Assessing the Need for a Medical Respite: Perceptions of Service Providers and Homeless Persons

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Assessing the Need for a Medical Respite: Perceptions of Service Providers and Homeless Persons

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For homeless persons, posthospitalization care is increasingly provided in formal medical respite programs, and their success is now reported in the literature. However, there is a dearth of literature on posthospitalization transitional care for homeless persons in the absence of a respite program. Through this formative study, we sought to understand the process of securing posthospitalization care in the absence of a formal homeless medical respite. Results demonstrated a de facto patchwork respite process that has emerged. We describe both human and monetary costs associated with patchwork respite and demonstrate opportunities for improvement in homeless health care transitions.

Implementation of the Affordable Care Act (ACA) has ushered in a new era of posthospitalization accountability and there is increased urgency as hospitals work to decrease readmissions to demonstrate care coordination quality and maximize reimbursement. Safety-net hospitals, those that disproportionately care for persons of low socioeconomic status, have higher readmission rates and will have to innovate to avoid readmission rate related penalties (Berenson & Shih, 2012). Effective transitional care, particularly for the most vulnerable patients, is needed to achieve and sustain health care reform under the ACA (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). The “triple aim” of health care improvement (improving the patient experience of care [including quality and satisfaction], improving the health of populations, and reducing the per capita cost of

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Effective transitional care has the potential to decrease hospital readmissions, even for high-risk populations (Jackson, Trygstad, DeWalt, & DuBard, 2013). Avoidable readmissions are high in some instances (van Walraven, Bennett, Jennings, Austin, & Forster, 2011); accurately identifying risk factors associated with avoidable readmissions is vital for effective transitional care program planning. Although many predictive models assume that risk factors are internal to the medical system and are related to quality-of-care issues, this is not always the case (van Walraven, Jennings, & Forster, 2012). Inclusion of external factors (e.g., baseline health, functional status, social variables) improves transitional care model discrimination (Kansagara, et al., 2011).

Identifying external variables that contribute to poor hospital-to-home transition outcomes provides an opportunity for clinicians to better understand their patient’s psychosocial needs and to incorporate social determinants of health into transitional care goals.

Homelessness is a major social variable that profoundly impacts a provider’s ability to ensure effective transitional care, and is especially taxing for patients. The inherent safety risks associated with homelessness are particularly devastating during illness, when physical and emotional defenses are low. Despite the important role that housing plays in recovery and the availability of assessment tools (Best & Young, 2009), housing status is not routinely assessed during hospitalization (Greysen, Allen, Rosenthal, Lucas, & Wang, 2013). Oftentimes, homeless persons requiring ongoing medical care have no place for recovery following hospital discharge. To fill this need, many communities have invested in formalized homeless medical respite programs.

As described by the National Health care for the Homeless Council, “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” (National Health Care for the Homeless Council [NHCHC], 2014). Homeless medical respite is becoming increasingly common with 59 such programs in the United States listed in the 2013 Medical Respite Program Directory (NHCHC, 2013a) and more in the works (NHCHC, 2013b). Common goals of homeless medical respite are reducing hospital utilization including emergency department (ED) visits and readmissions, connecting homeless persons to needed resources including housing, and decreasing health system costs. A recent systematic review demonstrated program success in most of these areas (Doran, Ragins, Gross, & Zerger, 2013).

However, there is a paucity of research on how transitional care of homeless patients transpires in the absence of a respite program or on what the organic process of de facto respite looks like in these situations. Moreover, the literature makes little reference to the experience of persons on both sides of de facto respite discharge planning. In this formative study, we sought to: (a) delineate the process of ongoing medical care for homeless persons in the absence of a medical respite, (b) identify the resources and options used for homeless medical respite in the absence of a formal place and process, and (c) explore the experiences of the patients and service providers involved in this transition.

METHOD

Study Design and Setting

A cross-sectional qualitative design was used as part of a systematic needs assessment for a homeless medical respite. The study took place in a mid-sized city in the southeastern United
States, known for its cutting-edge medical care and innovation. The university’s institutional review board approved all study procedures.

**Participant Recruitment**

A purposive sampling strategy was used. Prior to active participant recruitment, two study team members who worked in the community and provided services to homeless persons (Gamble, Manson) created two lists of all potential participants. The first list was of service providers, both community- and hospital-based, who worked to directly secure posthospitalization respite care for homeless persons; this list included key persons from the faith-based community. The second was a list of homeless persons in the local area who had undergone a medical procedure requiring ongoing aftercare within the previous year, or who were actively awaiting surgery but could not have it due to lack of place for postsurgery recovery. A total of 15 service providers and 8 homeless persons were identified, contacted, and invited to participate in the study via direct contact (phone, e-mail, or in person) by one or both of the team members mentioned.

**Data Collection**

Focus groups, which highlight group interaction and illuminate group processes and norms (Kitzinger, 1994) were chosen as the preferred methodology to facilitate a deeper understanding of the process and outcomes of attempting to secure medical respite for homeless persons. Three focus groups were held between January and May, 2013; two were for service providers who work to secure ongoing medical resources for homeless persons posthospitalization and the other for homeless persons who had the need (current or previous) for those services. Additional inclusion criteria were that all participants were English-speaking and at least 18 years of age.

Focus groups were held in a conference room at an emergency shelter and the local Health Care for the Homeless clinic and lasted between 40–69 min ($M = 55$). Snacks were available at all focus groups; no other incentives were provided. All focus groups were attended by two study team members (Biederman, Taylor) and audio-recorded; copious notes were also taken.

**Participants**

There were 18 participants across the three focus groups (12 service providers and 6 homeless persons). Service providers included a shelter administrator, health professionals in community-based programs, key persons from the faith community, and primary care providers, nurse and social worker case managers and/or program supervisors from three separate health systems. Homeless persons included persons who had undergone surgery or were awaiting surgery but unable to proceed due to lack of post-surgery recovery resources. Of the five persons who were invited but did not participate, four were service providers who had scheduling conflicts and one was a homeless person who did not feel comfortable in a group setting.

**Data Analysis**

Focus group audio files were transcribed verbatim by the first author, with pseudonyms used to protect participant identity. Data analysis then progressed in distinct phases. First, areas of
the transcripts that were relevant to the research questions were identified, extracted, and then crystallized into analytic poems in the process developed and described by Nichols (Biederman, Nichols, & Durham, 2010), which included extracting the exact words of the participants and keeping words and phrases in the order in which they were originally spoken and transcribed. Richardson (2000) suggested that poetry might “better represent the speaker” (p. 12), rather than the traditional quotes often used. In qualitative analysis, poetry is sometimes used in the process of crystallization, which allows researchers to recognize the complexity and facilitate a deeper understanding of the phenomenon under study (Richardson, 2000; Tracy, 2010), in this case issues related to the absence of a homeless medical respite. Next, all crystallized transcripts were read to identify in vivo codes; coding was done first within and then between transcripts. The crystallized coded segments were then compared back to the original transcript of each focus group to ensure all items germane to the research questions were captured. Constant comparison within and between transcripts resulted in the identification of themes that were relevant to the research questions and also contributed to the construction of a process map. Last, member checking was performed for findings verification. Throughout the data analysis process, memos were kept to maintain an audit trail. Study members met routinely to analyze data, make data decisions, document progress, and interrogate study findings. Qualitative research experts were consulted, as needed, for review of processes and findings.

RESULTS

The overarching themes that crossed all focus group sessions included the process used to patch together medical respite, the recovery options used in this process and associated outcomes, and the feelings related to the current patchwork respite system.

Patchwork Respite

In the absence of an established medical respite, a patchwork respite system has evolved (see Figure 1). One service provider described patchwork respite as “where we meet to divvy up a path to recovery.” This patchwork respite relies heavily on hospital discharge staff establishing and maintaining connections in the community. A shelter program director described the forging of one such relationship:

[She] came over, did a tour of the shelter [to] get a visual of what an individual has to deal with on a day to day basis. . . . She invited me over to talk with all the social workers about . . . some of the dilemmas we face. . . . Our relationship, I think, has totally changed and grown from that point. (Henry, Shelter program director)

These personal connections then form the basis for patchwork respite. These relationships are informal, rather than contractual, and as one service provider acknowledged, they rely on “peer pressure for accountability.” With no established process, each case was seen anew and likened to “a lump of clay” that results in system inefficiency as described by one service provider:

Housing issues are so time consuming it’s unbelievable. . . . We have to scramble around and find funds; it’s this church and that church, this agency, that agency. You have to wait for people to call you back it’s a, yes it’s a huge [issue]. (Dixie, Community-based Nurse Case Manager)
Another added that the time involved is not free from consequence and may compromise other client care: “It’s a lot of of hours and time. It really is. . . . The longer I—I spend with you the less I’m gonna spend with you” (Brooke, Social Work Case Manager).

Leaders of the faith community are often called upon during the discharge process and acknowledged the desperation of those responsible for establishing a discharge plan: “A lot of times they’re just calling desperate; they’re calling everyone . . . just trying to find a spot, a spot for them [homeless persons]” (Betty, Faith Community Leader).

The lack of a medical respite can result in differential treatment for some persons and may contribute to health care disparities. One social worker spoke of writing a grant to fund posthospitalization housing for one of her homeless patients but acknowledged that not everyone has the same opportunity:

He had advanced lung cancer. . . . He couldn’t go back to the shelter . . . so I wrote a grant so he could stay at [facility name] during his treatment. . . . For oncology, sometimes we have resources that you don’t. (Victoria, Clinical Social Worker)

A care coordinator added, “It’s pitiful when you rejoice when someone has a mental illness—it opens up another avenue.”

Medical Respite Options and Outcomes

The lack of a formal process and defined places for medical respite oftentimes resulted in suboptimal discharge arrangements for homeless persons. The posthospitalization options used in this patchwork process frequently included boarding houses, churches, family members, and shelters. However, in these settings, both safety and legal issues were cited as concerns. For instance, a
service provider described several safety issues with one boarding house, which prompted a client move:

She was living in a boarding house. . . . Physically she couldn’t climb the steps immediately after the surgery. . . . There was really nobody there during the day. It wasn’t a very safe environment. You know, people would steal other people’s food and things like that. We had a lot of struggles. (Dixie, Community-based Nurse Case Manager)

A homeless participant recollected safety issues related to living in a boarding house post-surgery. She spoke of having her pain medications stolen within half an hour of transfer from the hospital to the house, and also offered a description of a fellow boarding house resident:

We had one crazy girl. . . . She was smokin’ crack and gettin’ drunk and be outside cussin’ and whoopin’ and hollerin’ walkin’ up and down the stairs slammin’ doors, bangin’ walls. But they got rid of her, so it’s quiet now. . . . Now I do [feel safe] since they got rid of that crazy girl. (Caprice)

Clergy and church members were frequently mentioned as a source of assistance for homeless medical respite. However, their ability to assist was limited by legal concerns and finances. One pastor spoke of how a homeless gentleman who was receiving chemotherapy was made the volunteer sexton of her church to comply with local zoning laws after someone reported his sleeping in the church closet to local law enforcement. She further offered: “We just have no monetary resources right now. . . . We just say we can’t help you. . . . We’re at the point we can’t even put somebody up. . . . in a hotel room.” (Jane, Pastor)

Some participants spoke of families that were willing to take in homeless persons needing medical respite. However, finding family members was difficult. When available, oftentimes families were ill prepared, and sometimes even jeopardized their own housing by violating public housing policies:

He ended up having his leg amputated due to diabetes. . . . She [mother] took him but it’s putting her own housing at risk. . . . He’s not on the lease and he has a criminal record. . . . He fell the first day. . . . and dislocated his shoulder. Um, went to the ER, they didn’t have to admit him for that. . . . [The next day,] he had to call EMS to pick him up because he had slipped out of the chair. . . . He finally fell and landed on the stump and reopened the wound and then had to get admitted back to the hospital again. (Dixie, Community-based Nurse Case Manager)

When family is not available, sometimes patients rely on social contacts who may be ill suited to adequately provide for them. One homeless participant described her experience of being discharged to the care of a male companion following surgery:

The mental strain that I had to go through. . . . he promised to be there [crying]. But the bitchin’ and complainin’. . . . I wouldn’t have had it had I known that that was the outcome because [crying] . . . I had to depend on him to help me go to the bathroom, to get me something to eat, some days he would go out ‘cause he was pissed off [sniffle] and I’d be sittin’ there 11 or 12 o’clock, hadn’t eatin’ anything. (Chrystal)

Homeless shelters were cited as a challenge due to their lack of resources for medical provision. One service provider recounted a patient who had extended wound healing because she could not have a wound vac at the shelter:
A patient that we were not able to help... was unable to get home health and a wound vac because of being at the shelter and, sort of, as a consequence, remains with an open wound. (Wilma, Executive Director, Community-based Program for Uninsured)

This patient’s primary care provider clarified that the wound had been open for over a year.

A homeless participant who was discharged to a shelter described her experience with wound care:

[The most difficult thing was] keeping my, my wound clean 'cause I had a lot of infections after I had my surgery. And I stayed here at the shelter. And so, um, I mean, you know hand washing, having the gloves, hand sanitizer, everything, but still, I had a lot of infections. (Lacey)

She further offered how taking the medications ordered by her care provider was challenging in the shelter setting:

They keep 'em [medications] locked up. You have to be up there by 8 o’clock in the morning to get your medicine. . . . If you did not get your medicine, if you didn’t get it by 8 o’clock, you just shit out of luck that day. . . . 8 o’clock in the morning for the whole day. (Lacey)

Another option mentioned for medical respite for homeless persons involved an extended hospital stay. One service provider described the transformation of a homeless patient due to extended hospitalization:

You went from someone who’s homeless, disheveled, had substance abuse . . . mental health, I mean, all these things that were going wrong in her life. . . . We kept her in the hospital; she got her psyche meds on time, made all the connections; when she had left, she was sent to a place; she had new hope. . . . When she walked out, it was a totally different person. (Victoria, Clinical Social Worker)

Another provider recounted a patient who was initially discharged to the woods but, upon readmit had a similar transformational experience:

I had a homeless gentleman who had a substance abuse problem and who was hit by a car . . . and discharged back to the woods and came back like 3 days later in body bag covered in feces; so much on him that the EMS brought him in a body bag . . . It was just a really horrible, undignified situation and he actually stayed at [hospital] for probably 60 days. . . . the positiveness that came out of this—he was in one place for long enough that he actually got to go to his hearing for disability and actually got disability. (Brooke, Social Work Case Manager)

Only one positive case was recollected that did not involve an extended hospital stay. In this case, arrangements were made for a homeless man to recover from surgery in a house used for addiction recovery services. He recounted his experience:

The peace of mind that I got. The rest that I got, you don’t get that here at the shelter. . . . They told me, “Don’t lift nothin’; don’t do nothin’. You are just here for medical.” They understood that. . . . I got by with that and I felt comfortable. . . . I had a clean shower. . . . There was the other 12 people but you don’t have that risk, that high risk of 110 guys takin’ a shower. . . . I mean, it was totally different in my case. (Peanut)
Feelings Related to Lack of a Designated Medical Respite for Homeless Persons

Across all focus groups, participants described their feelings related to the lack of a homeless medical respite. For service providers, the predominant feeling was frustration often related to health care costs. One service provider described his frustration at differential care based on ability to pay:

It’s frustrating also when we see huge amounts of resources being invested in people who often have a, you know, a different situation. . . . Their ongoing care is futile; . . . they’re in the ICU. . . . They’re gonna die anyway. And we’re spending 10–12 thousand dollars a day on those people and then these tiny amounts of resources that we could deploy maybe in a more flexible way, could have such a big impact, but yet the money’s not there. (Gerald, Physician)

A nurse case manager expressed frustration at institutional focus on advanced procedures instead of simple fixes:

I can see where people would get burned out. . . . It can be very frustratin’ sometimes. . . . Any big institution that can do all these advanced medical procedures and all this, and yet you can’t fix some of these really simple things on your own doorstep. (Dixie, Community-based Nurse Case Manager)

And a minister described her frustration at not being able to meet her perceived ethical role responsibilities:

[I feel] like we’re not doing . . . like we’re, we’re leaving an open hole, we’re leaving a great need. . . . These people have nowhere to go. . . . It’s just like [pause] you’re not fulfilling you know God’s promise. (Betty, Faith Community Leader)

Although all service providers expressed primarily negative feelings associated with the securing medical respite resources for homeless persons, two service providers also described positive feelings. One spoke of how she focuses on individual cases referring to the positive outcomes “as your little starfish.” The other spoke of the need to focus on the positive stating:

It would be SO easy to focus on how dreadfully depressing it—you know, things can be . . . there, there’s pleasure when it finally does work so, that’s, that’s what I focus. I avoid, I do not look at how awful it can be. (Beth, Hospital Care Coordinator)

For homeless persons, the feeling of uncertainty was predominating. One woman who was still awaiting surgery described the stress that accompanies uncertainty:

Well, they’ve done canceled my surgery like twice. . . . They don’t want to release me to the shelter. . . . They was like, “We schedule you one more time, cancel then, we may not do it at all.” . . . It’s a scary thing, and it works on your mind and body, the stress. (Marie)

Another homeless gentleman offered an eloquent description of the general uncertainty of homelessness and how a medical condition complicates the situation:

You really don’t know where your next meal is comin’ from. You don’t know how you’re gonna get adequate medical care. And then if you do get medical care where am I gonna stay? How can I really heal and rest and get proper sleep and proper rest and proper nutrition [group affirmation] so I can come out on top? That’s what runs through your mind every minute of the day [Um hmm] and then the people you deal with. Who’s gonna take from me [that’s right; yeah]. You gotta worry about who’s gonna really take from me, hurt me. (Peanut)
DISCUSSION

In the absence of a formal medical respite and posthospitalization transition plan for homeless persons, a de facto patchwork process has evolved. In this study, both service providers in community and hospital settings and homeless persons reported monetary and human costs of the patchwork system. The direct monetary costs were primarily related to staff time involved and the cost of the patchwork respite (e.g., recovery house, boarding house, extended hospital stay) or readmission when patchwork respite failed. For service providers, human costs included negative emotions such as anger and frustration, as well as a sense of remorse at the inability to fulfill their professional and ethical role obligations. For homeless persons, the human costs of patchwork respite included stress related to uncertainty and poor outcomes related to suboptimal housing options for ongoing medical care and recovery. The goals of the aforementioned triple aim provide a useful framework for understanding how implementation of a homeless medical respite can address these issues. Also, opportunities exist for community health nurses’ (CHNs’) involvement to support existing or initiate new medical respite programs.

Implications for Improving the Patient Care Experience

Implementation of a medical respite can improve the patient care experience for homeless persons via several routes. In our study, homeless persons cited stress related to the uncertainty of medical care in the absence of a formal medical respite program and transition process. Emotional well-being is associated with long-term recovery from physical illness (Lamers, Bolier, Westerhof, Smit, & Bohlmeijer, 2012). Thus, optimizing well-being through decreasing the uncertainty related stress during illness or post-surgery may enhance the physical recovery process. Also, Greysen, Allen, Lucas, Wang, and Rosenthal (2012) found that homeless persons perceived a lack of coordination between hospital and shelter transitions, which resulted in homeless persons’ delay in seeking care. Although our participants did not purposely delay care, the uncertainty of housing stability resulted in delay of surgical procedures that prolonged patient pain and suffering; a homeless medical respite program would directly address this issue.

Similar to this study, Davis, Devoe, Kansagara, Nicolaides, and Englander (2012) found that lack of a standardized discharge process, especially for those with complex social needs, resulted in system inefficiency and chaotic transitions that resulted in poor patient outcomes and service provider dissatisfaction. Service provider job satisfaction is associated with patient satisfaction (Szecsenyi et al., 2011) and quality of patient care (Mache, Vitzhum, Klapp, & Groneberg, 2012; Mohr, Young, Meterko, Stolzmann, & White, 2011). Thus, a homeless medical respite may increase provider satisfaction and could have both direct and indirect effects on quality of care and patient satisfaction for homeless persons as they transition out of the hospital setting.

Implications for Improving the Health of Populations

Population health is sometimes difficult to measure (Berwick et al., 2008); understanding the aims and potentials of a homeless medical respite provides a starting place for determining program evaluation metrics. Hospitalization, in and of itself, is a stressful situation (Marks, Loehr,
& McCarthy, 2013). Transitional housing and case management, similar to medical respite services, demonstrated decreased ED visits (Sadowski, Kee, VanderWeele, & Buchanan, 2009) and decreased hospital days (Buchanan, Doblin, Sai, & Garcia, 2006; Sadowski et al., 2009). The fact that “the hospital is less and less often needed by the population” is indicative of success (Berwick et al., 2008, p. 768).

Also, as service providers in our study attested, with appropriate time and resources, medical respite can be a transformational experience for a homeless person. In this study, service providers recounted homeless persons who were stabilized on their medications, applied for and received disability, and were successfully housed when they had extended hospital stays through the recovery period. Other studies have demonstrated participants had moves into better housing situations following a medical respite stay (Meschede, 2010; Zerger, 2006). The events associated with these transformational experiences may serve as metrics for population health.

Reducing Per Capita Costs of Care for Populations

As this study demonstrates, the costs associated with the lack of a homeless medical respite are both human and monetary. Initiation of a homeless medical respite would have an immediate impact on the human costs of patchwork respite. Reducing the monetary cost of care for homeless persons through decreased ED recidivism and decreased hospital admission, as mentioned, is a potential (Basu, Kee, Buchanan, & Sadowski, 2012) but, depending on the level of care and services offered at the medical respite, is not always realized (Kertesz et al., 2009). Respite care costs much less to provide than hospitalization (Buchanan et al., 2006; McGuire & Mares, 2000). However, actual cost savings is difficult to measure (Berwick et al., 2008). Thus, reduced per capita health care costs may be a longer term goal.

Opportunities for Community Health Nurses’ Involvement

CHNs are instrumental in caring for, and helping to maintain, the health of many vulnerable populations and may contribute to the health of homeless persons through homeless medical respite programs in several ways. In areas where homeless medical respite programs are established, CHNs should familiarize themselves with program admission and exclusion criteria and how to make appropriate referrals. Also, there may be opportunities for employment, volunteering, or fund-raising activities. In areas where homeless medical respite programs are lacking, CHNs may serve as catalysts for change. As in our case, CHNs can participate in grassroots initiatives that include coalition building and needs assessments to substantiate the need for a medical respite program for homeless persons. The NHCHC (2014) has numerous resources for those interested in learning more about or attempting to initiate a medical respite program including a care provider’s network, medical respite tool kit, quarterly newsletter, listing of peer reviewed and media publications, and a registry of homeless medical respite programs in the United States and Canada.

Study Limitations

We acknowledge that our study has several limitations. First, the small sample size affects transferability of study results. However, our purposive sampling plan maximized participation of
those who have first-hand experience with crafting care transitions and securing medical respite options for homeless persons and homeless persons who were involved in the transitions. Next, the study was limited to adult English speaking persons. The literature on non-English speaking homeless persons in the United States is virtually nonexistent. However, a transitional care intervention for ethnically and culturally diverse persons that included non-English speakers (but who were not homeless) demonstrated promising results (Balaban, Weissman, Samuel, & Woolhandler, 2008). Homeless youth were also excluded from this study; their experiences of hospitalization and care transitions may be different than those provided by our participants.

Notwithstanding these limitations, our study makes an important contribution to the literature. To date, no studies have reported on de facto medical respite processes, options used for medical respite, or outcomes in the absence of a homeless medical respite. Acknowledgement and understanding of this patchwork respite process provides greater opportunity to advocate for formal transitional care and medical respite for homeless persons. Further, this study demonstrated opportunity for community- and hospital-based service providers to partner and intervene to affect all three areas of the triple aim strategy for health care improvement.

REFERENCES


Kitzinger J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness, 16*, 103–121.


