GUIDE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

A Framework for Medical Respite Care

2025

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Introduction

Medical respite care is defined as acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets or in shelter, but who are not ill enough to be in a hospital. While programs vary in size and structure, they all share the same fundamental elements: a short-term, safe place to stay, allowing people experiencing homelessness an opportunity to rest, recover, and heal in a safe environment while accessing medical care and supportive services. Medical respite care (also referred to as recuperative care) has grown substantially since its inception in the 1980's, as more communities are recognizing the need for programs that address gaps in affordable housing and health care[1]. As the field grows, so does the need for resources for programs and providers to ensure the clients* who access medical respite services are receiving safe and quality care.

This document is a framework to guide medical respite programs by:

1) **Defining the philosophy of medical respite care and**
2) **Articulating how the *Guiding Principles*, *Standards for Medical Respite Care Programs*, and the *Models of Medical Respite Care* are used in conjunction to provide quality care and an opportunity for recovery for people experiencing homelessness.**

Philosophy of Medical Respite Care

At the core of medical respite care is the philosophy that "housing is health care," and that every person deserves an opportunity to recover safely from acute medical events. With a significant lack of affordable housing across communities, medical respite programs provide dignity in the healing process while also meeting basic needs. As traditional medical care is centered around those with homes and housing, those who are unhoused with health care needs often cycle between hospitalizations and homelessness, without having adequate opportunities for rest and recovery. Medical respite care programs are essential in filling this gap in the housing and health care continuums; by connecting clients to community health care services while working towards the greater goal of permanent housing.

*Individuals served within medical respite programs may be referred to as clients, patients, consumers, etc. For the purposes of this publication, the term "client" is used.

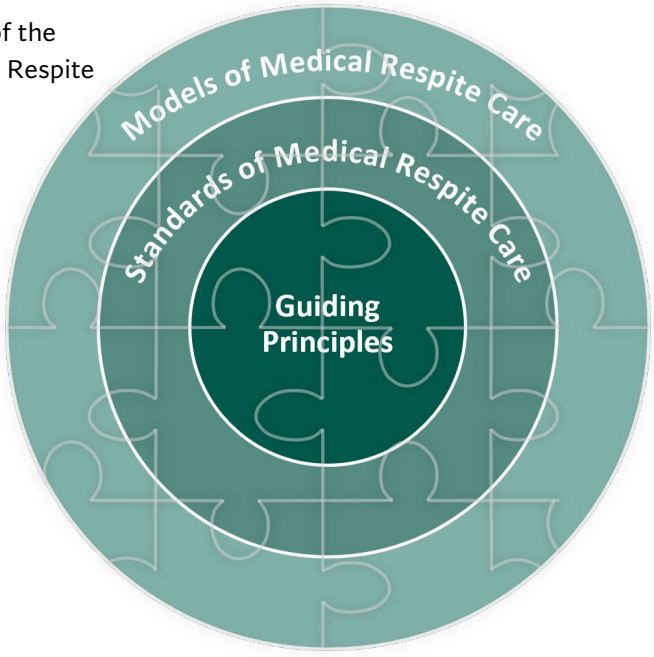
A Framework for Medical Respite Care

Due to its continued growth and expansion, the need for a framework to conceptualize the philosophy of medical respite care delivery has become more evident. A framework "provides a structure or base on which to build a system or concept"[2]. Acknowledging that each community will need to respond to their specific needs, resources, and populations, this Framework is not a prescription for practice. Instead, it is a foundation on which programs can construct their specific delivery of services while ensuring high-quality and client-centered care for those served within the program.

Grounded in the philosophy of medical respite care, the Framework for Medical Respite Care builds on the existing work of the **National Institute for Medical Respite Care (NIMRC)** and **Respite Care Providers Network (RCPN)**, and includes three overarching components:

1. Guiding Principles for Medical Respite Care (Guiding Principles)
2. Standards for Medical Respite Care Programs (the Standards)
3. Models of Medical Respite Care (Models of Care)

Figure 1: Relationship of the Framework for Medical Respite Care Components



Each of these components depicted in Figure 1 will be defined further in this document, along with considerations to apply each within medical respite programs.

Guiding Principles for Medical Respite Care

Guiding principles are precepts that guide an organization or person in decision-making throughout all circumstances[3,4]. The *Guiding Principles* are interwoven throughout *the Standards*, *Models of Care*, and resources developed by **NIMRC** in alignment with the mission of the **National Health Care for the Homeless Council (NHCHC)**. They are core concepts that underlie how medical respite programs develop and deliver services.

The *Guiding Principles of Medical Respite Care* are:

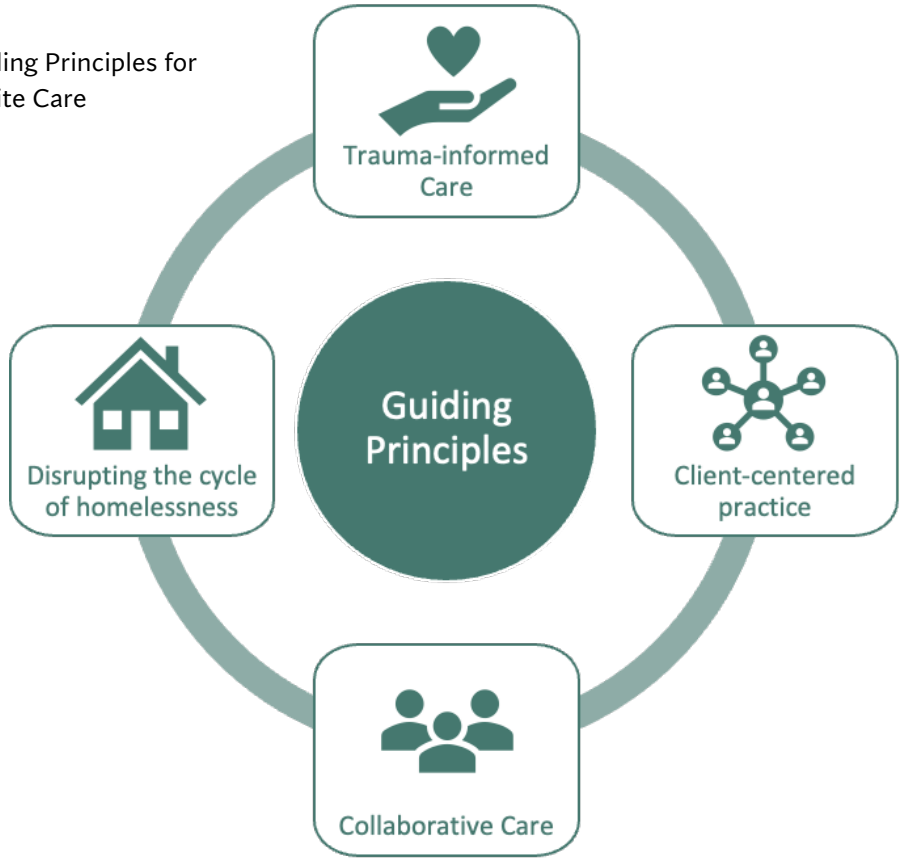
Trauma-Informed Care

Client-Centered Practice

Collaborative Care

Disrupting the Cycle of Homelessness

Figure 2: Guiding Principles for Medical Respite Care



Trauma-Informed Care

Trauma-informed care is an essential component of providing services to people experiencing homelessness, many of which have experienced substantial traumas in their lifetime as a result of being unhoused[5]. Trauma-informed care occurs when "a program, organization, or system … *realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization*."[6]. There are many contributors to a person becoming unhoused, many of which are rooted in experiences of trauma, such as adverse childhood events or racism (individual and systemic). In addition to histories of trauma, clients in the medical respite space may be grappling with significant medical conditions, responding to hospitalization, and adjusting to the transition to a new setting while learning to their manage conditions. The use of trauma-informed practices throughout the medical respite process is essential to promote safety and recovery, and increases the likelihood that care delivered will be equitable to all who enter the program, regardless of race, gender identity, or diagnosis. Further, trauma-informed practices support providers and direct staff who do the difficult work of navigating systems, managing complex health needs, and creatively address the challenges of providing care often with limited resources. Trauma-informed approaches should be integrated throughout the medical respite process, from admission to discharge, and be the foundation on which program policies and procedures are developed.

Client-Centered Care

Client-centered care (also known as patient-centered care) accepts and addresses all components of the person: physical, mental, and psychosocial. A client-centered organization sees the individual client's specific health needs and desired health outcomes as the driving force behind all health care decisions and quality measurements[7]. Within medical respite care, client-centered care also acknowledges that homelessness comes from a complex cycle of circumstances that can cause, or be caused by, physical health conditions, mental health conditions, and limited resources. Additionally, client-centered care recognizes intersectionality as it relates to homelessness, and thus seeks to identify, address, and prevent bias and stigma. These intersectionalities may include race, ethnicity, diagnosis, and gender (among others), as all of these factors impact a person's health, decision-making, and access to resources. Medical respite programs should be equipped to address all needs and priorities of a person, through direct services, community partnerships, and client engagement in quality improvement activities. The goals and priorities of the client remain central to decision making and care planning with an understanding of the uniqueness of each individual's experiences and preferences. Medical respite programs should seek to respect client self-determination while providing the needed care.

Collaborative Care

In order to implement client-centered and whole person care, medical respite programs must work to communicate effectively among providers and across systems. Medical respite care sits within a space in which it addresses both health care and housing needs and is often the bridge between these two continuums, connecting clients to the necessary supports for health, recovery, and housing. Collaborative care was initially developed for primary care as an evidence-based approach to integrate health care professionals and support systematic communication and shared treatment goals[8]. People experiencing homelessness often present with multiple complex needs that require engagement with multiple systems and providers to address. For medical respite programs, this requires collaboration both at a macro- and micro-level. Programs must develop collaborative relationships with community entities, such as hospitals, Continuums of Care (housing), and community providers (such as health centers and behavioral health programs). The care coordination provided within the medical respite program requires collaboration among clients, medical providers, and those providing care coordination and case management services. By collaborating together, the priorities and needs of the client can be addressed and ensure communication and support throughout the medical respite stay.

Disrupting the Cycle of Homelessness

It is the firm belief of the NHCHC and NIMRC that housing is health care, and that safe, accessible, and affordable housing is a basic human right for every individual. There is a strong relationship between a person's housing status and their overall health; those who are unhoused or unstably housed experience poorer health[9]. Housing is a fundamental priority and end goal of a medical respite. Ideally clients admitted to medical respite will be able to move from the program into stable housing. However, the continued decrease in affordable housing as well as underinvestment in housing for varying needs across communities may prevent this direct transition. Despite this, medical respite plays a critical role in disrupting the cycle of homelessness and must be intentional in stepping into that role. A medical respite care admission is a point in which clients can rest and address acute and chronic health needs. The stability of having basic needs met allows an opportunity to engage with services and take steps towards housing. In a trauma-informed environment, clients can begin to build relationships with providers who are able to meet their needs and appreciate the complexity of homelessness. This trust supports engagement in often a long and frustrating process towards housing. Additionally, improvements in health gained while in medical respite can facilitate engagement in communities and community-based services and prevent the unstable cycle of moving between hospitalizations and homelessness. Figures 3 and 4 depict how a client may engage and navigate various services required to move out of homelessness, however Figure 3 depicts the process when a person is hospitalized and discharged without medical respite, while Figure 4 demonstrates the impact of coordinated care within medical respite.

Figure 3: Disrupting homelessness without medical respite.

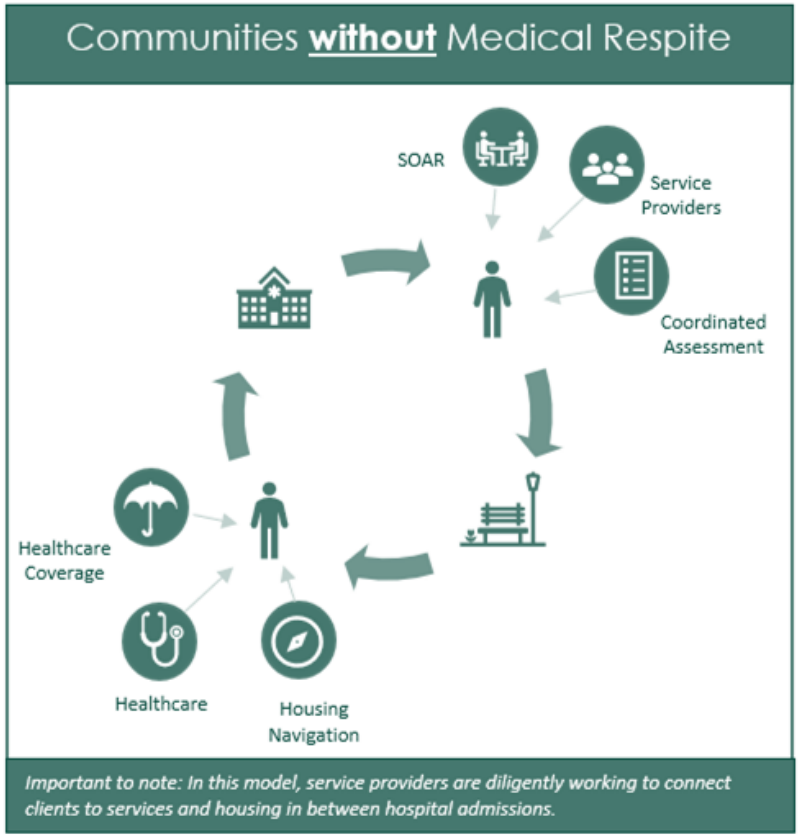
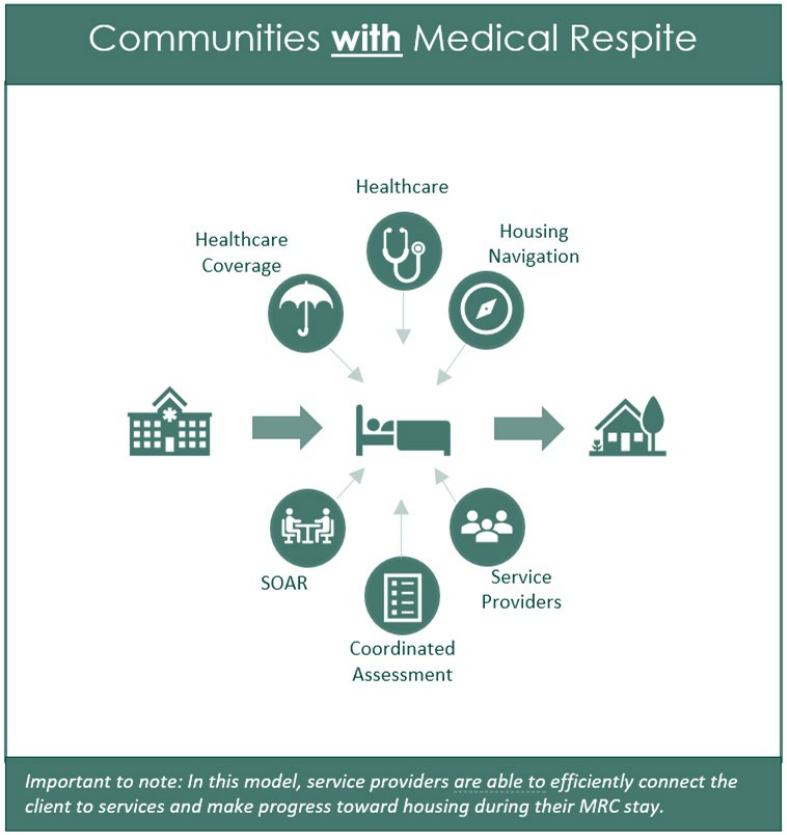


Figure 4: Disrupting homelessness **with** medical respite.

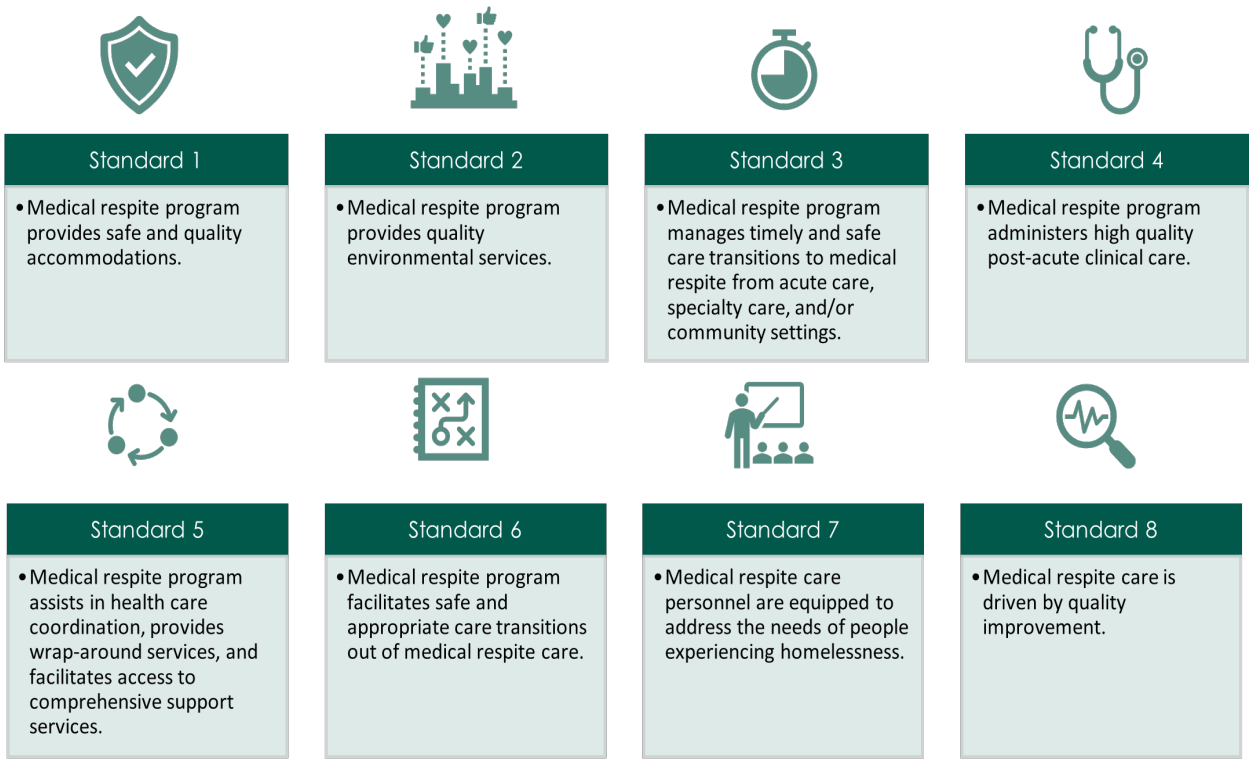


The *Guiding Principles of Medical Respite Care* are woven throughout programs and their service delivery, and collectively ensure that care is grounded and centered in the needs of the people it is intending serve. They should be considered as a continuum, with programs actively seeking to enact these principles, acknowledging there is always room for progress. The *Guiding Principles* are what differentiate medical respite care from other types of care often prevalent in systematized health care.

Standards for Medical Respite Programs

The *Standards for Medical Respite Care Programs* (the Standards) give direction for medical respite care programs to operate safely and effectively in providing care to people experiencing homelessness. *The Standards* are a tangible way to incorporate the *Guiding Principles* of medical respite care through program development, service delivery and implementation, and quality improvement. *The Standards* were developed from the RCPN and community of medical respite providers to ensure consistency in vital aspects of medical respite programs, despite the diversity in staffing, *Models of Care*, and partnerships. *The Standards for Medical Respite Care Programs* reflect the *Guiding Principles* and fidelity to *the Standards* ensures that services delivered within each *Model of Care* are high-quality and person-centered.

The Standards



Note: Programs should reference the Standards for Medical Respite Program publication for a complete description and for full criteria of each Standard.

Using the Standards in Practice

The Standards are applicable to all medical respite programs and *Models of Care*. Medical respite programs should utilize *the Standards* to ensure quality of services. Specifically, *the Standards* help to:

- Determine policies, procedures, and program processes that align with trauma informed care;
- Create access to medical care and care coordination provided by staff that are adequately trained and supported; and
- Generate quality improvement and outcomes processes that follow best practices.

Each Standard includes descriptive criteria, which provides specific details of what it means to meet each Standard. Programs may use *the Standards* when developing or expanding a medical respite program, to annually review their program operations, and identify program strengths and gaps, to move the program forward.

The Standards have been the central guidance for medical respite care programs since they were first developed and published in 2016. Applicable to all medical respite programs, *the Standards* provide a central structure that aligns medical respite programs despite their variability and unique attributes. *The Standards* also help communicate to external entities, such as hospitals or insurance payors, that medical respite programs have the unique capacity to provide quality, person-centered care within the community.

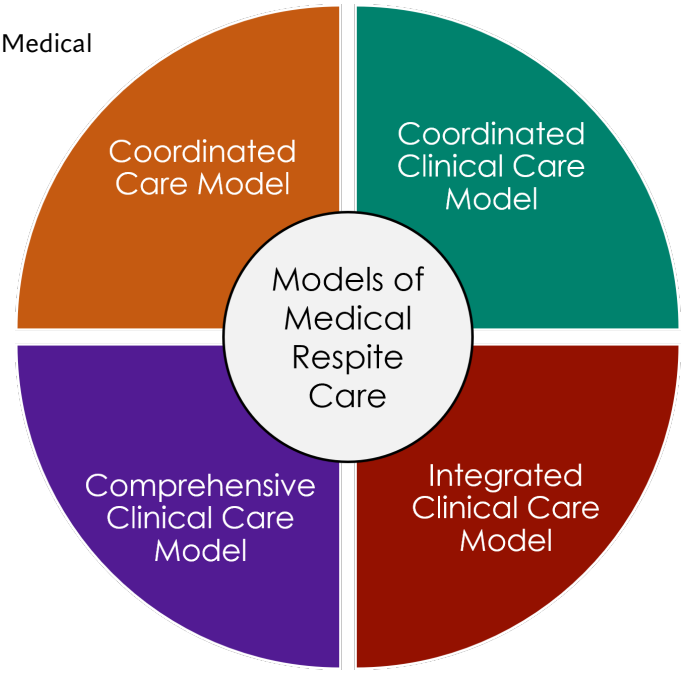
Models of Medical Respite Care

A model of care is "a multidimensional concept that defines the way in which health care services are delivered; it is a descriptive picture of practice which represents the real thing"[10]. While *the Standards* ensure quality in service delivery, the *Models of Medical Respite Care* provide an overview of the structure of, and the services that are implemented within, a medical respite program. Ideally, each program is designed in response to community and client needs, therefore, variability among programs is expected. However, the *Models of Care* describe the types and intensity of clinical, case management, and care coordination services that the client has direct access to within the medical respite program.

The four *Models of Medical Respite Care* are:

- Coordinated Care Model
- Coordinated Clinical Care Model
- Integrated Clinical Care Model
- Comprehensive Clinical Care Model

Figure 5: Models of Medical Respite Care



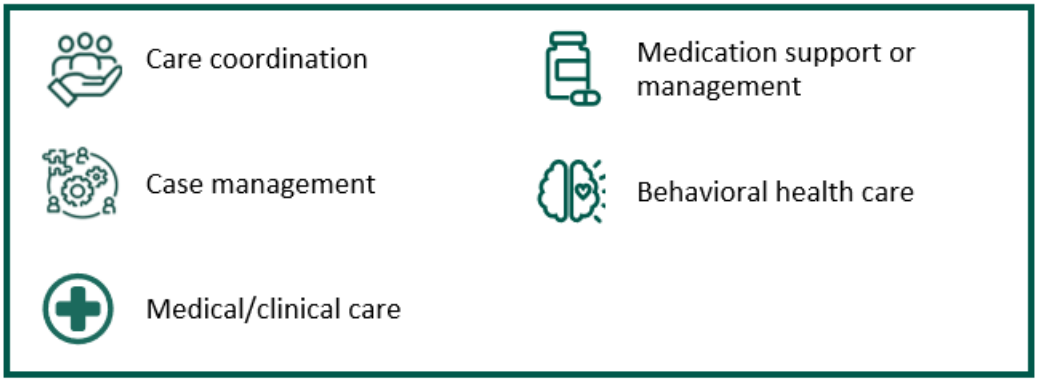
Key Components of All Models

All *Models of Medical Respite Care* include the following key components:

- 24-hour access to a bed
- 3 meals per day
- Transportation to any/all medical appointments
- Access to a phone for telehealth and/or communications related to medical needs
- Safe space to store personal items
- Wellness check at least 1x every 24 hours by medical respite staff

Medical Respite Program Services

In addition to the key components, each *Model of Care* includes the provision of the following services:



What differentiates each of the *Models of Care* is the intensity in which services are provided, and whether or not clients of the program have direct access to services within the program or if these program services are provided within community partnerships. Each Model includes the key components and program services, while aligning themselves with the *Standards for Medical Respite Care Programs*.

The following includes a brief description of each of the models, however, for more comprehensive information please review the *Models of Medical Respite Care full publication*.

Coordinated Care Model

Focuses on individualized case management and facilitating connections to community-based resources. This model requires a high intensity of collaboration with community providers to address medical, behavioral health, and social needs. This model includes:

- Individualized case management and care coordination for medical needs.
- Individualized case management and care coordination for social needs.
- Medication support.
- Space to engage with home-based clinical services.
- Screening for and connection to behavioral health and/or substance use resources.

Coordinated Clinical Care Model

Focuses on individualized case management and provides basic onsite medical services. Additional services are offered through community connections and partnerships. This model includes:

- Individualized case management and care coordination for medical needs.
- Individualized case management and care coordination for social needs.
- Provision of basic onsite medical clinical services, within the scope of license of staff and as indicated by discharge instructions.
- Medication management, supervised by licensed clinical staff.
- Space to engage with home-based clinical services.
- Screening for and connection to behavioral health and/or substance use resources.

Integrated Clinical Care Model

Focuses on individualized case management and onsite clinical supports that address the acute health needs of program clients. Additional services are offered through community connection and partnerships, especially in preparation for transition and discharge. This model includes:

- Individualized case management and care coordination for medical needs.
- Individualized case management and care coordination for social needs.
- Onsite clinical services.
- Connection and transition to primary care provider/health home before discharge if medical needs are managed by onsite clinical staff.
- Medication management.

- Behavioral health and/or substance use services through screening, onsite care, and referrals to community partners.
- 24-hour program staffing and on-call medical support.
- Care coordination and space to engage with home-based clinical services.

Comprehensive Clinical Care Model

Focuses on individualized case management and onsite clinical supports that address the health needs of program clients. This model is also able to support more intensive medical needs and treatment onsite. Additional services are offered through community connection and partnerships, especially in preparation for transition and discharge. This model includes:

- Individualized case management and care coordination for medical needs.
- Individualized case management and care coordination for social needs.
- Community health worker and/or peer support.
- Comprehensive onsite clinical services that may include specialty care services, management of chronic conditions in addition to acute medical needs, and management of higher acuity conditions.
- Connection and transition to primary care provider/health home before discharge if medical needs are managed by onsite clinical staff.
- Medication management.
- Behavioral health and/or substance use services through screening, onsite care, and referrals to community partners.
- 24-hour program staffing and on-call medical support.
- Care coordination and space to engage with home-based clinical services.

A program may fit within a model using partnerships/collaboration among agencies as long as operations are collaborative and meet the *Standards for Medical Respite Care Programs*. It is also important to note that there is not one recommended or "best" model of care; the ideal model is the one that is sustainable and responsive to the needs of the community and people experiencing homelessness.

Integrating the Guiding Principles, Standards, and Models of Care

The *Guiding Principles*, *Standards*, and *Models of Care* work together to create a program that is centered on the philosophy of medical respite care. By using *the Framework*, programs can ensure they are able to meet the needs of their clients, move clients forward on the path to housing, and provide quality medical and wrap-around care. Because of the variability in programs and their communities, each of these elements establishes a central framework to both guide programs and build an understanding of medical respite care to external partners. Every program, regardless of the *Model of Care*, should aim to have high fidelity to *the Standards* with the care provided grounded in trauma-informed, client-centered, and collaborative care in their work to address health and end homelessness.

Role of Medical Respite in the Healthcare and Housing Continuum

Medical respite was developed to address a significant gap throughout health and housing services, recognizing that people experiencing homelessness have no safe place to recover after hospitalization, or to address more intensive health needs. Medical respite care plays a pivotal role within both of these systems, by addressing and resolving acute medical needs while furthering someone's progress towards accessing affordable housing. Additionally, the focus on intensive care coordination that occurs within medical respite has been demonstrated to effectively reduce gaps in services and increase the use of community-based resources that support a person's health, even if they do not immediately transition into housing [1,11]. Figures 6 and 7 on the next page demonstrate medical respite's role within both health care (Figure 6) and housing (Figure 7) continuums.

Acknowledgement of Barriers and Tensions in Practice

Although the evidence that demonstrates the importance and effectiveness of medical respite programs is growing, many challenges in providing medical respite care remain[1]. Programs may not be able to fully implement best practices due to limited resources available and support from their community. Because programs are situated among health and housing continuums, they must be flexible in meeting the demands and need of multiple partners, while remaining true to their mission. The complexity and intensity of the needs of the population served in medical respite can present challenges, especially when relying on systems that are under-resourced or have enacted policies that inhibit the ability to deliver best practices. Finding skilled staff has become a greater challenge in health and homeless services, limiting the quantity and scope of services programs are able to provide.

None of these are small challenges, and yet medical respite programs continue to creatively respond to and address them. However, continued advocacy is needed to recognize the integral role of medical respite, establish consistent funding to ensure sustainability, and remove policies that result in barriers to care and housing.

Figure 6: Medical Respite's Role within the Health Care Continuum

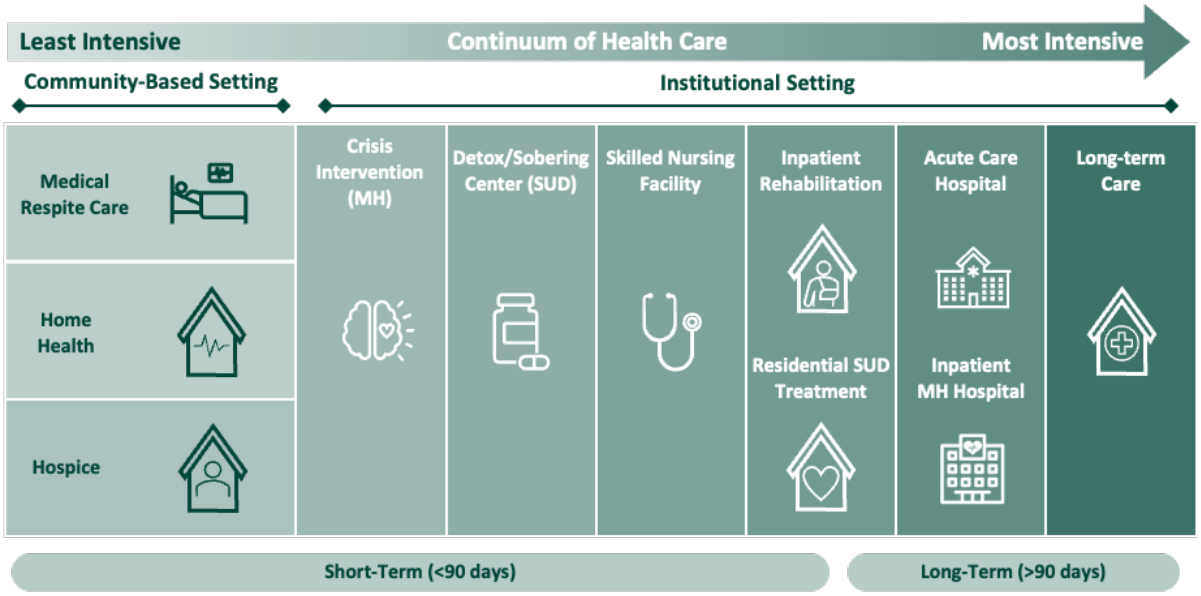
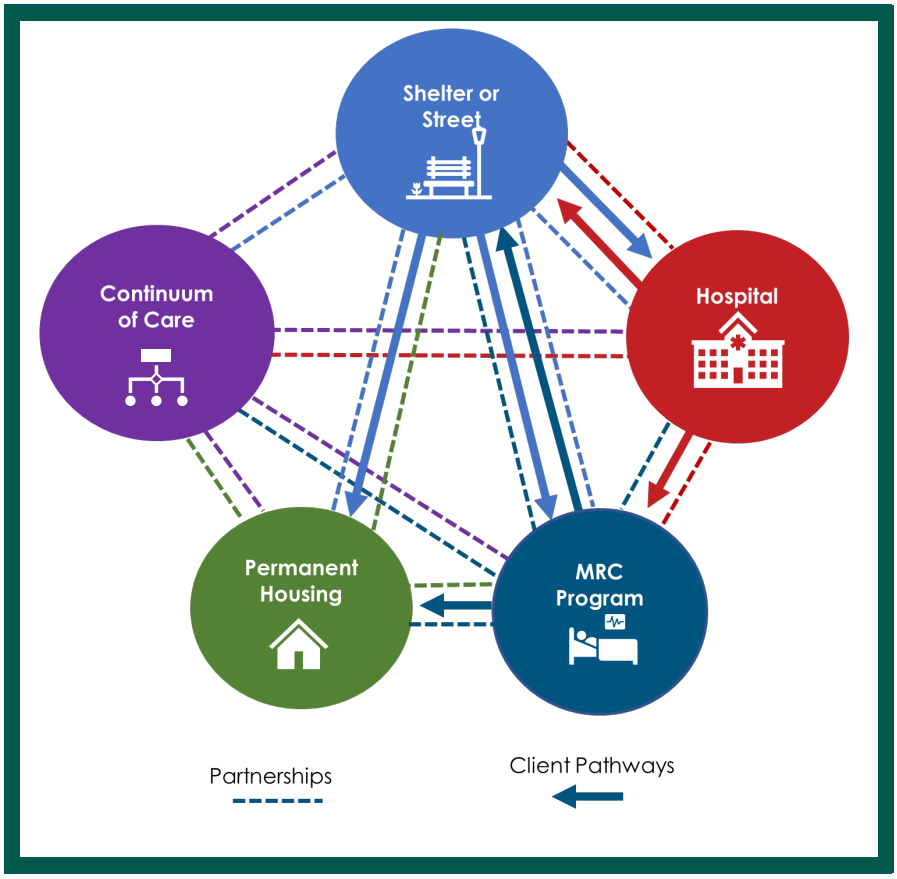


Figure 7: Medical Respite's Role within the Housing Continuum



Conclusion

Medical respite care has become an established and critical practice within health care and homeless services. As it grows and expands, it is essential to ensure that medical respite care remains grounded in its philosophy as a mechanism to positively impact the trajectory of a person's health and housing status. By using this *Framework*, which defines medical respite care's *Guiding Principles*, *Standards*, and *Models of Care*, programs can align themselves with best practices and ultimately continue their mission to provide opportunity to rest, recover, and heal.

CHCF

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