using Emergency Department as Primary Care and avoiding inpatient stays)
- Connection with primary care home
- End homelessness with permanent supportive housing

PURCHASED SERVICES:

- 24-hour onsite medical staff: registered nurses (RNs), licensed practical nurses/licensed vocational nurses (LPNs/ LVNs), and nurses' aides (CNAs)
- Medical oversight provided by James Chudleigh, MD
- Resident evaluation and care planning
- Lab draws
- Medication management
- Toiletries
- 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
- 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
- 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
- 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
SNAP SHOT OF HIGHEST FREQUENT SERVICE USERS

<table>
<thead>
<tr>
<th>Client</th>
<th>Before RCP</th>
<th>After RCP</th>
<th>Percent Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Andrew</td>
<td>28 ER visits and inpatient stays in the 12 months prior to RCP admission</td>
<td>3 ER and inpatient stays post-discharge, along with 7 clinic visits</td>
<td>89%</td>
</tr>
<tr>
<td>#2 Manuel</td>
<td>20 ER visits and inpatient stays in the 12 months prior to RCP admission</td>
<td>6 ER and inpatient stays post-discharge, along with 1 clinic visit</td>
<td>70%</td>
</tr>
<tr>
<td>#3 Tim</td>
<td>10 ER visits and inpatient stays in the 12 months prior to RCP admission</td>
<td>0 ER and inpatient stays post-discharge, along with 19 clinic visits</td>
<td>100%</td>
</tr>
<tr>
<td>#4 David</td>
<td>22 ER visits and inpatient stays in the 12 months prior to RCP admission</td>
<td>2 ER and inpatient stays post-discharge, along with 4 clinic visits</td>
<td>91%</td>
</tr>
<tr>
<td>#5 Mike</td>
<td>12 ER visits and inpatient stays in the 12 months prior to RCP admission</td>
<td>0 ER and inpatient stays</td>
<td>100%</td>
</tr>
</tbody>
</table>

“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 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. JAMA 2009; 301(17):1771-1778.

RCP RESULTED IN A 70% REDUCTION IN ER VISITS

Emergency Room Transports Cost Millions

Hospital emergency room treatment is one of the most expensive forms of healthcare delivery and is so often the primary source of healthcare for homeless individuals. To access this care, the homeless often rely upon emergency transport services, also at a considerable cost to the community.

In 2011, an estimated 2,700 homeless individuals received EMS transport to area emergency rooms.*

Through medical respite and managed care programs, Austin can greatly reduce emergency visits, emergency transports and indigent healthcare costs while improving the overall health and well-being of the homeless.
Tim was one of the first clients at the Austin Resource Center for the Homeless when it opened in 2004. At that time, he was drinking heavily and working sporadically to get money for alcohol. He stayed at the ARCH off and on when he wasn’t camping. Tim first engaged with case management services in 2006 and worked with various case workers until 2011. His life changed in 2011 when he started attending Streets of Hope, a recovery group held at the ARCH. When he graduated from Streets of Hope (he still has his certificate of completion), he stopped drinking, started attending church and began ‘living his faith.’

While living outdoors in a campsite in 2010, Tim’s foot became frost bitten and developed into a chronic health issue. An infection in this foot sent Tim to the hospital and resulted in an eventual referral to Front Steps’ Recuperative Care Program. Tim did very well in Recuperative Care. He maintained his spirits by reading his Bible, praying, and attending the Bible study groups held by the nursing home. When his stay was over at Recuperative Care, he returned to the ARCH for a short time until a permanent supportive housing unit at Spring Terrace Apartments became available.

Today, Tim is very proud of his efficiency apartment, has made new friends and says that he is very content in his new life. We are very impressed with Tim and the way he has turned his life around. He celebrated one year of sobriety in September 2012.

For more success stories, and general information on the program, please visit: http://www.frontsteps.org/what-we-do/recuperative-care/success-stories

Front Steps case managers assist some 200 homeless men and women transition from the streets and into housing each year.

Over 140 homeless men and women died on the streets, in parks and campsites in and around Austin in 2012.

Tim’s apartment is provided through a collaboration between HUD, Caritas of Austin and Foundation Communities.
Rhonda’s Story

Prior to her stay in Recuperative Care, Rhonda had been homeless for 13 years. Being stuck in an abusive marriage and addicted to heroin kept her on the streets for years at a time. Rhonda left the streets long enough to have her three children, but she was never able to remain housed. As such, she lost custody of her children.

After she lost custody, she returned to the streets feeling like she was ready to give up. She was camping in the woods when she developed an infection, which sent her to the hospital. From there, she was discharged to the Recuperative Care Program.

Being in Recuperative Care was difficult for Rhonda, as it placed her in a structured environment for the first time in many years. It was also the first time she had been clean and sober since losing custody of her children. While in RCP, Rhonda took control of her health and began attending mental health support groups. She also joined Streets of Hope, Front Steps’ alcohol and drug recovery program and made friends with others in recovery.

Rhonda has been selected by Front Steps as a candidate for our Permanent Supported Housing program and is now living in her own apartment. She has worked very hard to decorate her apartment and create a quiet, homey environment for herself.

Making a new life and reintegrating into the community has meant big changes for Rhonda. She says the RCP program helped set her on this new path. “I’m working on new days, now.” she says of her life. Rhonda continues to make progress through individual and group counseling in addition to focusing on her addiction recovery. She is working with an attorney to finalize her divorce and is also in the process establishing legal contact with her children. We are very proud of the hard work and progress Rhonda has made and the positive direction she has chosen.

For more success stories, and general information on the program, please visit:

62% of patients leaving RCP were successfully housed. 12% were discharged to shelters, 4% died and 22% returned to the street.

57% of patients received ongoing case management from RCP post-discharge. 20% were followed by social work via another program, 4% died and 19% discharged with no desire for further case management.

During the program year, 203 homeless adults were referred by area hospitals to RCP, only 30 unduplicated clients were admitted due to limited bed space.

Average length of stay was 50 days.

RCP patients carry an average of 14.8 ICD-9 Diagnoses.

Of 30 patients admitted during the designated time period: 1 had funding upon admission, 3 had already applied for benefits by the time they reached RCP and were awarded benefits while in the program, 14 did not apply because they had no permanent disabling condition and 9 are still pending or were denied. 3 were approved for benefits due to an application submitted by RCP.

Reimbursements to local hospitals from RCP patients who were awarded Medicaid was over $52,701 in year 4. 80% of RCP admissions have been identified as “Frequent Service Users” *.

93% of all patients served in year four reduced their ER and inpatient stays during the 12 months following their stay in RCP.

RCP provided 1369 occupied bed days in FY 2011-2012.

Referral Sources for RCP Admissions

The chart illustrates the sources of all referrals to Recuperative Care. The vast majority of the referrals come from University Medical Center Brackenridge (173 referrals). St. David’s South Austin Hospital referred 12 patients, Seton Main referred 8 patients, and St. David’s Main Campus referred 6 patients. Seton Hays, Shoal Creek, Seton Southwest and Reliant Rehab Hospital each referred one patient during the period.
New Transitional House Serves As Next Step
Not every Recuperative Care Program participant has permanent housing available to them when they have recovered enough to leave the nursing home facility. In many of these instances, Front Steps has been able to offer transitional housing in group setting. Our new house is clean, bright, spacious, has a roomy kitchen and 3 roomy bathrooms. The owner of the new location is very responsive to our needs and is invested in keeping the property in good condition. Any maintenance needs are addressed within 24 hours of notification.

The transitional house is funded in part by the Religious Coalition to Assist the Homeless and was largely furnished with donations from generous community members. The residents have their own rooms, with the exception of the master bedroom, which is big enough for two people.

There is a spacious yard and porch that is ideal for sitting and enjoying the evening breeze. Residents report they are really enjoying the house. Weekly group sessions and monthly house meetings are held at the house by Front Steps staff to ensure the residents are continue progress toward their goals.
As a result of the rapport established with program staff, 57% of RCP Patients have engaged in intensive case management following the inpatient portion of the program. Of the remaining patients, 12% discharged to the shelter, 4% died and 22% returned to homelessness.

Safe and stable housing was obtained for 62% of RCP patients within 6 months of discharge from the inpatient portion of the program. Of the remaining patients, 12% discharged to the shelter, 4% died and 22% returned to homelessness.

As a result of the rapport established with program staff, 57% of RCP Patients have engaged in intensive case management following the inpatient portion of the program. Of the remaining patients, 4% died, 20% started receiving case management through another program and 19% left the program with no further contact.
To learn more about the Central Texas Recuperative Care Program, visit: www.frontsteps.org

Key program staff 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

**Sarah Connell, LMSW,** Transitional Case Manager (half time), Master of Science in Social Work, Clinical Concentration from University of Texas at Austin, Bachelor of Science in Psychology from Baylor University

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

**Kameron Fowler, LMSW,** Director of Programs, Master of Science in Social Work, Clinical Concentration from the University of Texas at Austin, Bachelor of Arts in Social Work from Texas Tech University