WHITE PAPER

Development and Application of the Fidelity Measure to the Guiding Principles of Medical Respite Care

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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 place to stay that allows people experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services. Medical respite care (also referred to as recuperative care) has grown substantially since its inception, as more communities are recognizing the need for programs that address gaps in affordable housing and health care[i]. 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.

Existing Resources to Support Quality Care

The National Institute for Medical Respite Care (NIMRC) has developed several resources to guide and support medical respite programs to deliver high quality care, while providing flexibility to accommodate the diversity of program and community needs.

The Framework for Medical Respite Care provides an overview of three central, guiding resources:

- **The Guiding Principles for Medical Respite Care**
- **The Standards for Medical Respite Care Programs**
- **The Models of Medical Respite Care**

Each of these resources are distinct but work collectively to create a framework of medical respite care, as depicted in **Figure 1**.

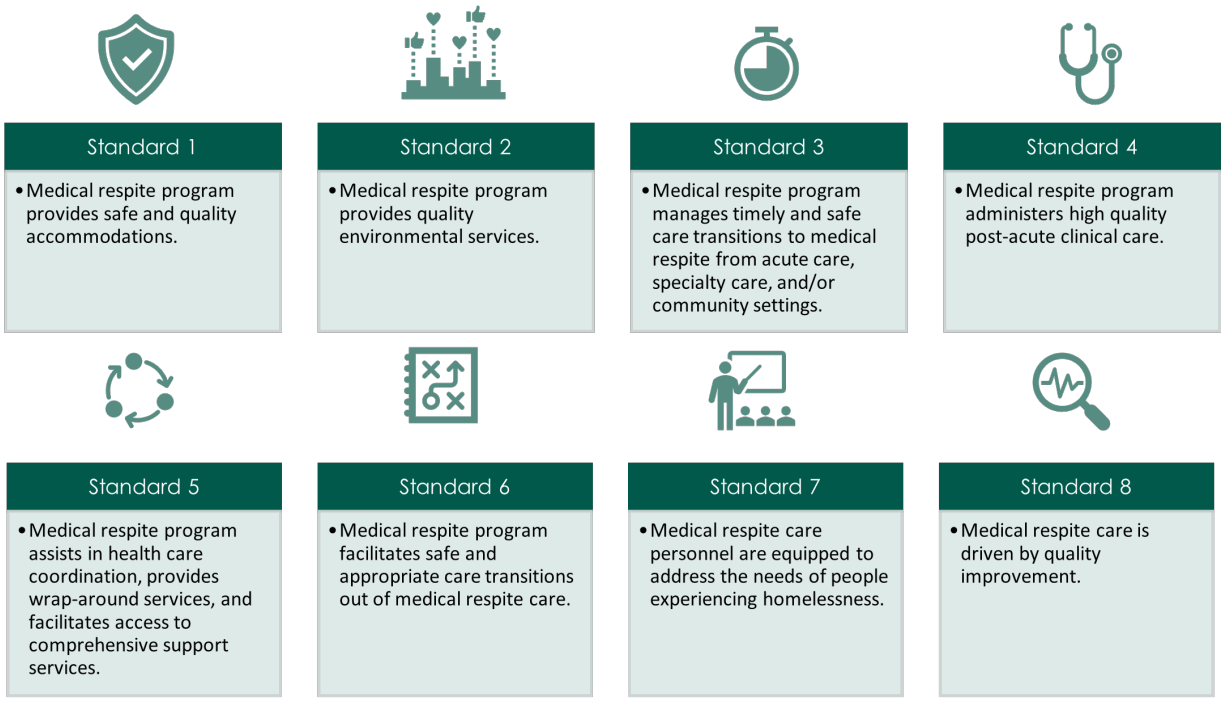
Figure 1: Relationship of the Framework for Medical Respite Care Components

[*]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.

The Standards for Medical Respite Care

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 primarily focus on program operations and are depicted in **Figure 2**. In order to measure a program's alignment to the Standards, NIMRC offers the Medical Respite Care Standards Self-Assessment. In this tool, programs have the opportunity to indicate whether or not they "meet" the criteria that make up each of the Standards, which are then converted into a percentage of criteria met by each Standard, and then to the Standards as a whole. Ideally, programs will meet at least 70% of the criteria for each Standard.

Figure 2: The Standards for Medical Respite Care Programs



Models of Medical Respite Care

The *Models of Medical Respite Care* (Models of Care) give a description of the different ways in which programs can be structured and are focused on what services the client has access to while in the program. Each Model of Care includes the same key components and program services (care coordination, case management, medical/clinical care, medication support/management, and behavioral health care). Programs within each Model of Care may have a variety of staffing structures and partnerships to provide their services and clinical care. There is not one recommended "best" model, instead the ideal model is the one that meets the need of the local community.

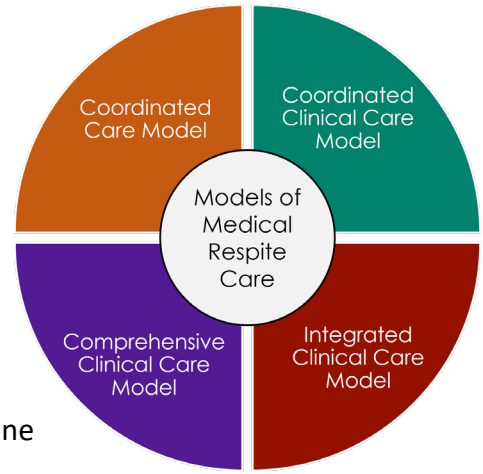


Figure 3: Models of Medical Respite Care

The Guiding Principles for Medical Respite Care

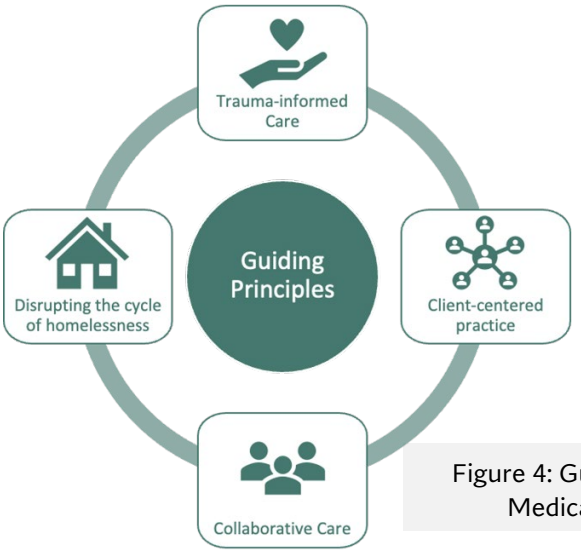


Figure 4: Guiding Principles for Medical Respite Care

The *Guiding Principles for Medical Respite Care* (Guiding Principles), grounded in the philosophy of medical respite care, are core concepts that underlie how medical respite programs develop and deliver services. The Guiding Principles are what differentiate medical respite care from other shelter and health care services, focusing both on the care coordination and health services while the person is in medical respite, and also focusing on ending and resolving the person's experiencing of homelessness.

Need for a Fidelity Measure to the Guiding Principles

The Medical Respite Care Standards Self-Assessment has been useful for programs in identifying their alignment with the Standards. However, this tool does not fully capture the approaches to care that are essential when working with people experiencing homelessness. *The Guiding Principles* are rooted in evidence-based practices and were developed with input from the field of medical respite care providers; they are central to how services are implemented. Therefore, NIMRC identified the need to establish an additional tool that would measure fidelity to the Guiding Principles. The development of this tool, The Fidelity Measure of the Guiding Principles of Medical Respite Care (Fidelity Measure), is described in the next sections of this document. Also included in this resource are instructions for how programs may access and use the Fidelity Measure.

Development of the Fidelity Measure

The development of the Fidelity Measure involved a thorough review of validated measures and a multi-phase, iterative pilot testing process to reduce the items included while maintaining the content validity of the original measures incorporated.

Review of Anchor Constructs

The team reviewed several materials in the process of developing the initial, long-form fidelity measure, including: the Standards for Medical Respite Care established by the Respite Care Providers Network (RCPN) (2021) and Medical Respite Care Standards Self-Assessment instrument, the literature review of medical respite care effectiveness compiled by NIMRC (2021), and the summary findings from the qualitative interviews of medical respite care providers and consumers (2022), which identifies the principles of successful programs related to best practices. All of these materials were synthesized and discussed with subject matter experts and Council leadership to develop a set of essential components for assessment of the *Guiding Principles*. The *Guiding Principles* described above were used to directly inform the dimensions of the fidelity measure and the initial tools used to build it.

Dimension Scales

Initial measurement tools for each dimension were primarily derived from a priori, validated measurement scales specific to each dimension. After an extensive review of the available scales and supporting evidence on validity and reliability, the following measurement scales were selected:

- Trauma-Informed Care: Harm Reduction Assessment Scale (HRAS)[ii]
- Client-Centered Care: Person-Centered Care Assessment Tool (P-CAT)[iii] and Healthcare Providers Attitudes Toward the Homeless Index (HPATHI)[iv]
- Collaborative Care: Collaborative Practice Assessment Tool (CPAT)[v]

The full scales of each of the above tools were adopted and included in the phase 1 (long form) measure for initial piloting. In addition, the items for the dimension: Disrupting the Cycle of Homelessness were developed through an iterative engagement process with subject matter experts, including the National Health Care for the Homeless Council (NHCHC) medical respite team staff and leadership. This process yielded 20 potential items for inclusion in phase 1 of the measure, adopting the most common response scale to match.

Phase 1 (long form)

Thirty-four programs were invited to participate in completing the long form, first draft of the measure. The sample frame included only those programs who had completed the Organizational Self-Assessment measure. Including the introductory questions about background and role in a medical respite program (beginning), demographics (end), and job satisfaction, the long form of the measure included 593 individual items. A series of standard psychometric tests were applied to the responses, with allowance for the small sample size including descriptive tests, intercorrelation matrices, exploratory factor analyses, and correlation tests against the Organizational Self-Assessment of compliance with the eight Standards for Medical Respite Care Programs.

Phase 1 Results

Twenty-one responses were received (a 62% response rate). Intercorrelation matrices showed low item-item correlation across the long-form instrument and within each dimension, which was confirmed by the factor models, which yielded multiple factors within each adopted measurement scale. Alignment with the Standards was not a selection criteria for inclusion in the short form. Instead, the MRF-27 prioritized items that showed the strongest loading onto sub-factors within each of the original 5 domains, in order to capture the larger instruments' content validity.

Therefore, items selected for inclusion in the second pilot phase (short form measure) were identified based on the strength of their loading onto a single factor (i.e., highest association with a subdimension of each dimension included in the Fidelity Measure). The number of factors were determined by the number of contributory variance explained (eigenvalues >1.0). In the few instances when multiple items loaded onto a single factor with similar loading scores, the items were reviewed by the same subject matter expert group to prioritize items that captured a) organizational over individual traits, b) items most applicable to medical respite programs, and c) generalizability to all staff and not just healthcare providers. In addition to the items collecting background and role (8), demographics (4), and job satisfaction (1), the short form (MRF-27) of the Fidelity Measure consisted of the following item numbers in each domain:

- Trauma-Informed Care (5)
- Client-Centered Care: (3)
- Attitudes toward the Homeless: (4)
- Collaborative Care (10)
- Disrupting the Cycle of Homelessness (5)

Phase 2 (short form)

The second, short-form version of the Fidelity Measure consisted of 40 items (MRF-27, plus role (8), demographics (4), and job satisfaction (1)). This new version was piloted through the RCPN Steering Committee and membership (1,878 individual members), with the additional guidance that multiple respondents from each organization were invited to participate. To balance the input from each dimension, the unbalanced item scores in each dimension were averaged, and the average of those dimensions was taken as the overall score. Responses were tested for reliability (intra-class correlation) within organizations and confirmation of a 5-dimensional model using a confirmatory factor analysis.

Phase 2 Results

Eighty-seven (87) respondents from 48 medical respite provider agencies responded to the survey. Confirmatory factor analysis (CFA) showed reasonably good fit, as measured by standardized root mean-squared residual (SRMR) and coefficient of determination (CD). For those organizations that provided multiple responses, tests of reliability within organizations showed moderate levels of clustering of overall scores by organization. Additionally, CFA testing suggested that the items in the HPATHI dimension (4) diverged slightly and split loading scores with the Trauma-Informed and Client-Centered dimensions' items, 2 each, suggesting the option of a 4-factor fidelity model:

- Trauma-Informed Care (7)
- Client-Centered Care: (5)
- Collaborative Care (10)
- Disrupting the Cycle of Homelessness (5)

Phase 3

A new round of administration of the Medical Respite Fidelity Measure (MRF-27) was disseminated, yielding an additional sample. The analysis involved an exploratory factor analysis of this sample, in replication of results presented from phase 2 previously, and a confirmatory factor analysis done of both the 5 and a 4-factor model of the 27 items, driven by alignment with the four Guiding Principles. CFA fit testing measures (SRMR, CD) were again used to compare the two factor models for significant differences in model fit to the data. This sample was also used to test for associations between overall score, and individual dimensions with respondent demographics and occupational characteristics.

Phase 3 Results

Ninety-one (91) responses were received across 15 organizations. CFA results showed reasonably good fit for both the 5 and 4-factor models. The Likelihood Ratio of the chi-squared test of the model fit versus a perfectly saturated model (LR chi-squared) was 667.5. The standard root mean squared (SRMR) for the 4-factor model was 0.132 (vs 0.128 for 5-factor model) and the Coefficient of determination (CD) was 0.995 (vs 0.997 in 5-factor model).

However, comparison of the LR chi-squared statistics showed a slight improvement over a saturated model for the 4-factor rather than 5-factor model.

Additional items were identified to be removed from the short form (2 items within Collaborative Care) or moved into a domain with a more appropriate fit. Demographic analysis revealed one significant difference between Black and White respondents, with Black respondents scoring lower overall. However, the small sample size may have contributed to a potential false positive, and scores recorded still met the recommended threshold for fidelity, as currently applied in the NIMRC Certification process. Further monitoring for racial disparities is recommended in future application of the tool.

Future Recommendations

The Fidelity Measure of the Guiding Principles of Medical Respite Care has been found to be an accurate measure to assess a program's fidelity to the *Guiding Principles of Medical Respite Care*. However, continued evaluation of the measure is recommended as the tool is used by NIMRC and medical respite programs to evaluate the reliability, validity, AND equity of the instrument going forward. In particular, inter-rater reliability over time and inter-organizational reliability between raters should be studied to improve understanding of the MRF-27 as a measure of organizational fidelity over individual attitudes.

Importantly, this pilot analysis identified small, mostly non-statistically significant, trends toward disparity between racial and ethnicity groups in overall and individual dimension scores on the instrument. Given the small sample sizes there are acknowledged risks of random fluctuations in the associations of scores and demographics. Therefore, these findings do not require action at this time but should be closely monitored to understand the role and the impact of potential differences between demographic groups could have on meeting thresholds for certification or assigned training for medical respite care programs in the future.

Application of the Fidelity Measure to Programs

The goal of the Fidelity Measure is to assess a program or organization's overall fidelity to the Guiding Principles. There are currently two methods to access and use the Fidelity Measure.

1. The Fidelity Measure of the Guiding Principles of Medical Respite Care is one component of the NIMRC Certification Process. Programs within the Certification process will receive guidance on how to instruct their staff to submit responses and how to interpret results and findings once it has been completed.

2. Programs who are not currently within the NIMRC Certification process can also use The Fidelity Measure of the Guiding Principles of Medical Respite Care, but need to reach out to the NHCHC Medical Respite Team for access and guidance to use the tool. This process will require multiple staff to complete the measure, and results should be used to inform future quality improvement activities of the program.

Using Fidelity Measure Results

NHCHC Medical Respite Team staff will provide each program with their overall score, and whether or not this score is above the threshold for "good" fidelity. To offer more specific insight, average scores in each of the four domains will also be provided. Based on their Fidelity Measure scores, programs can determine appropriate action items.

If fidelity was good, programs can:

- Discuss with staff overall responses to taking the Fidelity Measure.
- Identify areas of program strength.
- Identify areas for improvement.
- Identify how these can be incorporated informally and as part of a formal Quality Improvement plan.

If fidelity was low, programs should:

- Discuss with staff overall responses to taking the Fidelity Measure.
- Identify areas where the program staff were not in alignment with each other and/or with the Guiding Principles.
- Identify tangible actions for improvement, such as changes to procedures, organizational structures, or staff training.
- Identify how these findings can be incorporated as part of a formal Quality Improvement plan.

Conclusion

The *Guiding Principles of Medical Respite Care* underlie the work of medical respite programs and are incorporated in program policy, procedures, and service delivery. In order for programs to assess their fidelity to the Guiding Principles, The Fidelity Measure of the Guiding Principles of Medical Respite Care was developed. The development process engaged over 84 unique medical respite programs and 199 providers across the field of medical respite care. This tool can be utilized by programs to identify their alignment with the Guiding Principles, and ideally ensure that the care provided within their program meets the needs of their clients and contributes to the process of disrupting homelessness within their communities.

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[i] National Institute for Medical Respite Care [NIMRC]. (2021). *Medical respite literature review: An update on the evidence for medical respite care*. https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf

[ii] Goddard, P. (2003). Changing attitudes towards harm reduction amongst treatment professionals: A report from the American Midwest. *International Journal of Drug Policy, 14*, 257-260.

[iii] Edvardsson, D., Fetherstonhaugh, D., Nay, R., & Gibson, S. (2010). Development and initial testing of the Person-centered Care Assessment Tool (P-CAT). *International psychogeriatrics*, *22*(1), 101–108. https://doi.org/10.1017/S1041610209990688

[iv] Buck D. S., Monteiro, F. M., Kneuper, S., Rochon, D., Clark, D. L., Melillo, A., & Volk, R. J. (2005). Design and validation of the health professionals' attitudes toward the homeless inventory (HPATHI). *BMC Medical Education, 5*(1), 2. https://doi.org/10.1186/1472-6920-5-2

[v] Schroder, C., Medves, J., Paterson, M. Byrnes, V., Chapman, C., O'Riordan, A., Pichora, D., Kelly, C. (2011). Development and pilot testing of the collaborative practice assessment tool. *Journal of Interprofessional Care*, 25: 189-195.

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