This report represents Center for Respite Care, Inc.'s responses to Charting Impact, a joint project of BBB Wise Giving Alliance, GuideStar USA Inc, and Independent Sector. Charting Impact uses five simple yet powerful questions to encourage strategic thinking and help organizations share concise information about their plans and progress toward impact.

**Mission:**

MISSION: Provide quality, holistic medical care to adult homeless people who need a safe place to heal, while assisting in breaking the cycle of homelessness. The staff at Center for Respite Care (the Center) accomplishes our vital mission through the implementation of our programs and services to homeless adults. At the core of everything we do – every medical treatment that is issued – a homeless adult heals. They heal physically and emotionally. It is not just about their physical recovery. Staff work diligently to make sure our clients have opportunities for socialization, recreation, healthy eating, medical empowerment and a place to live upon discharge. Yes, they stay laser-focused to help each homeless adult heal and help them transition to self-sufficiency, which is the core of our mission. The Center is the only 24/7 facility in the Tri-State area to offer medical recovery care. Each person is treated in a respectful, caring manner by a skilled team of professional...
The content of this Charting Impact Report is the sole product and responsibility of Center for Respite Care, Inc.. This report does not in any way represent an endorsement from Independent Sector, BBB Wise Giving Alliance, or GuideStar, nor does it represent fulfillment of the BBB Wise Giving Alliance's *Standards for Charity Accountability*. For more information on Charting Impact, visit [www.guidestar.org/chartingimpact](http://www.guidestar.org/chartingimpact)
1. What are we aiming to accomplish?

The Center for Respite Care has four key goals: Goal 1: To provide quality, holistic medical care to homeless people who need a safe place to heal. Goal 2: To assist sick, homeless people in transitioning to self-sufficiency. Goal 3: To assist disabled homeless people to remain stable in housing. Goal 4: To help disabled homeless people to obtain disability income and public benefits.

2. What are our strategies for making this happen?

Key strategies include: (1) Meeting emergency needs: Respite Care provides 24-hour bed rest, three healthy, balanced, dietetically approved meals each day, showers, laundry facilities and clothing as needed; (2) Medical care: Includes medical evaluations, lab testing, medications, nursing care, physician visits, health education, nutrition education, coordination of medical and mental health follow-up care or surgeries; (3) Transition to Self Sufficiency: Social worker creates individual service plan and refers clients to services available through existing agencies in the community (services are not duplicated). Individuals are enrolled for public benefits (food stamps, Medicaid, SSI/SSDI etc.) in collaboration with other Continuum of Care agencies. The program focuses on becoming an important link in the transition to self-sufficiency. The recovery period at the Center for Respite Care also provides an ideal opportunity to begin the critical first phase of treatment for debilitating mental health conditions for patients who might otherwise fall through the cracks. Other homeless people in transitional housing who require hospitalization or acute care are able to return to their shelter programs after recovery at Respite Care. (4) Housing: CRC also operates a unique HUD-funded housing program for homeless individuals who should qualify for disability income but have not yet been approved. By providing housing while assisting clients in navigating the filing process, we help them to obtain a secure income, become self-sufficient and remain stably housed. Clients being discharged from the medical respite facility are placed in apartments of their choosing throughout the area and then helped with filing for disability and other benefits. A HUD grant pays the rent, deposit and utilities for up to 24 months until the client has income and is stable enough to be self-sufficient. The process of obtaining disability income generally takes 12 to 24 months, during which time staff provides intensive medical case management as well as traditional case management. These staff members coordinate all of the clients' medical needs, including medications, medical appointments, surgeries, recovery needs, as well as mental health and substance abuse treatment. During their time in the program, clients are gradually weaned from the intensive support and taught to manage their own care. Because many of the clients have inconsistent work histories, they are only eligible for SSI ($710 per month). Therefore, at the end of their time in the Respite Housing Program, staff will help them move to affordable housing which will allow them to pay only 30% of their income in rent.

3. What are our organization's capabilities for doing this?

The Nurse Manager and Patient Care Coordinator, Mildred Williams, is an LPN with over 30 years of clinical and supervisory experience. She has extensive experience working as a psychiatric nurse (over 25 years at The Christ Hospital) and has volunteered to help the homeless and underserved in Cincinnati for over 30 years. She is also a certified Homeless Front Line Worker Supervisor and has coordinated social service needs for Center for Respite Care for 7 years. Her efforts on behalf of our patients played a large role in Center for Respite Care receiving the 2008 Caracole Living Award. Because of the outstanding outcomes, CRC was chosen to receive the 2013 “Medical Respite Award for Excellence”. This new award, established in 2013 by the National Health Care for the Homeless Council, recognizes outstanding contribution to the field of medical respite care as determined by the impact on improved health and quality of life for people experiencing homelessness. CRC is the FIRST medical respite in the country to receive this distinction. The Executive Director has 35 years of business, planning, financial analysis and management experience ranging from managing major projects within Fortune 500 companies to business planning for small owner-operated companies. She coordinated development of the original proposal that launched the Center for Respite Care. In addition, she arranged and maintained the collaboration of hospitals and homeless agencies that conceptualized, planned, and developed the Center. She is a certified in Homeless
Front Line Worker Supervision and has served as the agency's director for 8 years. Robert Donovan MD, whose time is generously donated by the Cincinnati Health Network, is the Center for Respite Care Medical Director. He has provided health care to the homeless community for over 22 years as a physician on the Homeless Medical Van, at the Health Resource Center and, starting in 2003, at Respite Care. He brings a wealth of experience as well as continued contact with the homeless community outside of the Center. He is able to follow-up with patients on the Med Van, for example, even after they leave Respite Care. He is also a Marianist brother who has dedicated his life to serving the homeless in our community. Dr. Donovan has been recognized in the press multiple times and received several awards for his commitment to serving the homeless population. He received the 2009 Ministry Award at the 2009 Religious Brothers Conference Brotherhood Awards. He was recognized by the Ancient Order of Hibernians; he received the 2009 Shining World Compassion Award from The Supreme Master Ching Hai International Association; he was the first recipient of the Transformation Awards in 2011; He was awarded the 2012 Molina Community Champions Award; and he was a Cincinnati Business Courier 2013 Health Care Heroes Finalist.

4. How will we know if we're making progress?

Plans of care, treatment and progress are documented in patient charts by physician and nursing staff. A Health Improvement Assessment is completed by physician at discharge. Key data is entered into the Homeless Management Information System (HMIS), a HUD-funded HUD-audited system which tracks name, DOB, SSN, income/benefits, diagnoses, special needs, medical encounters, case plan, referral source, exit destination etc. Outcomes measured include:
1. Completed medical recovery
2. Discharged to housing or treatment
3. Remained stable in housing
4. Obtained employment or disability income and public benefits
Medical recovery and discharge placement are compared to goals, prior periods, and other homeless medical respites across the US. Hospital readmissions are computed using hospital data for CRC patients, who sign HIPAA releases allowing sharing of patient data between CRC and 9 area hospitals. Hospital ER & inpatient data is then compiled for CRC patients. The rate of readmission due to improper healing is compared to results before being admitted to CRC to identify improvement and cost savings. Results are also compared to a similar study conducted just prior to opening CRC. Program results are reported to the Program Committee and the Board of Directors (bi-monthly), as well as the hospitals and foundation funders, HUD, City, State (quarterly, semi-annually or annually).

5. What have and haven't we accomplished so far?

Nationally, 55% of homeless patients of homeless medical respites complete their medical recovery before they leave, and only 30% are discharged to housing or treatment facilities. However, the Center for Respite Care focuses on healing the entire person, physically, mentally, emotionally, socially & spiritually, profoundly affecting the lives of people who are sick and homeless. As a result: In 2012, 1. 90% of patients complete their medical plan of care at the Center for Respite Care. 2. 90% of patients leaving Respite Care move into housing or treatment facilities. 3. 92% of housing clients remained stably housed at exit from the Respite Housing Program. 4. 92% of clients leaving the program in 2012 had income, and 100% exited with non-cash benefits.