**BRIDGING THE GAP BETWEEN HOSPITALIZATION OF THE HOMELESS, SELF-CARE AND HOUSING: A PROPOSAL**

by

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BA, University of Pittsburgh, 2006

Submitted to the Graduate Faculty of

Behavioral and Community Health Sciences

Graduate School of Public Health in partial fulfillment

of the requirements for the degree of

Master of Public Health

University of Pittsburgh

2008

UNIVERSITY OF PITTSBURGH

Graduate School of Public Health

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The purpose of this thesis is to propose the use of a program planning model that will address the lack of respite care, or in other words, the lack of a specific place for recuperation after an illness or injury available for homeless people in Allegheny County. This proposal will incorporate a program planning design of a potential respite program in Allegheny County. This respite care intervention is designed to be part of a county wide effort to eliminate homelessness in Allegheny County led by the Allegheny County Homeless Alliance. This proposal will incorporate the Mobilizing for Action through Planning and Partnerships (MAPP) program model for the intervention design. This is a six-phase process that emphasizes community collaboration and assessment as the driving forces for the creation of an intervention. The six phases of the MAPP model are 1) Organizing for Success/Partnership Development; 2) Visioning; 3) The Four MAPP Assessments; 4) Identify Strategic Issues; 5) Formulate Goals and Strategies; 6) The Action Cycle. This proposal will describe how the Allegheny County Homeless Alliance can conduct the phases of the MAPP model using information previously collected as well as ways they can obtain additional information. The proposal will describe a respite care intervention that is an example of a possible respite care program in Allegheny County. The goals of the program are to improve the health of the homeless as well as to create social support for this population and an opportunity to transition into permanent housing. The

public health significance of this proposal is that it will create an intervention for the homeless population of Allegheny County that will allow them to achieve better health status through respite and follow-up care, greater social support and, most importantly, the opportunity to obtain permanent housing in a more direct way than what is the norm.

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# 1.0    INTRODUCTION

Homelessness in the United States has increased since 2000 despite efforts by community leaders and organizations. The increase of homelessness in Allegheny County is consistent with the trends found across the country. The majority of people who are homeless are single older men. However, the fastest growing populations among people who are homeless are families with children around the age of eight (Allegheny County Homeless Alliance (ACHA), 2005).

Eliminating homelessness in Allegheny County is a goal that will require many different strategies and solutions. Homelessness is a condition that takes many forms and occurs for various reasons. Some of the reasons for homelessness include poverty and lack of affordable housing. In 2004, 2,187 people were homeless in the City of Pittsburgh in Allegheny County (Allegheny County Department of Human Services (DHS), 2006). This number had grown from the findings in 2000 (DHS, 2006). The underlying factor that causes homelessness is poverty. According to the National Coalition for the Homeless, the poverty rate in the US population has increased from 12.5% in 2003 to 13.3% in the year 2005 (2007). Although the poverty rate is increasing, the amount of public housing and public assistance available is decreasing. In the 1970s there was a large loss of public housing to developers who made such units into condos

and other private housing. Today, people need to earn more than the minimum wage to afford to rent a one or two bedroom apartment in every state (ACHA, 2005).

In Allegheny County there are several resources for the homeless such as emergency shelters, transitional housing, domestic violence safe havens, and single room occupancy hotels along with rental assistance. Support can be found through government sponsored programs such as food stamps and Medical Assistance as well as Case Management programs and mental and physical health services. Although there are resources available for Allegheny County's homeless community, most needs are not being met. Currently, there are no medical respite care programs available for homeless people who have been discharged from the hospital or are suffering illnesses in shelters in Allegheny County (ACHA, 2005). Medical respite care is acute or post-acute medical care for homeless people when they are too ill to recover from an illness or injury on the streets but are not sick enough to be in a hospital (National Health Care for the Homeless Council (HCH), 2007). Emergency shelters can feel overwhelmed and ill-equipped to deal with these clients when they do not have the resources, and medical care within the shelters is often sporadic (Bear, 2007). A medical respite care program will be another tool to end homelessness in Allegheny County.

The homeless population has an increased risk of morbidity and mortality simply because of their living situation (Hwang, 2001). This is a public health concern. The poor health associated with being homeless is a health disparity that needs to be addressed in order to provide equal health care for all Americans. It is difficult to design health interventions for the homeless. The transient nature of homelessness poses a problem for researchers and organizations who want to design long-term solutions to this problem. This proposal will explain a program planning model that will be most useful for the organizations that already exist in

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Pittsburgh to design a respite care program. Also, this proposal will give an example of a possible respite care program for Allegheny County.

# 2.0    BACKGROUND

## 2.1    PROFILE OF HOMELESSNESS IN AMERICA

There are different states of homelessness. A homeless person may be sleeping in a place that is not meant for human habitation or in an emergency shelter. This definition also includes those who are in transitional or supportive housing and who came from the street or an emergency shelter. People who are living in temporary shared housing or in unsafe or condemned buildings are also considered homeless. A near-homeless person is someone who is facing eviction and will have to vacate his current living situation unless some kind of payment is made. A chronically homeless individual is one who has been sleeping in places that are not meant for human habitation or he has been using an emergency homeless shelter for over a year. Those who have had four or more periods of homelessness over the period of three years are also considered chronically homeless (ACHA, 2005).

The five common categories of people who are homeless are single men and women, couples, families with children and children who have left home. Each of these categories has its own set of unique health-care needs. People experiencing homelessness have greater health needs and concerns than those who have housing. They are among the least healthy members of society. It is believed that more than half of homeless people experience psychiatric or substance abuse disorders (Rosenheck & Selby, 1998). Little resources for these conditions are available

for the homeless while they are living on the streets or in shelters. Homeless people will suffer from chronic health conditions at almost twice the rate of those who are housed (Gills & Singer, 1997). These conditions can be diseases such as diabetes, heart disease, HIV or tuberculosis. Along with an increase in chronic diseases, the homeless also are at a greater risk for illness from the everyday reality of being homeless (Gills & Singer, 1997). They may be constantly exposed to the weather, living in crowded shelters or unsanitary conditions that breed communicable disease and have poor nutrition or insufficient time to rest (Gills & Singer, 1997). There is also an increased risk of trauma from violent acts such as muggings or rape (Gills & Singer, 1997). The mortality rate is higher for people experiencing homelessness (Hwang, 2001).

According to the National Survey of Homeless Assistance Providers and Clients performed by the US Department of Housing and Urban Development (HUD), 46 percent of homeless people reported having one or more chronic health conditions such as arthritis, high blood pressure and joint problems (1999). Homeless clients were more likely to report one or more chronic health conditions (HUD, 1999). The most commonly cited place for a source of care was an emergency department. The study found that 24% of those surveyed reported they needed to see a doctor in the past year but did not. Following this trend, 46% of those surveyed had not seen a dentist when they had a need for dental services. The survey also found that 39% of their sample should be taking at least one prescribed medication that they did not currently receive. The study found that 68% of homeless persons in families reported having medical insurance as compared to 41% of homeless persons who were single. Overall, 55% of the homeless clients did not have medical insurance (HUD, 1999). This report shows that there is a high amount of medical need that is not being met within the homeless community.

## 2.2    PROFILE OF HOMELESSNESS IN ALLEGHENY COUNTY

A Point in Time survey conducted in January of 2008 counted a total of 2,130 persons who were receiving housing or a service that is targeted towards homeless people. The estimated number of homeless in emergency shelters, transitional housing and unsheltered homeless in July of 2007 was 1,308 persons. This number has been consistent since 2005 and 2006 when the number of homeless people found in these conditions was 1,241 and 1,297, respectively. Despite efforts to decrease and eliminate the number of people experiencing homelessness, the number of homeless persons has not declined significantly (DHS, 2007).

The Allegheny County Continuum of Care for the Homeless is a group of housing and supportive services targeted towards homeless people (DHS, 2006). In the fiscal year of 2006-2007 the financial report states that 100 programs for the homeless were provided in Allegheny County. The services include emergency shelters which are available to people who are in immediate need of housing. In the 2006-2007 fiscal year there were 202 emergency shelter beds in Allegheny County provided by 16 emergency shelter programs. Safe Haven is supportive housing that services people who have severe mental illness and are on the streets and have not been participating in supportive services. The Safe Haven housing provides 24-hour residences that are either private or semi-private rooms and there is no specific duration for participation in this program. Another form of housing support is Bridge Housing, PennFree Bridge Housing and Transitional Housing. These services provide transitional housing that facilitates the move of homeless persons into permanent housing within a time frame of 12 to 24 months. Shelter Plus Care provides rental assistance to needy individuals through matching dollar funds from a grant recipient and a non-profit organization. There are other types of rental assistance available with an emphasis on families with children. Other services include Case Management, Supportive

Services to address the needs of homeless persons. Also, Innovation Programs are used to provide solutions for individual situations that lead to homelessness. Finally, Allegheny County has Permanent Housing services for people with disabilities (DHS, 2006).

Despite the variety of programs available to the homeless in Allegheny County there are no programs or services that specifically deal with homeless persons after they are discharged from the hospital or respite programs. One study interviewed emergency shelter staff about people who had been discharged from a hospital to their facility. The staff described situations where they received a client who needed extensive medical care or complex medication regimens and no one on the staff had the skills and appropriate knowledge to assist these individuals. Although half of the shelters had medical professionals volunteer their time and care on a regular basis, there was still a consensus that the shelters did not have the capacity to help recently discharged homeless clients who still needed additional care. Seven out of 22 people interviewed believe that medical/psychiatric respite care could be a solution to this problem for both shelters and hospitals (Bear, 2007).

## 2.3    2.3 MEDICAL CONDITIONS THAT AFFECT THE HOMELESS

Prevalent medical conditions among the homeless include seizures, Chronic Obstructive Pulmonary Disease (COPD), and musculoskeletal disorders. Skin and foot problems are common from exposure while living on the streets without adequate footwear, long periods of walking or standing and minor trauma that is not resolved right away. Chronic diseases are often poorly managed and they can escalate quickly because of a delay in seeking care. Homeless people are

at a higher risk of contracting tuberculosis. They also frequently suffer from poor oral and dental health. There is a higher risk of sexually transmitted infections and unintended pregnancies. Violence is another common threat to health along with accidental injuries (Hwang, 2001).

## 2.4     BARRIERS TO HEALTH CARE

There are many reasons why people experiencing homelessness do not receive the type or amount of medical care they need to be healthy. The process of finding care can be a great challenge in itself. Homeless people have competing priorities that clash with their need to seek medical attention while they are living on the streets (Gelberg, Gallagher, Anderson & Koegel, 1997). Another study found that homeless people in Los Angeles who had infrequent difficulty in meeting their sustenance needs were one third more likely to have a regular source of health care when compared to those who reported frequent difficulty in meeting sustenance needs (Gallagher et al., 1997). They also were more likely to report that they had gone without needed medical care if they had frequent trouble feeding themselves and their families (Gallagher et al., 1997). Competing priorities, such as the basic needs of food and water, prevent homeless people from seeking preventative care or care in the earlier stages of an illness. Often, homeless people do not seek care until their illness is too much to cope with (Gallagher et al., 1997). This was especially true among women, according to another study (Gelberg, Browner, Lejano, Arangua, 2004). The women said they knew where they could obtain free medical care but this was not a concern unless they had a medical ailment that interfered with their everyday life (Gelberg et al., 2004). Medical comorbidities are another factor that interferes with access to health care among the homeless. Another study found that homeless with medical comorbidities were more likely to

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say that they were unable to receive care. Those with three or more medical comorbidities are at a higher risk for becoming hospitalized (Kushel, Vittinghoff & Haas, 2001).

Another barrier to medical care is a lack of insurance. Those who had health insurance were less likely to report poor access to health care (Kushel et al., 2001). Other barriers include lack of transportation, poor access to care, difficult registration procedures, restrictive hours, negative attitudes towards health care and other needs that are a higher priority (Gills & Singer, 1997). Specifically, women said that they felt their care was affected determinately by the fact that they were poor and homeless (Gelberg et al., 2004). They questioned the quality of care they received and that the staff at clinics did not treat them with respect. The issue of respect was also discussed in another study that involved men. The feelings that they were treated rudely and ignored discouraged men in this study from seeking medical care at all. The men did not trust the medical establishment when they felt that they were not treated fairly (Wen, Hudak & Hwang, 2007). The reasons that the homeless do not seek care most certainly vary with the individual.

## 2.5     DETERMINANTS OF REGULAR SOURCES OF CARE FOR THE HOMELESS

Health care is still a concern for people experiencing homelessness in spite of competing needs in their lives. One study found that "need factors" such as health problems, injuries and a self-need for health services were a strong predictor for whether or not a homeless person will visit the Emergency Department (Padgett, Struening, Andrews, Pittman, 1995). Health insurance can be an enabling factor that drives a homeless person to seek medical care. There are other pre-disposing factors that make a homeless person most likely to seek care such as being older and having more social connections (Padgett et al., 1995). When given an opportunity, most

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homeless persons will elect to seek care, especially if their health problems have a significant negative impact on their everyday lives. One study found that those with more than 10 restricted activity days because of their health were more likely to have a regular source of care. Those who are younger than 41 and have been homeless for longer are less likely to have a regular source of health care. Also, those who are more socially isolated and who have been homeless longer are less likely to have a regular source of care. Homeless with Medicare or Medicaid are no more likely to seek care than those without it (Gallagher et al., 1997).

## 2.6 PLACES FOR HEALTH CARE

The homeless population can seek care in a variety of places. The most common site for care is the emergency department of a local hospital. One study found that over half of survey respondents who reported using the emergency department for health care were uninsured (Kushel, Perry, Bangsberg, Clark & Moss, 2002). Other factors associated with emergency department use among the homeless are less stable temporary housing, worse health states, having Medicaid or Medicare, being involved with crime and being female and white. This study found that homeless people were about three times more likely to use the emergency department but the 8% of people who used the emergency department four times or more in a year compromised the majority of emergency department use. The study suggested that repeat users should be targeted the most when trying to curb use of the emergency department in order to reduce overcrowding (Kushel et al., 2002). It may be difficult for the homeless to plan for health care so an emergency department in an ideal place for them to seek care. Emergency departments are accessible at all hours of the day, it is not necessary to have an appointment and they have the

capacity to deal with almost all ailments. Women in one study reported that long waits at clinics and limited hours affected their ability to seek medical care (Gelberg et al., 2004). Another significant finding is that people with more stable housing are less likely to use the emergency department (Kushel et al., 2002). Violence is another strong factor associated with emergency department use according to one study. The physical ailments incurred due to the dangers that lurk on the streets of New York were the most common reasons that homeless people visited the emergency room (Padgett et al., 1995).

Another study looked at emergency department use among homeless people. This study found that homeless with health insurance were not found to be using the emergency department incorrectly. This was the opposite of what previous studies had found (Han & Wells, 2003).The study found that those who were recently hospitalized and had a higher number of ED visits were significantly less likely to use the emergency department inappropriately. Having fewer primary care visits, difficulty accessing care and having no health insurance were not associated with inappropriate ED use. The emergency department is not the ideal setting to deal with many ailments, especially the comorbidities that many homeless people face and it is also hard to follow up with patients who leave the ED for continuity of care. Some of these patients will have to be hospitalized in order to monitor their recovery (Han & Wells, 2003).

## 2.7    HOSPITALIZATIONS AMONG THE HOMELESS

Hospitals are not required to collect or report homelessness data so it is difficult to know the exact number of homeless people who are hospitalized (Tsai, Weintraub, Gee, Kushel, 2004). The definitions that a hospital uses to define homelessness may not be the same as the definitions

used by agencies that help homeless people. This lack of coordination makes it difficult for the two groups to organize their efforts. Also, housing status may change while the patient is in the hospital so that the housing information that may have been collected upon admission is no longer true at discharge (Tsai et al., 2004). Collecting this critical data could help hospitals give more accurate care to people who experience homelessness.

Homeless people tend to stay in the hospital longer than people with permanent housing. One study found that homeless people who were hospitalized stayed in the hospital 5.1 days longer than housed patients in the same private hospital (Salit, Kuhn, Hartz, Vu, Mosso, 1998). This study found that physicians delayed discharge of homeless people who would need follow up care because they knew their access to this follow-up care or the means to comply with treatment guidelines were limited (Salit et al., 1998). Physicians might be more likely to admit a homeless patient when otherwise they would have sent a housed patient home with the same condition with the understanding that they had the means to seek follow-up care. A study that examined homeless veterans and their use of Veteran Affairs (VA) services found that homelessness was associated with a 13% increase in health care costs for the entire year. The increase in cost came from longer hospitalizations, high hospital readmission rates and greater use of outpatient services (Rosenheck & Selbyl, 1998). These results may not be generalizable to the general homeless population but it can be assumed that if health care costs are affected by housing status among VA services then government and private services could be affected as well. A study of the urban homeless in Hawaii attempted to estimate the cost of excess hospitalizations for homeless people. In this population homeless individuals were admitted to the hospital five times more often than the general population and one hundred times more in the state psychiatric hospitals. The study estimates that the state of Hawaii spends 2.8 million dollars

for excessive hospitalizations among homeless people (Martell, Seitz, Harada, Kobayashi, Sasaki & Wong, 1992). It is best for both the people experiencing homelessness and the people serving them to find the best way to provide them with medical care to prevent costly visits to the Emergency Department and hospitalizations.

## 2.8    STUDIES IN RESPITE CARE AMONG THE HOMELESS

Communities have been developing their own solutions to the problems of providing health care to the homeless. Some communities have special programs for homeless individuals after they have been discharged from the hospital in order to help them recuperate. The Fourth Street Clinic Respite Program in Utah uses a multidisciplinary model to provide care to people experiencing homelessness while they are recuperating from an illness (Gundlapalli et al., 2005). The program has four components. One component is a shelter-based day program where emergency shelters provide a bed for individuals during the day so they can rest while they recover from their illness. Another component is the motel program where patients with family members or who require oxygen or intravenous medication or who might have a communicable disease can stay for the duration of their recovery. The tuberculosis housed program is for homeless people with active TB and are being treated for that infection. Finally, the fourth component of the Fourth Street Clinic Respite program is the nursing home program where individuals who need nursing facilities after discharge can stay during their recovery. This multifaceted model addresses all the different types of aftercare that might be required after a hospital discharge. However, the demand is greater than the supply and not all homeless people who could benefit from this service can participate in this program (Gundlapalli et al., 2005). Not only does this program

give homeless people a safe place to recuperate, but it provides continuity of care and reduces the number of days that a homeless person needs to stay in the hospital and reduces healthcare costs. The ideal outcome of this program is that after respite care the homeless individuals would transition into permanent housing but this is rarely the case (Gundlapalli et al., 2005).

Another study examined the effects of respite care using a cohort study in Chicago (Buchanan, Doblin, Theophilus & Garcia, 2006). The respite program that this study followed was a group living facility for those who needed additional care that was not especially complex enough to constantly need the assistance of doctors and nurses. They found that respite care reduced homeless patients' use of inpatient services. The respite care group had 58% fewer days as an inpatient in a hospital and 49% reduction in hospital admission over the course of the 12 months that the study examined. Emergency department usage among the respite group was 36% less which was not a significant difference but a drop in usage nonetheless. The average cost of an average respite day was $706 which was much less than the $1500 cost associated with daily hospitalization (Buchanan et al., 2006). Respite care can be an excellent way to serve the health needs of the homeless community while helping to find solutions to their homelessness that would transition them to permanent housing.

## 2.9    CURRENT PROGRAM MODELS

There are two types of possible medical respite care models. A freestanding medical respite unit is a separately owned and operated program that exists independently of the shelters in the area. This type of respite care has its own staff, its own administrative and operational procedures and policies and well as a space that is adapted to meet the medical needs of the people who use the

facility. An example of this type of medical respite care model is the Barbara McInnis House in Boston, Massachusetts. This program has a building with 90 beds available for recuperating patients. It admits people 24 hours a day, seven days a week. Homeless individuals are recruited from hospitals, shelters, clinics or from the street. The program provides participants with three meals a day. There are also private, semi-private and shared rooms for the patients. Along with medical care, patients can receive dental and behavioral care as well as medication and case management. There is on-site laundry available, educational services and group activities (HCH, 2007).

There are many advantages to having a freestanding respite clinic. The freestanding respite program will control everything about the program. They can operate 24 hours a day and control all admissions and discharges. This type of program might be able to provide more comprehensive medical services for the clients. It might also be able to serve a wider variety of clients. The environment is completely controlled by the respite program. There can be more individualized services for clients depending on their medical status and history as well as more individualized attention from the staff. However, a project such as this would require the adequate amount of funding it takes to begin this type of respite care. The amount of money required depends on who will be providing services, where and what kind of permissions, permits and approvals it takes to begin such a program. There is also the challenge of finding the appropriate facility located in an area that will be accessible by the most people and also welcomed and supported by its neighbors.

The other type of medical respite care model is the shelter based model. In this model, the respite care takes place inside of already established shelters. There may be an area in the shelter that is set aside for continuous medical care. The shelter also can have a few beds that are set

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aside for respite care and they will allow the recuperating client to use these beds and the shelter facilities during the day. The types of services provided depend on the shelter and the kind of capacity that the shelter has. Generally, medical care will not be provided around the clock. Instead, clinicians will come to the shelter during specified hours or days and then a medical person would be on-call in-between those visits. This model is best for those who are recuperating but are still able to take care of themselves for the most part (HCH, 2007).

An example of this kind of program is the Colorado Coalition for the Homeless Medical Respite Care Program. This program operates 35 beds which are located in three different shelters in Denver. Unlike the Boston program there are specific admission criteria in order for patients to enter the respite program. Some of the criteria are that the patient has to be clean and sober for at least 72 hours, be alert and oriented, be continent, be able to perform all activities of daily living independently and be willing to follow the rules of the facility where their bed is located. The program provides a nurse for the clients along with dispensing and storage of medications. There is also case management, housing support, meals and transportation. Clients may be linked with primary care providers, mental health and substance abuse programs and vision or dental care through the program. Additionally, the program helps uninsured clients apply for medical assistance through the state government (HCH, 2007).

The advantage of this model is that there is already a starting place for the respite program. The program can piggyback of the experience of existing shelters and health care service providers. Clients may already be familiar with where they are going and may be more comfortable. There are opportunities to have multiple sites throughout the city so that more people can be served by the respite program. There is an infrastructure already in place that can be adapted to include the respite program. Using an existing facility may reduce costs to start and

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keep up the respite care program. It places the respite care program into the middle of community collaborations and partnerships that have already been established. This will help the respite care program gain acceptance more quickly from the surrounding community and hopefully from people who are homeless than if the respite program was starting from the ground up. Also, using an existing shelter helps the clients access a variety of services that a standalone respite care program might not have the time or resources to run (HCH, 2007).

However, there are disadvantages to this model. The respite program would have to follow the guidelines and policies of the shelters that it recruits to participate in the program. Some of these policies might not fit the respite program's ideal vision. The respite program may not have the same kind of autonomy as it would like. Also, some potential clients may be reluctant to enter the respite program if they have had a bad experience with shelters in the past. There also may be conflict over admissions from the shelter that might have their own bad experiences with different populations of clients. Also, the respite program may not have control over the actual environment of the shelter in terms of health and safety issues. They will not be able to control exposure to other diseases and violence like they would be able to in a freestanding respite care program (HCH, 2007).

## 2.10    SIGNIFICANCE OF BACKGROUND

Studies have identified health conditions that affect the homeless more than the general population. Most of these conditions are chronic diseases that need regular care and supervision from a doctor. This is something that is generally not available for the homeless. They also have analyzed the access to health care available to the homeless and motivators as well as barriers

that lead or impede the homeless when it comes to seeking health care. In order to help the homeless seek health care communities must plan and implement ways to overcome these barriers and motivate the homeless to seek health care. The homeless may choose to go to an emergency department because there is access to care at all hours. They may be admitted to the hospital after visiting the emergency department. Studies have shown that homeless people who have fewer competing needs and greater stability have better outcomes. A hospitalization is a good opportunity to address these issues and help the homeless person achieve better health outcomes through creating greater support and stability in their lives. However, hospitals are not equipped to offer the homeless these kinds of opportunities. There is not even an efficient reporting system in place to identify homeless people who are admitted into the hospital. Once a homeless person is released from the hospital he is not always released into a helpful situation. A respite care program could be a solution to this. The cohort study showed favorable results in terms of reducing hospitalizations re-admissions and lessening health care costs (Buchanan et al., 2006).

Allegheny County does not have a respite care program in place. Respite care would be a dynamic solution that can tackle many different aspects of the homeless situation in the county. A respite care program would be another tool to fight homelessness as well as eliminate the situation. This paper will describe a model to planning and creating this respite program in Allegheny County which includes the city of Pittsburgh. It will incorporate the goals and ideas of the Allegheny County Homeless Alliance so that the group can spearhead this effort. The paper will give a model of a program planning model and a respite care intervention that could work in Allegheny County and will take advantage of the collaborations that are cultivated during the program planning process. The intervention proposed in this program will only be an example of

what can come of this program planning model. The respite program will be a compliment to the work that has already been completed in this area of interest. The most important aspect of this program proposal is describing the process of planning and implementing an intervention that will utilize all the organizations and resources that are available in Allegheny County.

## 2.11    PROGRAM PLANNING MODEL OVERVIEW

The program planning model used in this proposal will be the Mobilizing for Action through Planning and Partnerships (MAPP) model. MAPP was created by the National Association of County and City Health Officials (NACCHO) with the CDC in order to give public health practitioners some structured guidance with creating community-based strategic programs (2004). The MAPP process was created to be theoretically sound and accessible to all community workers. The programs created through the MAPP process are meant to be sustainable for the long term and they will evolve through community discussion and program evaluation. The MAPP model has a heavy emphasis of communication and visioning. This model allows for intense collaboration between many different community stakeholders. It also will benefit from the amount of public health leadership that Pittsburgh already has. This model can help Pittsburgh improve its public health infrastructure to include more marginalized populations The MAPP model is very open to community involvement by professionals and laypeople alike. The MAPP model was chosen to drive this program proposal because it offers such a depth of collaboration.

The MAPP process consists of six phases. These six phases are 1) Organizing for Success/Partnership Development; 2) Visioning; 3) The Four MAPP Assessments; 4) Identify

Strategic Issues; 5) Formulate Goals and Strategies; 6) The Action Cycle. Each phase has several steps that will help complete the overall task of the specific phase. The first phase is called Organize for Success and Partner Development. Community leaders and agencies initiate the MAPP process during this phase as they begin to organize themselves and others. The second phase, Visioning, is when all involved parties discuss how they envision their community in the future. The visioning process can influence long term goals. The third phase consists of four assessments that can happen simultaneously -- Community Themes and Strengths Assessment, Local Public Health System Assessment, Community Health Status Assessment and Forces of Change Assessment. These assessments will help the people involved with planning see health issues from many different perspectives. This will assist the planners in creating a more dynamic program to address these issues. The fifth phase is called Formulate Goals and Strategies. This phase focuses on formulating goals and strategies that will be used to create the actual program. The program will be tailored to address the goals that are created in this phase. The final phase of the MAPP process is the Action Cycle. This is when the committees and community members explicitly plan their program, implement the program and evaluate the program. This phase incorporates all of the assessments and planning performed in previous phases. However, the MAPP process does not end with the final phase. The process is circular. Each phase feeds into the other. The Action Phase will provide feedback that can be used in the first phase of the MAPP process for a different project or to improve the current one. This process is designed to work with the community's capacity in order to create greater capacity as well as change that starts from the core of the community instead of tunneling a program into the community from the outside.

This model emphasizes community-driven strategies and solutions to community problems. Collaboration and community involvement is the cornerstone to developing and implementing a respite program in Pittsburgh. The MAPP process is built for partnerships and a shared vision as well as the strategic thinking and open dialogue that is necessary to make this program a reality. There are many opportunities for collaboration and partnership in Allegheny County. The MAPP process will help identify these agencies and invite them to be a part of the planning, implementation and evaluation process (NACCHO, 2004).

## 2.12    EXAMPLE OF THE MAPP MODEL

The MAPP model has been piloted and documented in several counties and health departments across the United States. One case study that is similar to Pittsburgh is the San Antonio Metropolitan Health District (SAMHD) which is responsible for health programs in San Antonio and Bexar County. SAMHD has jurisdiction over a population that is roughly the size of the population in Pittsburgh, about 1.4 million. Over the course of two years SAMHD implemented the MAPP process in order to conduct a community health needs assessment and identify issues that would be addressed and monitored by different sub-committees within the program.

SAMHD started the MAPP process without a clear idea of the type of public health issues they would like to address. At first they had trouble gaining the community's support when they began to administer needs assessment surveys. Once SAMHD educated the community about what this process was trying to accomplish there was more community participation and they were able to move forward from there. The SAMHD example shows how diverse the findings from this MAPP process can be. Through discussions, surveys, focus groups

and other tools such as visioning and Focused Conversations, SAMHD was able to identify six diverse issues to address through this planning process. This demonstrates the MAPP process has potential to produce different results for a broad question and will function in the same capacity on a smaller scale. The MAPP process will focus on a more specific topic in Pittsburgh—the topic of health care and the homeless—but it will still be able to produce the breadth of ideas that it created when it was used in the similar metropolitan community of San Antonio (National Association of County & City Health Officials, 2004) . This process will be the most interactive and encompassing way to plan the best respite program in Pittsburgh.

## 3.0    METHODOLOGY

### 3.1    OVERVIEW

This section will focus on the explanation of the MAPP model in the specific context of creating a respite program for Allegheny County. This proposal will serve as a guide to conducting the MAPP model and will give suggestions about ways to help this process run smoothly. One important thing to note about the MAPP model is that it is not linear. Steps in the model can happen concurrently or they can be repeated as needed. While the MAPP model is presented in a linear way it is truly designed to be flexible and meet the needs of the participants in the program. This section will describe how the MAPP model works and how it can be applied to Allegheny County.

The MAPP process requires a lead organization to begin the process of collaboration among different organizations and agencies in the Pittsburgh area. This paper will focus on the Allegheny County Homeless Alliance as that lead organization. The Allegheny County Homeless Alliance is a public-private partnership that consists of providers, consumers, faith-based organizations, government agencies and the academic community. They have been working on issues related to homelessness in Allegheny County for over 20 years. The Alliance is composed for different committees which focus on various aspects of the homeless situation in the community such as the Health Resources and Service Delivery Committee. Through its

history and long-standing presence in the community, the Homeless Alliance has a variety of connections to homeless-care providers and other agencies throughout the city. The Homeless Alliance proposed a Ten Year Plan to end homelessness in Allegheny County in 2005 so this group has experience with planning large initiatives (ACHA, 2005). The Homeless Alliance is an ideal choice to lead this intervention.

The Homeless Alliance already has an overall plan with recommendations and strategies designed to eliminate homelessness in Allegheny County. The organization created its own Ten Year Plan to end homelessness in response to a call to action from the United States Interagency Council on Homelessness. The plan titled "Ending Homelessness Now: Creating New Partnerships for Change Executive Summary" describes different plans to be implemented over the next ten years in order to eliminate homelessness in Allegheny County. The document recognizes that homelessness is a multifaceted problem with many contributing factors and opportunities for solutions. The recommendations in the plan address the layered nature of this problem (ACHA, 2005). Recommendation 8 best addresses the lack of respite care for the homeless in Allegheny County. Recommendation 8 states "To advocate for comprehensive health and behavioral health services that are accessible, reliable and effective for people experiencing homelessness" (ACHA, 2005, p. 18). The document explains that there have already been steps taken to achieve towards advocacy through a SAMHSA grant that has helped link mental health and primary health care clinics so that they can treat the homeless person more efficiently. The grant also allows these services to share records. Still, this grant does not address all of the healthcare gaps that exist for the homeless in Pittsburgh. The document specifies, "For example, a chronically homeless person diagnosed with the flu has no place to go to recover

from the illness" (ACHA, 2005, p.18). The creation of a respite program will address this service gap.

The Allegheny County Homeless Alliance recognizes that the Ten Year Plan is just words on paper without a commitment to do what's necessary to move the plan forward. In their plan the Alliance declares they will be responsible for "promoting collaboration and partnerships through Continuum of Care" (ACHA, 2005, p. 19) and "Assisting in implementation and evaluation towards achieving the recommendations set forth in the plan and modifying the plan, as adjustments are required over the ten-year period" (ACHA, 2005, p.19). These self-appointed roles make them the ideal organization to take charge of facilitating the MAPP model. The section of the proposal will describe how the Allegheny County Homeless Alliance will lead the MAPP model program planning process.

## 3.2    ADVANTAGES OF THE MAPP MODEL

One challenge to employing the MAPP model is gaining the acceptance by the Homeless Alliance. The model has many steps. It requires a significant amount of time and energy before the program implementation even begins. While the model has extensive instructions about how to obtain information for the visioning process and different assessment it does not give specific guidance to how to create program activities and conduct an evaluation. It can seem overwhelming. However, the advantage of the MAPP model is the Homeless Alliance has already performed many phases of the planning process in order to create their Ten Year Plan. An important component of creating the Ten Year Plan was a three-day conference that involved different leaders and stakeholders in Allegheny County. The conference brought these

individuals together to discuss how homelessness and solutions do this problem. During the three day conference called "Ending Homelessness: Creating New Partnerships for Change" the sixty-five participants performed a variety of activities to explore the problem and to brainstorm ideas for why this problem exists and how they can help eliminate homelessness. Many of these activities can be incorporated into the MAPP model. This makes the MAPP model a natural program planning model for the Homeless Alliance because they are already familiar with how the process works. The MAPP model will just put their work into more formal terminology. This should help the tasks involved with this model look less daunting because a majority of the tasks have already been completed. A large part of implementing the MAPP model will be revisiting the work that was already done and then updating and adapting that work for this current project.

Another advantage of the MAPP model is that it will give the Homeless Alliance an opportunity to review their plan during the midway point. It has been roughly four years since the Ten Year Plan was created. All of the information gathered to create that plan is still relevant. However, there is new information available that will add to the recommendations, strategies and insight of the overall plan. Obtaining updated information will allow the Homeless Alliance to update their plan as a whole. They will have a chance to look at the brainstorming and planning they completed in 2004 and 2005 with fresh eyes. They might be able to create ideas that might have been missed or clarify existing ideas. The goal of this planning model is to have a variety of viewpoints while creating the program. Utilization of the MAPP model might attract additional stakeholders and community leaders who were not present during the initial program planning activities. These new participants could add rich information to the Ten Year Plan as a whole. Also, using the MAPP Model will give the Homeless Alliance an opportunity to practice this program planning model on a smaller scale. Usually, this planning model is used to select a

problem that is unique to a community and then create solutions for that problem. This proposal is adapting the MAPP model to address a specific problem which is the lack of respite care in Pittsburgh. So each step of the MAPP model will explore information that is relevant to this problem. The Homeless Alliance can think of this program planning process as a trial run of the MAPP model. It can help them learn the process and how they will put it to use for other project or instruct other organizations on the best way to use it. The main advantage of the MAPP model is that will further empower the Homeless Alliance and give them yet another tool towards reaching their goal. Creating public health leadership is an inherent component of the model. Using this model will strengthen the public health leadership of not only the Homeless Alliance but of other organizations and stakeholders in the region. It will help with community collaborations, partnerships; idea-sharing and other characteristics that will help Allegheny County unite again homelessness. This program planning model fits well into the responsibilities and previous work of the Homeless Alliance. Hopefully, this knowledge will allow the Homeless Alliance to adopt the MAPP model as their strategy instead of other program planning models that are available to them.

### 3.3    DESCRIPTION OF THE MAPP MODEL

The first phase of the MAPP model is called "Organize for Success/ Partnership Development." In the first phase of the plan, the lead organization, the Allegheny County Homeless Alliance, should have a clear understanding of why they will use the MAPP process to help create their program. The MAPP model is an ideal program planning model for the Homeless Alliance because it fits well with the philosophy of their Ten Year Plan. Not only does it fit their

philosophy but the program planning tasks that are necessary for the MAPP program planning process have already been completed by the Homeless Alliance in preparation for their Ten Year Plan. Although the Homeless Alliance did not follow the MAPP model implicitly they performed many of the tasks that the model requires. This proposal encourages the Homeless Alliance to incorporate what has already been done into the planning that will create a respite care program in Pittsburgh.

The second step of the first phase of the MAPP process is to identify and organize participants. The Homeless Alliance has a long history in the community. They have made many contacts and connections in Allegheny County. The Ten Year Plan names some of the partnerships that the Homeless Alliance already has. Some of these relationships provide funding for various programs such as the Pennsylvania Department of Public Welfare, the PA Department of Health and HUD. Sixty-five people attended the conference that created the Ten Year Plan. These participants represented private foundations, local agencies as well as government entities. The Homeless Alliance has already cultivated many of the ties that are needed to conduct the MAPP model. The Homeless Alliance has already created partnerships for their ten-year plan project. They have partnered with the 17 Emergency Shelters in Pittsburgh, Dan Onorato, the Allegheny County Chief Executive, the Allegheny County Department of Human Services, the United Way, Mercy Behavioral Health, CYF Housing and the US Department of Housing and Urban Development in order to start initiatives created by the Ten Year Plan. These partnerships will be invited to put their energy into this latest project. Along with existing partners the Planning Committee will want to identify other partnerships that they will need for this respite program. One important partner will be local hospitals, an essential part of the developing plan. Mercy Hospital is already a partner with the Homeless Alliance. Recently

it was incorporated into the University of Pittsburgh Medical Center family of hospitals. The Homeless Alliance could use allies already established inside of Mercy hospital to court partnerships with other UPMC institutions. There are other hospitals in the area including the West Penn Allegheny Health system that will also need to be identified as participants (ACHA, 2005). The Homeless Alliance will need to court aid resources such as social work and advocacy organizations in order to have experts in the field of finding and obtaining resources that can help a person stay well and stay in permanent housing. Another important participant will be the local colleges and universities who have the ability to bring employees and resources to the program. The Homeless Alliance also will want to create partnerships with current and potential funders who will be essential to the program planning process. Also one of the most important partnerships in this program planning model will be members of the homeless community or those who have firsthand experience with homelessness and illness. These individuals and families will be invited to be a part of this process. During the process of courting and creating these relationships, both old and new, the Homeless Alliance might discover more partners that were not initially identified. The Homeless Alliance already has partnerships and collaborations that it will tap into in order to plan this respite program so this step of the MAPP model should be somewhat familiar and comfortable for the Homeless Alliance.

Phase Two of the MAPP process is called Visioning. This process guides the MAPP participants so they can create a picture of the community they would like to have in the future. The main goal of this second phase of the MAPP process is to facilitate the creation of a shared vision of the future for all the MAPP process participants so they can move forward in the process with a clear understand of what they are ultimately striving to achieve This visioning process has already been done by the participants in the conference that helped create the Ten

Year Plan. The participants will revisit this visioning exercise to have a clear reminder of the vision of the Ten Year Plan because this new program will be part of this plan. Four years have elapsed since the "Focus on the Future" exercise. Participants were asked to imagine life in 2024 and all the aspects of living and working in the future. There were eight groups and they created eight different visions of the future. This visioning process described the strengths in these ideal future communities. There were common themes among all of the scenarios, although each scenario was quite unique and creative. Most scenarios were concerned with removing the stigma that is associated with homelessness. In their ideal future communities this stigma was no longer a concern and everyone was educated about homelessness making the problem a true community concern. These scenarios also emphasized equal educational opportunities for all. They saw that the people in these future communities had a strong sense of worth that was universal. These future communities had support services that were easily accessible and available under one umbrella. Social support services are coordinated and no one is denied access to these services. All of these future communities saw a marked decrease in homelessness, although not all communities were envisioned to be devoid of homeless people (ACHA, 2004).

It will be important to revisit this visioning exercise with the MAPP program planning committee. The committee will want to be aware of the type of vision that their program should be a part of. This will give the committee a greater sense of the overall goals that this specific respite care program will help to achieve towards the elimination of homelessness in Pittsburgh. Revisiting this visioning process also will give the committee a greater sense of context in which they will be creating this respite program. Now the planning committee can perform an additional visioning exercise that is specific to this particular project. This is important because while this project is a complement to the entire Ten Year Plan it is still an arm of the plan with

its own challenges, visions and goals. It is important for the planning committee to explore the vision for how a respite care intervention can affect the future of homelessness in Pittsburgh. This additional visioning process is important because it will help unify the group and really connect them to this specific project. It will help jumpstart the group's collective imagination. It will be helpful for the group to imagine how a respite program could change the state of homelessness in Pittsburgh. This will help the program planning participants see further good that can come from this program.

The third phase of the MAPP Process is the four MAPP assessments. These assessments are the Community Themes and Strengths Assessment, the Local Public Health System Assessment, the Community Health Status Assessment and the Forces of Change Assessment. The collective analysis of all four MAPP assessments will give a complete picture of the public health status of Allegheny County. These four assessments can occur simultaneously. It is important for the planning committee to determine the linkages between the programs. If they believe that one assessment will have a significant influence on the other, then that assessment should be conducted before the one it influences. Each assessment will require a planning period. The Planning Committee should draw out the plan for conducting their assessment along with the tools they will need and the people they will need to contact in order to conduct the assessment. After the data is collected it should be compiled and shared with the Planning Committee, the program planning participants, and the community at large. The assessment part of the MAPP model gives the planning committee an opportunity to revisit the assessments and data that they accessed while creating the Ten Year Plan. It also will give them an opportunity to collect new data as four years have passed since the Ten Year Plan was created. The collection of

new and updated data is a task that can benefit the Ten Year Plan as a whole so it is a worthwhile task for the planning committee to undertake under the MAPP program model.

The Community Themes and Strengths Assessment is designed to explore community thoughts, opinions and concern. This assessment is used to understand the issues that are important to the community. It will also determine what assets are in the community and what areas need improvement according to the community members. This assessment is an important part of mobilizing the community as a whole so they become more invested in the program that is being planned. The Homeless Alliance has already conducted something similar to this assessment in the context of the "Ending Homelessness Now" conference. At this conference the local community members gathered to discuss the homelessness situation in Pittsburgh. Part of this discussion included naming strengths that different groups of stakeholders had concerning the homeless community. There were eight group of stakeholders identified at the conference: Consumers, Government, Funders, Providers, Business/Developers, Faith-based/Planners, Government Academic and Training and finally, Health, Behavioral Health. Each of these groups named what they were proud of and what they were sorry about (ACHA, 2004). For this assessment the Planning Committee would look at areas of which the stakeholders were proud. For example, the Health, Behavioral Health group said they were proud of "Collaboration with Beth Haven Wellsprings" and "Integrate medical and behavioral health and substance abuse" (ACHA, 2004, p. 18). The concepts that these different groups are proud of will be counted towards community strengths. It will be important for the planning committee to analyze this data as part of the Community Themes and Strengths assessment.

The Community Themes and Strengths assessment asks for more information that has been previously collected for the Ten Year Plan. The additional information can be gathered

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through open discussions, dialogues, interviews, surveys and focus groups. It is important to obtain a sense of the quality of life in the community that exists currently. Another important activity is to create a map of community assets. This way, the Planning Committee and program planning participants can have a richer sense of the capacity of the community from actual members of the community who are the most familiar with their own community strengths. The Planning Committee will conduct windshield tours in the community, once they have the permission of community leaders. It is important to gain community buy-in before conducting any assessment activities. Other methods of gathering data can be focus groups, surveys that are distributed in the community as well as observing town hall or other community meetings. The members of the Planning Committee will be the gatekeepers that will encourage community members to participate in these assessments.

The Local Public Health System Assessment looks at the strengths and weaknesses of the local public health system as defined by the 10 Essential Public Health Services. Not only does this assessment help the Planning Committee and MAPP participants learn about their internal capacity as a local public health organization, it can help the local public health system define their role in the community and help them determine how well they are functioning. The 10 Essential Public Health Services from standards created by the National Public Health Standards Performance Standards Program are:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.

6. Enforce laws and regulations that protect health and ensure safety.

7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable

8. Assure a competent public health and personal health care workforce.

9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

10. Research for new insights and innovative solutions to health problems. (NACCHO, 2004)

An important part of this assessment will be identifying a trained facilitator who is not directly involved with the local public health structure of the community. The facilitator should be familiar with how public health works but the facilitator should also function as a partial observer. Potentially, the same facilitator who ran the visioning process could also work on this assessment which will focus on a group discussion between local public health leaders in the community. The Planning Committee will identify appropriate participants from the local and state government, the local board of health, hospitals, community service organizations, universities, businesses and faith-based organizations. An effective way to obtain data for this assessment is by organizing a retreat for the participants so there can be discussion over a weekend. However, schedules may be hard to facilitate for such a trip. This assessment also can be done through a series of meeting in the community. During these meetings or during the retreat the local public health leaders will have a guided discussion about the 10 Essential Public Health services and how they contribute to these goals. This discussion will help orient the participants to the topic of this assessment. It also will allow them to reflect on their personal

experiences with trying to achieve these goals, which is important for the second step of the assessment.

This second step still will have the participants complete a survey that is located on the CDC website. This survey is an instrument that can evaluate the performance of a local public health organization. The participants can answer the questions on this survey to obtain a sense of how their public health system works within the context of the 10 Essential Public Health services. While participants will fill out these surveys separately there will need to be consensus about answers to the survey questions in order for the data to be analyzed for the community. After everyone has had a chance to complete the survey there will be further discussion about the way public health functions in the community. Once consensus has been reached concerning the survey questions the facilitator can enter the responses on the CDC website and the CDC will create a summary report in about 48 hours. There will be a wrap-up meeting to disseminate the results from the CDC summary report. At this time, the participants can reflect on their enhanced understanding of the public health functions that occur in their community. The results can be used to set priorities for change and improvements within the local public health community. These priorities can be addressed through the current intervention or by separate interventions that occur simultaneously with this one or at a separate time. This assessment will give local public health agencies a deeper look into how they are prepared to help facilitate the intervention that is being planned and created.

The Forces of Change Assessment is the third in the MAPP model. This assessment looks at changes in the community that can affect the health of the community. This assessment consists of a comprehensive brainstorming that will discuss the types of changes that occur in Allegheny County. The most important aspect in defining a potential "force of change" is a

change that affects local public health and is out of the individual's control. The Homeless Alliance has already conducted a version of this survey during their conference. They discussed the changes in trends of homelessness in Allegheny County from 1975 to 2004. The timeline discussed the many reasons people became homeless as well as solutions used to combat homelessness. This is an extensive list that covers the gamut of life in Pittsburgh as accurately as the conference members can recall the different situations that have passed over the years (ACHA, 2004). The Planning Committee should revisit this timeline and discuss its accuracy and if there is anything they would like to change and delete. The Planning Committee can discuss changes that are political, environmental, social, technological, ethical, and economical or any other category a person can create. They may find a whole category that was not discussed during the conference and may fill in the timeline from ideas from this particular category. One aspect of the timeline that this brainstorming session will really focus on is the health aspect of this timeline. The Planning Committee will want to make sure that there is an accurate picture of the health services available to the homeless through the year and how this has all changed. It will be important for the Planning Committee to involve as many committee members as possible in this brainstorming session so they can have the most diverse sharing of ideas. Adding to the existing timeline will allow this assessment to be completed quicker and it will also incorporate this planning process into the entire Ten Year Plan so that the two proposals influence and complement each other. This is an assessment that really builds on the previous work of the Homeless Alliance and the Ten Year Plan. This assessment may be reviewed and reassessed on an as-needed basis.

The fourth assessment in the MAPP model is the Community Health Status Assessment (CHSA). This assessment will look at the health status of the community. There are 11

categories for data in the CHSA assessment: 1) Demographic Characteristics, 2) Socioeconomic Characteristics, 3) Health Resource Availability, 4) Quality of Life, 5) Behavioral Risk Factors, 6) Environmental Health Indicators, 7) Social and Mental Health, 8) Maternal and Child Health, 9) Death, Illness and Injury, 10) Infectious Disease and 11) Sentinel Events. The most important task for the Planning Committee members and other program planning participants is to locate and collect all sources of community health data that are available. This involves talking to different community partners in order to determine what kind of information they can collect. The MAPP model suggests collecting data for the past five years in order to see a trend in the data. State and local agencies will be a valuable source of information as well as community efforts which have conducted assessments that will address the eleven core data categories in the CHSA. Participants will identify what data they can bring to this assessment or what kind of data they can collect from their community contacts.

The Planning Committee will review the collected data often to ensure that they have data for each of the eleven core categories. If there are discrepancies or holes more community contacts will be established so that they can collect this data. Additional indicators may be selected for analysis as the assessment progresses. For this proposal, it will be important to collect data on all aspects of homelessness in Allegheny County. The committee will have to look for unusual and hidden sources for data so that there can be a comprehensive view of the overall community. Once the data is collected it will be analyzed according to age, gender, race/ethnicity and any other categories that are deemed important by the community. This should create a document that describes the health of the community. This document should be disseminated throughout the community in different ways such as newspaper articles, fact sheets, posters and a comprehensive full report available to anyone who requests one. After the data is

analyzed and reported, the Planning Committee can identify ten to fifteen opportunities to increase the health status of the community. These opportunities can serve as a brainstorming warm-up for the next phase of the MAPP process.

Phase Four of the MAPP process is Identifying Strategic Issues. This phase incorporates the assessments done with the previous stage and extracts specific issues to address in order to move towards the shared vision of improved community health. This phase lays the foundation for the latter part of the MAPP process. This phase unites the community partnerships, the shared vision and the results from the assessments. Similar exercises have already been conducted by the Homeless Alliance when they created the Ten Year Plan. During the conference, the participants identified six concepts that were important issues for them to tackle in the next ten years. The MAPP model suggests framing the Strategic Issues in the form of a question. The Homeless Alliance did not follow this suggestion exactly but the categories that they created are very similar to what the MAPP Model asks from the participants. For this program planning process, it will be important for the participants to familiarize themselves with these important concepts. The Planning Committee will discuss these results.

Another example of Identifying Strategic Issues is the Ten Year Plan itself. This plan has eight recommendations which represent the problems that the Homeless Alliance will solve through their plan. These recommendations describe the issues that are most important to the Ten Year Plan. These recommendations should be reexamined for the MAPP process. The eighth recommendation in the plan is the strategic issue that most pertains to the creation of respite care. It may seem like the task of creating strategic issues has already been completed but the current Planning Committee can modify this phase so that they can brainstorm strategic issues that are specific to creating a respite program based on the group's vision of what a respite program is

and what it can do for the community. This exercise will allow the committee to imagine the resources that are required for this respite program. An example of a strategic issue that might result from this brainstorming is, "How can we foster community acceptance for this respite program?" This exercise will be important so that the committee is aware of the type of barriers that they will need to address in order to create this program. This exercise will also highlight the benefits of the program and other salient points. Most importantly, this phase will highlight the multifaceted issues that are involved with creating and maintaining a respite program in Pittsburgh. The committee will then address what issues are most important while they are planning the program. The point of this phase is to appreciate the complexities in creating a respite program. The committee will also want to realize that they might not be able to address all the issues that may come up while they are planning, implementing and evaluating this program. They should choose what they are truly going to focus on so that the committee does not become overwhelmed or obsessed with a level of perfection that is impossible to achieve.

Phase Five of the MAPP process is Formulate Goals and Strategies. Goals are defined as the anticipated end result. Strategies are the ways that the community will achieve their goals. During this phase the vision statement will be first and foremost on everyone's minds. The committee will consider the overall vision of the Ten Year Plan and the vision that this current committee has created for the purposes of the respite program. This phase should focus on the goals and strategies that are specific to creating the program. The vision statement, the four assessments and the strategic issues will form the framework that will drive the creation of these goals and strategies. The goals and strategies created should create a link between the vision statement and the strategic issues. An example of a strategic issue from earlier is ""How can we foster community acceptance for this respite program?" This phase will attempt to answer this

question. The goal will be to help the respite program gain community acceptance. A strategy to address this problem might be to hold two or three town meetings throughout Allegheny County to discuss the respite program and air any concerns or ideas about this plan. The MAPP participants will also create strategy alternatives so there will be a variety of strategies around the same goal and strategic issue. This will allow for more choices when coming up with plans for implementation.

After all of the goals and strategies have been brainstormed and identified the groups will discuss barriers to implementation. Identifying barriers will not necessarily make a strategy undesirable; it will simply bring these possible barriers to light. Each group will identify barriers for the strategies that they brainstormed themselves. The committee will also want to take a look at the action plan for Recommendation eight in the Ten Year Plan. These actions may be applicable to creating a respite program and it will be important to include these ideas as possible strategies towards implementation. The group will think broadly about how they will implement these ideas as this is preliminary work for the final phase of the MAPP process. They will brainstorm ideas about essential activities, resources and the timeline that the intervention will need. The groups will also need to redistribute activities and responsibilities in order to ensure full representation from all partners in the MAPP process on an as-needed basis.

The next step in this stage is to choose the strategies that will be implemented in the final program. The strategies selected should be the ones that will best accomplish the groups' chosen goals. These strategies will be adopted and implemented by the program participants. Finally, the Planning Committee will write the strategies and goals into a planning report that outlines the strategic processes that will occur in the community while the program is underway. All of the MAPP participants will agree to follow and adopt the strategies that are outlined in the planning

report. This planning report will also be disseminated throughout the community and to other members of the Homeless Alliance and the Ten Year Plan who were not involved in this process.

The sixth and final phase of the MAPP process is the Action phase. This phase is the result of all of the planning, collaborations and assessments that were conducted during the first five phases. In this phase, the program is planned, implemented and evaluated. At this phase is it important to determine if all of the stakeholders in this program are truly involved. The role of various leaders should be clear before plans are finalized. Responsibilities should be delegated among participants in a logical way. Together, the community partners should develop measurable objectives that will drive the program planning process. They will develop a dialogue that will articulate and refine these objectives so everyone is clear on what this program is supposed to truly accomplish. The objectives will further help to clarify responsibilities and roles among the community partners.

The next step will be to develop action plans or specific activities for the program. The community partners will implement these activities. Specific tasks will be assigned to the different partners. All of the participants in the planning process should be involved in the implementation of the actual program in some capacity. Once the program goals and activities and roles are established it is time to implement the program. All of the action plans and the timetable should be reviewed before implementation begins. It is important to establish that everyone is still aware of what is going to happen during this program implementation. Community Partners involved in the implementation process should have consistent communication in order to ensure that everyone is following the same blueprint. The program activities should be constantly monitored. This will collect data for process and outcomes evaluation. Also, it will help the community partners make any adjustments they may need

during the actual implementation of the program. The participating organizations will also be a part of the evaluation process, although outside evaluators may be invited to help with that process (NACCHO, 2004).

# 4.0    RESULTS

## 4.1    PROGRAM JUSTIFICATION

This program will be a component of the Homeless Alliance's Ten Year Plan to end homelessness in Allegheny County. This program will address the lack of resources for health services and respite care in Allegheny County. This intervention will bridge access to adequate health care to obtaining permanent housing for the homeless. In order to best access these services the respite program will need to be involved and connected with the shelters and partnerships that already exist in the city. This is why it is best to use a shelter-based model for a respite care program in Pittsburgh. There are already medical programs and shelters that can be linked to a respite program. A multidisciplinary approach to the respite care program will help utilize all of the different services available in Pittsburgh and allow the respite program to reach out to the greatest number of people who may need it. The following intervention is an example of what could be created for Allegheny County from the MAPP model. It is a suggestion of a plan that was created separately from the Ten Year Plan but still uses the same information, priorities and values.

## 4.2    PROGRAM FRAMEWORK

The program will be framed by the Social-Ecological model. The Social-Ecological model is a way to look at all the different levels that influence personal behaviors. Activities in this program will be designed to address these different levels. The five levels of the Social-Ecological model are 1) individual, 2) interpersonal, 3) organizational, 4) community and 5) society (National Cancer Institute (NCI), 2005).

1. The individual level refers to a person's personal behaviors, attitudes, barriers and beliefs about certain health behaviors. There will be program activities, such as increasing individual skill sets, which will affect a person's individual influences.

2. The interpersonal level describes relationships that can enhance or inhibit different health behavior. This program hopes to create healthy relationships between the clients and program workers in order to increase healthy behaviors.

3. The organizational level refers to organizations that have an influence of personal health behaviors. This program will involve many different organizations who will strive to help the clients as much as they are able.

4. The community planning focus of this intervention ties into the community level of the Social-Ecological model. The community is involved in providing a solution to this problem so they have an influence over health behaviors as a whole.

5. Finally, public policy is not something that is directly affected by this intervention but will hopefully be an offshoot of the work done through the program. This program could help Pittsburgh and other cities find viable solutions to creating long-term change in the

health status and living situation of the homeless people in their community (NCI, 2005).

## 4.3    PROGRAM THEORY

The program will use the constructs of the Health Belief Model to shape and guide its activities. The Health Belief Model is meant to address individual level health behaviors and perceptions that can lead to poor health outcomes. The constructs of the theory revolve around health motivation. They describe the different attitudes and beliefs that can affect a person's behavior. This theory postulates that people are ready to change their health behaviors if they believe they are susceptible to the health condition, believe that it has serious consequences, believe that taking some sort of action would reduce the consequences of the condition and if they believe that the difficulties of taking action will be outweighed by the benefits. They also must be exposed to elements that prompt them to take action and feel confident that they are able to make these health behavior changes (NCI, 2005).

One construct of the Health Belief Model is perceived susceptibility which is personal belief about a person's chances of contracting a certain health condition. In this program there will be education activities for the clients that will raise awareness of the health problems and risks that are associated with being homeless. The goal will be to help the client become more vigilant about these health conditions so they can seek medical care sooner. Perceived severity describes a personal belief about the severity of a health condition and the consequences associated with the condition. The program will include activities that will educate clients about the consequences of leaving health conditions untreated. It will emphasize the importance of early intervention, even when the health condition is not a large burden on their everyday life.

Also, it will be important to discuss the importance of follow-up care and how health conditions that seem to be resolved can flare again if they are not properly taken care of (NCI, 2005).

Another important construct of the Health Belief Model is the perceived benefit of certain health behaviors. This refers to a person's personal belief that taking certain actions to reduce a health risk will be effective and beneficial. There will be activities about the benefits of preventative, follow-up and acute care for health conditions. The activities will emphasize the benefits of regular care even when there is not an apparent health problem. Another area of the program that ties in with this construct is education about the benefits of participating in programs that the clients may have been hesitant about in the past. The other side of this focus in the Health Belief Model is the perceived barriers towards health behaviors. The program will seek to remove many barriers—physical, financial and mental—so that clients can access the resources they need to perform appropriate health behaviors (NCI, 2005).

The final two constructs of the Health Belief Model are self-efficacy and cues to action. Self-efficacy is the confidence that a person feels about performing a certain health behavior. The program will strive to build the self-efficacy of the clients so they feel better equipped to access health services and perform healthy behaviors that will reduce their risk for further hospitalization and health crises. If they do experience a crisis the program wants the client to feel capable of responding to the health problem in the early stages. Cues to Action is a construct that describes factors that help a person become ready to change. In this program these cues will be tangible reminders that the clients can take with them after they leave the care center (NCI, 2005).

Social Support is another important aspect of this intervention. Social Support is not a concept that is easily theorized. It can be described and divided in a variety of ways. The

program will seek to increase clients' emotional support, informational support and instrumental support or support than includes the provision of tangible items. Also, the program will assess the social network of each client and his social integration into the community in order to see where social ties can be created, strengthened and utilized (NCI, 2005).

## 4.4 PROGRAM STRUCTURE

This respite program will be shelter-based so that all program activities will take place within an existing homeless shelter. The program will consist of two program managers who work full time, one part-time nurse practitioner and four part-time outreach workers called Transitional Assistants (TAs). The program managers will be responsible for fielding requests for placements, assigning TAs to clients, organizing specific resources for different cases, assisting the TA with creating an action plan for their client, maintaining relationships with referral partners and supervising the TAs. The nurse practitioner will visit clients in the shelters for about eight hours a week to provide follow-up care. The nurse practitioner will have physician backup as needed. The TAs will be responsible for contacting clients in the shelters, providing educational activities, developing a relationship with the clients and conducting the appropriate follow-up once the client has left the shelter. The overall goals for this program will be to provide the client with a place to recover from illness, provide them with the tools they need to manage various health conditions, reduce use of the emergency department or hospital, create a network of social support and transition the client into permanent housing.

## 4.5    PROGRAM ACTIVITIES

The program will be structured to meet the individual needs of the clients as well as to provide social support for them. Potential clients for the program will be identified by hospital discharge personnel. Hospital staff may refer any in-patient or emergency department discharge that was classified as homeless at any time during their stay in the hospital if they believe they need a respite from their current living situation in order to recover from an illness. The hospital should refer appropriate clients with at least 24 hours notice before they will be discharged. Also, shelters will be able to refer clients to the respite program if they feel that the homeless client will benefit.

Basic requirements for admission to the shelter-based respite program will be that patients are ambulatory and able to take care of daily living needs on their own, such as bathing and using the bathroom. They must not be using drugs or alcohol. They must be able to administer their own medication. They must not have signs of communicable disease. They must be mentally alert and competent. They must be willing to follow the rules of the respite program as well as the individual rules of the shelter.

Once clients are identified they will be evaluated by the program managers before they are allowed to enter the program. Respite program staff may refuse or accept a referral on any grounds. However, it is expected that the majority of evaluations will simply ensure that a potential client meets the inclusion criteria. Once admitted in the program, the client can stay as long as it takes to recuperate. The client, nurse practitioner and TAs will assess when a client is fully recuperated. One of the rules of the program is that the client agrees to stay as long as the clinician and the case manager deem necessary and to leave the program no sooner or later.

The program will first be implemented in three emergency shelters in Pittsburgh with plans to expand when the program is successful and there is a need for expansion. The shelters will each have three beds available for the program. The beds do not have to stay empty if there are no program participants. However, they should be available within 24 hours notice. Shelters must have the capacity to stay open during the day for the specific respite client. The respite program will provide the meals for the client through community partnerships with essential organizations such as soup kitchens. There will be beds in the respite care program for men, women and families.

When clients first enter the program they will be evaluated by the nurse practitioner. This evaluation will supplement the hospital discharge records and also assist with the action plan for clients. This evaluation will identify health behaviors and conditions that should be addressed during the program. The health behaviors will be addressed in a way that is personalized to the individual using the constructs of the Health Belief Model. For example, for a homeless person experiencing mental illness the action plan could include activities that address barriers for receiving treatment for the illness and the client's perceived susceptibility about negative outcomes that are associated with not treating this disease. The program managers and TAs will be responsible for incorporating the Health Belief Model into the individual action plan for the client.

The TA will interact with the client on a regular basis. They will be trained to dispense medications as needed and help with follow-up care for the client. The TAs will conduct the surveys and other assessment tools that are necessary for the evaluation of the program. The TAs will discuss possible referrals that will be helpful to the client. If the client agrees to these referrals, the TA and Case Managers will work to make these referrals happen. One TA will be

assigned to each shelter so that there will be continuity of care. TAs will assist with keeping the living area clean and possibly help with any small conflicts that might occur between program participants and staff. The TAs will be the main source of social support for the clients in the program. The goal is to create a social tie between the client and TA through continued interaction while the client is involved in the program. The TA will provide the client with informational support and instrumental support through specific means that are identified in the action plan. The most important aspect of social support that this program wants to address is emotional support. It will be difficult to manufacture emotional support but the goal of the TAs will be to be a source of emotional support for the client and help them desire support. Also, the TA will be connecting the client with other agencies so that their needs can be better met. This is another source of social support for the client.

TAs can conduct educational sessions for the clients either individually or in a small group depending on the number of clients and the nature of the educational sessions. Small group sessions will introduce the clients to other participants in the program and this could be another source of social support for them. The educational sessions will provide education and skills about certain health behaviors. For example, the TA can speak with an asthmatic client about asthma control techniques that will be feasible within their current situation. Another function of these sessions is to prepare the client for the processes that will help them transition into permanent or transitional housing. The clients will need to know what is expected of them and what to expect from the different organizations they will be interacting with in order to achieve the goal of obtaining housing.

Clients will be discharged on an individual case basis. The clinician will have the final say as to when a client is discharged from the shelter, meaning the client has been assessed to

healthy enough to return to everyday activities. Once clients are discharged from the shelter they will be placed in a more long-term shelter through the referral services. The TAs and Case Managers will contact them 1, 3, 6, 12 and 18 months after discharge from the shelter. These contacts will allow the program to track the progress of the referrals and see if the clients are adopting any health behaviors that have been discussed. They will also assess the type of follow-up care that the clients have received since their discharge from the shelter. It will be important that the program continues to document the type of personal beliefs and behavior that the client has throughout the program in order to determine how the program is working.

While respite care is an effective way to reduce hospital stays, readmissions and emergency department visits, the literature has found that the best way to achieve these goals and to keep homeless people healthier is to help them obtain stable housing. The main goal of this respite program is to provide needed medical care and help clients take better control of their health as well as helping them move from the streets and shelters into stable housing. This is the ultimate goal for the respite program.

## 4.6    PROGRAM EVALUATION

This is a program that will be phased into all hospital and shelters who can accompany the program if it is found to be a success. In order to determine the success of the program there will need to be an evaluation of the pilot year of implementation. In the first few months of implementation it will be essential to determine whether or not the program is being implemented correctly. This type of evaluation is called a process evaluation. The process evaluation will need to occur before the outcomes of the program can be ascertained.

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### 4.6.1   Process Evaluation

In order to facilitate the process evaluation, continuous data collection measures will be set in the framework of the program, a component that's called program process monitoring. The program will ask participating hospital to keep records of people who present as homeless, according to the standard definitions used in this paper, at the time of discharge. This will help the program track the population that it has been created to serve. The program staff will keep track of the referrals that are made from each source. They will also keep a record of which referrals result in successful matriculation into the program and which ones are unsuccessful. Reasons why a person is admitted or denied will also be tracked. The program staff will be required to keep these records updated at least weekly. The shelter staff will keep track of the beds they have available for the respite program and when they are free or when they are occupied and how long they are occupied. They will record the resources and services that they receive from the program for their respite program clients. They will record if there are any instances where respite program clients do not follow shelter rules. The clinical staff will record visits they make to shelters and clients. They will keep track of on-call calls received and what was discussed. They will keep track of medications prescribed and any other medical intervention that they perform for clients. They will record their observation and exam notes on patients and give explicit details about why they think a client is ready for discharge from the program. TAs will record the hours they work and the contact they make with clients. They will record the health and social topics they discuss with clients. They will record the materials given to clients, record contacts made with agencies on the client's behalf or the contacts that the client reports making and keep track of the client's plans after discharge from the program.

These records will be essential for evaluators when conducting the process evaluation. By monitoring the implementation practices of the program it can be determined whether or not the program is reaching its full target population. Also, it will determine whether the program is truly feasible in everyday practice. The main goals of the process evaluation will be to judge if the program is being implemented as designed. The acceptable standards used to judge the process methods of the program will be administrative standards agreed upon by the evaluation committee from their professional judgment and experience. Each of the process activities will then be operationalized into objectives that can be measured.

**Table 1. Process Evaluation Objectives**

| Recruitment | Recovery | Re-habitation |
|---|---|---|
| 70% of eligible program participants will be referred to the program | 100% of client contacts will be recorded by clinical staff. | 90% of TAs will meet with clients at least twice a week to discuss health and social goals. |
| 50% of referrals will meet the criteria for entry into the program and agree to participate. | 75% of clinical contacts with clients will include a medical exam of some type. | 100% of contacts with agencies concerning clients made by a TA or caseworker will be recorded. |
| 90% of participating hospitals will track housing status of patients upon discharge | 100% of on-call telephone contacts will be recorded by clinical staff. | 80% of clients will have at least three discussions about health behavior and future housing options facilitated by TAs. |
| 95% of referrals will be successfully recorded and tracked by program staff | 100% of medications provided by the program will be logged by clinicians and shelter staff. | 80% of clients will be contacted at 1, 3, 6, 12 and 18 months by TAs and case managers after discharge from the shelter. |

The process evaluation can help determine bias through looking at who is eligible for the

program and who actually participates. Perhaps those with substance abuse problems are less

likely to participate in the program. This information could be used to better tailor the program for their needs. The process evaluation is also used to determine if there is any kind of implementation failure. A program intervention can be deemed an implementation failure if there is no intervention actually implemented, if the wrong intervention is implemented or if the intervention is unstandardized and differs wildly across different sites (Freeman, Lipsey & Rossi, 2004).

## 4.6.2  Outcomes Evaluation

The outcome evaluation will evaluate the intended outcomes of the program. These intended outcomes stem from the goals of the program. The program goals will be discussed and agreed upon during the program planning process. The current goals for this intervention are to provide the client with a place to recover from their illness, provide them with the tools they need to manage various health conditions, reduce use of the emergency department or hospital, create a network of social support and transition the client into permanent housing. The measured outcomes for this program evaluation are as follows:

- 90% of community agencies contacted agree to be program partners in the respite program
- 95% of clients will be fully recovered from illness at time of discharge from the shelters.
- 75% of program participants can identify community agencies that they will work with towards improving their health and obtaining housing.
- 75% of clients report at least three continuity of care contacts with the same clinic in twelve months.
- 70% of clients report increased self-efficacy in controlling their medical problems in twelve months.

- 70% of clients report fewer barriers in terms of obtaining medical care and housing in twelve months.

- 80% of clients accepted into the program will agree to participate.

- 75% of clients will transition into permanent housing by eighteen months.

- 75% of clients will report fewer problems with their health by eighteen months.

- 75% of clients report that they haven't had to return to a hospital or emergency department in twelve months.

- 70% of clients increase their list of valuable contact people by one person in twelve months.

- 100% of hospitals in Allegheny County implement the respite program.

- 90% of clients remain in permanent housing in three years.

- Hospitalizations and emergency departments for Pittsburgh's homeless population will decrease by 50% in three years.

The evaluation design will be a single group time-series design. This means information about behavior, lifestyle and other relevant changes will be collected from the subjects. This type of evaluation is useful to assess the impact of the intervention over time. Baseline will be collected during the intake to the program. This data will be compared to data collected at the time the client enters the program, one month after discharge and then 6, 12 and 18 months after discharge. Outcome data will come from both quantitative and qualitative methods. The TAs will engage in one-on-one interviews with the homeless clients in order to ask them key open ended questions about Health Behavior Model constructs such as self-efficacy, perceived barriers and cues to action. The insights gained from these open ended interviews can help evaluators create surveys for the program. Biological measures will be taken in order to evaluate the health status of the clients along with a review of medical records and asking clients to recall their health problems over a certain short periods of time. Clients will also report contacts they have with other agencies and the services they receive. The case managers will track the clients'

participation in other agencies in order to cross-reference the clients' self reports and give a more

objective look at who is transitioning into housing or continuing medical care at clinics after

their discharge from the shelters. All of this information will be collected and analyzed using

statistical software and other methods to analyze qualitative data such as coding.

Data collection for the evaluation will need to be ongoing and aggressive. After their stay in

respite care, all clients will be discharged to a transitional housing unit. If the client enters a

program that is sponsored by one of the partners in this intervention it will be easier for the TAs

to contact them for follow-up. However, this may not always be the case. There may be times

where there are not any spaces available for the client or the client may refuse to enter in a

housing program. Also, clients may choose to leave a housing program or move or any similar

situation where it would be difficult to keep track of their whereabouts. These scenarios could

lead to attrition which is a probable case of bias in this intervention. Dropout will occur if the

clients cannot be reached or they refuse to participate in outcome measurements. The program

implementers will have to gain the trust and buy-in of the client in order to limit attrition. The

difficulty of this task will vary depending on the individual and how long they are at the shelter

under respite care. Another threat to the validity of this evaluation is secular trends. There may

be a time period in Allegheny County where more homeless people use the hospitals and health

clinics or stay in transitional housing programs. This trend may not have anything to do with the

program even if it affects homeless people who are involved in the intervention. Interfering

events will also be a source of bias that the evaluators should be aware of. Once the clients leave

the shelter-based respite program they will be interacting with other agencies that may have a

significant influence on their individual outcomes. The most prevalent form of bias that is

inherent in this program design is selection bias. This intervention will not be a randomized

controlled trial. The clients are homeless people who volunteer to enter the program. Before

entering the program the clients will be evaluated to make sure they fit the criteria for the

program. It's possible that the population that chooses to enter the program is somehow

different from the overall general homeless population. It is important for the evaluator to

understand that the results from this program may not be generalizable to the entire homeless

population in Allegheny County because of this bias. However, this does not mean it is not

important to evaluate the impact of this program. The results could be generalizable to the

specific population that this program services and that is valuable information. The results of this

evaluation could be used to further refine and expand this program so that it can reach other

segments of the homeless population (Freeman, Lipsey & Rossi, 2004).

# 5.0    DISCUSSION

This proposal was designed to piggyback off of the planning and coordination that the Homeless Alliance has already completed for their Ten Year Plan. However, the reality of the MAPP model is that it still requires time and energy in order to update and add to the information that was already collected. The MAPP model will require a high degree of commitment for a small sub-set of the expansive plan to end homelessness in Pittsburgh. The Homeless Alliance will have to decide if the effort is worth the reward. One point they might consider is that more than one problem can be tackled simultaneously while using the MAPP model. While they are brainstorming and gathering ideas for a respite program and following the steps of the model they can also discuss another program that they would like to create. The participants would most likely overlap as stakeholders for both potential programs. The MAPP model is extensive and also flexible. It can be adapted and changed to fit the Homeless Alliance's needs.

The proposed intervention requires a great deal of cooperation between the operational group, the emergency shelters and the community partners that agree to be involved. However, if the MAPP model is executed carefully and correctly the required stakeholders will have a vested interested in ensuring that this program model functions effectively because they were the people who created the program and brought it into fruition. This respite program design is similar from those found in the literature and those described in a handbook of all the respite programs in the

US. The important difference in this program is that its main focus is continuing good health by increasing social support, modifying attitudes and helping create a more stable environment for the homeless individual. This program is looking to take a step beyond providing respite care and referrals to other support services. There are many factors that contribute to someone losing their housing and this program will not be able to address every one of those. However, it is hoped that the program will help the individual overcome their health and social barriers enough in order to obtain housing that will start them on a path to housing security. The program will have no control over the resources allocated for housing support. This may impede upon one of the program's main goals as it currently stands. Many homeless people experience co-morbidities. One of the challenges of this program will be addressing these co-morbidities. The program is designed to deal with one medical problem in the hopes that the participants will use what they learn from the program and start to manage all of their medical conditions, especially because so many diseases and conditions are related.

The feasibility of this program will be studied during the first 18 months of implementation. It is important to see if shelters can truly handle this program, if hospitals are able to track the data this program needs and if the clients involved in the program are responsive to program activities. If the program is successful, it will help alleviate the long hospital stays that occur with people who are homeless and admitted to the hospital. It will also reduce hospital readmissions. The burden on emergency departments will be lessened because the program participants will more likely use ambulatory care.

The public health significance of this program design is that it is designed to improve the health of a special population here in Pittsburgh and creates a program that would benefit agencies such as emergency shelters and hospitals that provide services to the homeless. The

program could be a hub for agencies who work with people experiencing homelessness in the Pittsburgh area. It will help lessen the health problems that people experience when they are homeless that could be exasperated by their living situation and may have even caused their current living situation.

The main advantage of this program is that it uses existing resources in the community. These resources already exist, they just aren't utilized in the most helpful and succinct way they could be in order to assist the homeless after they are discharged from the hospital. This program will encourage and facilitate greater communication between the different organizations. It will also encourage individual creation of initiatives that can be utilized within the program and also be used independently for other similar populations.

Hopefully, this type of collaboration and resource sharing program will be self-sustaining in the sense that it will be written into hospital procedures and budgets. The program requires hospitals to change their policy so that they will have a system that will collect information on housing situations upon discharge from the hospital. This could be an obstacle for proper program implementation. If clients are not referred to the program it will be difficult to determine whether or not this intervention design is a success during evaluation. For this reason it is important to ensure that hospital leaders are involved in the program planning process so they will be invested in making the necessary changes they will need to make. Also, the shelter must agree to be a part of this intervention by not only referring clients but also letting their facility be the space for program activities. It will be important for the Planning Committees to involve shelter leaders in the process so that they will know the best ways to utilize the shelter space so that the presence of this program will not be too intrusive to the everyday activities of the shelter. If there is too much intrusion or conflict created by this intervention the shelters may

elect to no longer participate. The cooperation and partnership of participating hospitals and shelters will be crucial to the success of this program. The components of the MAPP model will enhance these essential partnerships.

This program can also be used as a model of how the use of the MAPP program planning creates more collaborative programs for other problems in the city. With a city as dynamic as Pittsburgh the possibilities for collaboration are endless. The MAPP model is a communication-driven process. This program could be a pilot program that can influence the program planning and implementation habits of other organizations in the city. The program could also contribute to the case studies and peer-reviewed literature written about the MAPP program process. The actual implementation of this planning process and then the resulting intervention may lead to new discoveries about how best to make this program planning model function in a contemporary, urban setting. There will be heightened awareness of the homelessness problem in Pittsburgh and of the possible and actual solution through the planning and implementation of this program.

The leaders of the program planning process will need to be efficient at managing conflict. The MAPP model is seeking consensus from the program partners on a variety of different issues and in a number of different steps. It takes hard work and patience to reach this consensus and the consensus will certainly not be unanimous on all topics and decisions. However, there needs to be an understanding that everyone is working towards the same goal. This is why the MAPP model spends five phases identifying the most important issues to tackle in the community and also why the visioning phase is so crucial to the rest of the program planning process. While no one anticipates great conflicts to occur between the collaborators, the program planning leaders should always be aware of the possibility and prepared to deal with

such a situation if it does arise. There might be competing interests among community partners. This is when it might be helpful to plan two interventions at the same time using the MAPP model. The other possibility is to put other issues aside but reassure others that the MAPP process can be repeated for these concerns at a later date. Community partners might feel restless and conflicted when they identify other problems they would ideally like to work with while they are participating in the MAPP model. The community partners should be reminded of what they hope to accomplish through this program. They should also be reminded that this program planning process and the resulting program can be used as a template for solving other problems or creating similar situations in the community.

It is important to remember that this type of work does not exist in the vacuum. The progress and result of the MAPP model process should be shared with the community as a whole. The experience of the program planning process and the evaluation of the resulting intervention can be written up as a journal article and shared with public health professionals who share the same challenges. Not only will frequent dissemination of information help others it will also help the intervention become an integral part of the community. The dissemination of the information that is gained from this process will help the program become an integral part of the target community, therefore strengthening its sustainability and evolution in the future. A respite program is just one solution to a large problem. People are homeless for many reasons. One single intervention cannot address all the concerns and challenges that exist in the homeless population. This program planning process can be the inspiration for other programs that will contribute to the overall goal. This can jumpstart creativity and new ways of thinking for the benefit of the homeless population in Allegheny County as a whole. Perhaps the real route towards eliminating homelessness is not one big intervention but many small interventions that

interconnect and weave together in order to create a safety net that makes it impossible for people to slip through the cracks and into homelessness. The Homeless Alliance and others can use the MAPP model to keep creating the programs and interventions that will change and enhance the lives of thousands who face homelessness every day. The MAPP model should be seen as a program planning process that can further empower the Homeless Alliance and the community as a whole. The benefits are worth the time and energy that is required to complete this process.

# 6.0    CONCLUSION


The MAPP model is a natural choice for a program planning model for the Homeless Alliance because it complements the work that the organization has done in the past. It will create a new level to the Ten Year Plan both by creating an intervention that will address one of the priorities in the plan and also by adding to the information that helped create the plan so it can stay current and true to the concerns of the community. This proposal was designed to introduce the MAPP model to the Homeless Alliance in order to give them a sense of how they could incorporate it into the activities of their organization. The MAPP model will give the Homeless Alliance a sense of empowerment and confidence that they have the tools to create long-standing solutions to old problems. Hopefully, these ideas will jump start fresh excitement and motivation towards reaching the goal of eliminating homelessness by the year 2015.

This sample program designed in this proposal is designed to take advantages of the breadth of resources that are available in Pittsburgh which is an inherent component of the MAPP model. There are many agencies and institutions and individual minds that can come together to change people's lives for the better. It will contribute to the Homeless Alliance's Ten Year Plan to eliminate homelessness in Allegheny County. The purpose of this intervention is to create a system of social support for homeless people after they are discharged from the hospital while they are unable to fully care for themselves. The respite program will be a bridge between hospitalization and self-care. It will take advantage of the wealth of individual organizations that

provide social support services to those who need them. The program will make it possible for homeless persons to access these types of support when they have the greatest need. The effects of this program are predicted to be far-reaching. This program will contribute to improving the overall health of the homeless population in Pittsburgh. They will receive personal follow-up care and they will learn the skills necessary to access resources that will assist them in the current time of need and also in the future. The clients will receive a personally invested contact person they can utilize. Ultimately, this program will factor into the vision of a Pittsburgh where everyone has a safe and adequate place to sleep at night. The program will assist the clients with obtaining permanent housing in order to truly improve their health.

The Allegheny County Homeless Alliance has recognized that it will take many solutions to solve the common problem of homelessness in this region. This proposal describes a way to create a program that will link better health care with more permanent housing thus increasing the health status of someone who is experiencing homelessness. Not only will this intervention improve the health and housing situation of a homeless person who participates but it has the potential to increase the social support that the individual client can access. The activities and results of the intervention will be individualized for the participant but the overall goals will be the same for everyone involved. These overall goals are to provide clients with a place to recover from their illness, provide them with the tools they need to manage various health conditions, reduce use of the emergency departments or hospitals, create a network of social support and transition the clients into permanent housing in order to end homelessness in Allegheny County This program will serve as a model of a commitment to solving community problems with solutions that include the input and valuable talents of the community as a whole in Allegheny County and other communities. It will be an example of the type of change that comes from

strong community partnerships. This proposal will not only benefit the goals of the Allegheny County Homeless Alliance but might help other similar interventions design their own program planning model and intervention. The sharing of information and new ideas among groups and individuals is an important step on the path towards a better, stronger, healthier and more connected Pittsburgh.

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