

GUIDE

NATIONAL
INSTITUTE
—for—
MEDICAL
RESPITE
CARE

Models of Medical Respite Care

2023



Introduction

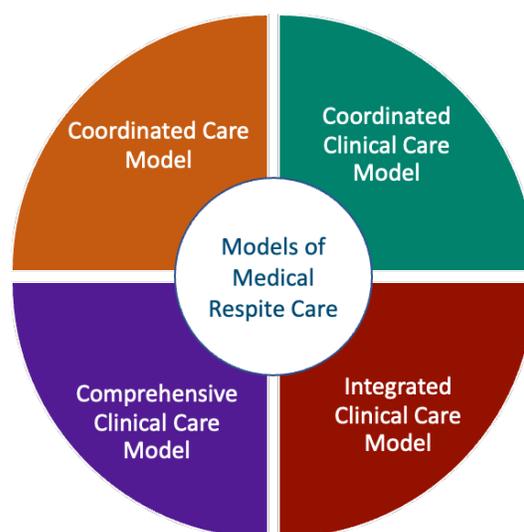
Medical respite care¹ (MRC) is defined as acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. While programs vary in size and structure, they are all grounded in the [Guiding Principles for Medical Respite Care](#) and the [Standards for Medical Respite Care Programs](#). Every medical respite care program shares the same fundamental elements: short-term residential care that allows people experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and supportive services.

The Models of Medical Respite Care (Models of Care) were established by the National Institute for Medical Respite Care (NIMRC) in response to the need for programs and policy makers to have clearer guidance on what constitutes medical respite care. Each MRC program's services are developed in response to the needs of the community and clients², thus variability is expected. However, each program should include the same [key components](#), and align their service delivery with one of the Models of Care.

This document serves as a guide to describe the Models of Medical Respite Care and types and intensity of clinical, case management, and care coordination services that can be expected within each MRC setting.

The models are structured to describe what services the client has access to while in 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](#)



Page 14 provides a visual overview of the Models of Care and the services included within each Model.

¹ The terms medical respite and recuperative care may be used interchangeably as they describe the same service.

² People experiencing homelessness who receive services in a medical respite program may be referred to as clients, consumers, patients, etc. For the purposes of this resource, the term *client* will be used.

Medical Respite Service Delivery

To achieve the essential goal of medical respite care to provide a safe place to heal, recover, and connect to health care services, every program, at minimum, should include the key components described in [Figure 1](#). Further, each program (and Model) includes the services described in [Figure 2](#). The location, intensity, and delivery of services is variable by each Model, and informs the acuity and types of conditions that can safely be served within the medical respite program.

Figure 1: Key Components of Medical Respite Programs

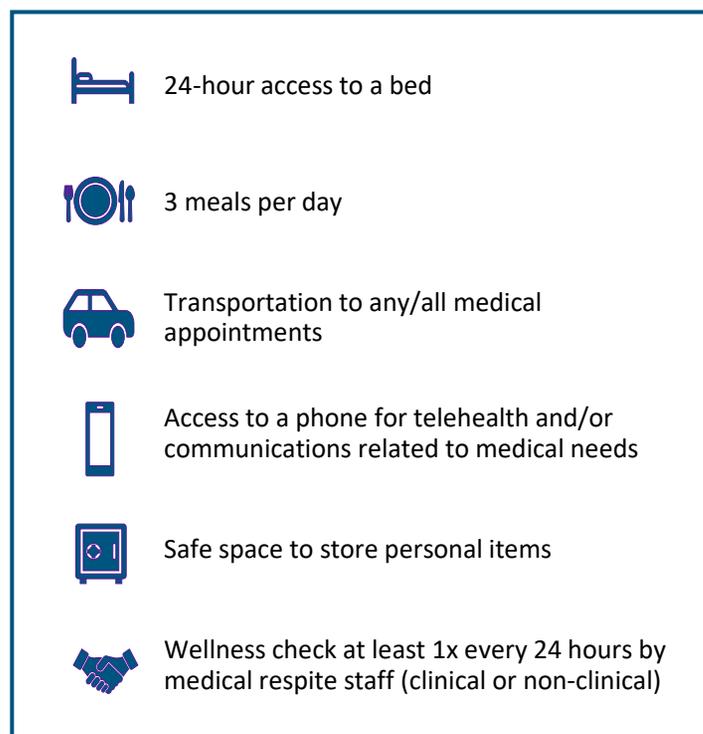


Figure 2: Medical Respite Program Services



³ For more information on providing medication support in medical respite care, please see [Medication Support and Medical Respite Care: A Guide for Programs](#).

⁴ Behavioral health is defined as “the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions” ([SAMHSA, 2014](#)).

Partnerships and Determining a Program's Model of Care

The key components and services may be provided through collaborations and partnerships of two or more organizations. Partnerships are important to all models of MRC programs, and often facilitate clients' connection to existing community programs and minimize duplication of services. Engagement and connection with partnerships can facilitate smoother transitions from medical respite into the community and develop community-based and natural support systems.

Determining the Program's Model of Care

A medical respite program should identify which Model of Care their program most aligns with by using this document and description of each Model. A program can include services provided by partners when determining their model of care. When determining which model is most applicable, programs need to consider which services the client has access to without having to leave the medical respite facility, and the intensity of the onsite services provided. The Models of Care specifically focuses on the care coordination and clinical services provided and does not describe the additional operational services or prescribe the operational structure of the program.

Programs may use a variety of staffing structures to implement their Model of Care. The resource, [Potential Skills and Staffing of Medical Respite Care](#), provides an overview of the various skills needed to implement each Model and the potential staffing to implement the services described.

It is likely that each program offers additional services or resources that are not listed here. As noted above, each program should identify their Model based on which one they most align with. However, when describing services to funders, potential partners, and community organizations, programs will want to highlight any additional or unique services and supports provided beyond their Model of Care. Examples of these additional services may include recreational and leisure activities, onsite groups facilitated by partners/community organizations, or facility structures (such as private rooms and all-gender bathrooms).

Finally, it is important that all programs in every Model of Care ground their work in the [Guiding Principles](#) and the [Standards for Medical Respite Care Programs](#). As depicted in [Figure 3](#), each of these components work together to ensure safe and quality services for clients of the medical respite program.



Coordinated Care Model

The **Coordinated Care Model** focuses on individualized case management and facilitating connections to community-based resources. This model includes:

1. Individualized case management and care coordination for medical needs, which may include:

- Conducting an individual needs assessment and developing a care plan
- Connection to Primary Care Provider (PCP)/health home
- Connection to home health (as indicated/referred)
- Coordination of medical appointments, including arranging transportation and support and accompaniment to appointments
- Connection to pharmacies and support for navigating pharmacies to access medications
- Support to access durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed)
- Specialty care coordination and connection
- Insurance navigation

2. Individualized case management and care coordination for social needs, which may include:

- Identifying clients' eligibility for community resources and services
- Identifying resources needed to transition into housing (e.g. documentation/identification, income)
- Connection to community case management for services not available onsite and to prepare for discharge
- Developing discharge and transition plans
- Facilitating connection to, and coordinating with, any pre-existing case management supports

3. Medication support, which includes:

- Safe and secure space for clients to store medications
- The client is responsible for self-administering all medications
- Supporting the client to access all prescribed medications (e.g. ensuring the hospital discharges the client with medications or prescriptions)

4. The client has space to engage with home-based clinical services (e.g. home health, home nursing care, physical therapy, speech, occupational therapy)

5. Screen for behavioral health needs and connect to community behavioral health and/or substance use programs (as appropriate)

Coordinated Clinical Care Model

The **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:

1. Individualized case management and care coordination for medical needs, which may include:

- Conducting an individual needs assessment and developing a care plan
- Connection to Primary Care Provider (PCP)/health home
- Care coordination with home health and home-based clinical care services
- Coordination of medical appointments, including arranging transportation, and support and accompaniment to appointments
- Connection to pharmacies and support to navigate pharmacies to access medications
- Support to access durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed)
- Specialty care coordination and connection
- Insurance navigation

2. Individualized case management and care coordination for social needs, which may include:

- Identifying clients' eligibility for community resources and services
- Identifying resources needed to transition into housing (e.g. documentation/identification, income)
- Connection to community case management services for services not available onsite and to prepare for discharge
- Developing discharge and transition plans
- Facilitating connection to, and coordinating with, any pre-existing case management supports

3. Provision of basic onsite medical clinical services, within scope of license (of clinical staff), and as indicated by discharge instructions, which may include:

- Vital signs and condition monitoring
- Health education and support for the client to follow discharge instructions

4. Medication management, supervised by licensed clinical staff, which may include:

- Medication reconciliation at admission to the program

- Storage of medications by designated MRC staff, or safe and secure space for clients to store medications
 - Dispensing of medication by qualified MRC clinical staff
 - Client self-administers medications
 - Education, identification of strategies, and skill development to self-manage and administer medications
- 5. Client has space to engage with home-based clinical services (e.g. home health, home nursing care, physical therapy, speech, occupational therapy)**
- 6. Screen for behavioral health needs and connect to community behavioral health and/or substance use programs (as appropriate)**

Integrated Clinical Care Model

The **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:

1. Individualized case management and care coordination for medical needs, which may include:

- Conducting an individual needs assessment and developing a care plan
- Connection to Primary Care Provider (PCP)/health home
- Connection to home health (as indicated/referred)
- Coordination of medical appointments, including arranging transportation, and support and accompaniment to appointments
- Connection to pharmacies and support to navigate pharmacies to access medications
- Support to access durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed)
- Specialty care coordination and connection
- Insurance navigation

2. Individualized case management and care coordination for social needs, which may include:

- Identifying clients' eligibility for community resources and services
- Identifying resources needed to transition into housing (e.g. documentation/identification, income)
- Completion of case management and supportive services onsite as applicable (e.g. MRC case manager can complete coordinated entry intake process)
- Connection to community case management services for services not available onsite and to prepare for discharge
- Developing discharge and transition plans
- Facilitating connection to, and coordinating with, any pre-existing case management supports

3. Onsite clinical services, which may include:

- Daily evaluation (or as indicated by plan) by clinical provider
- Provision of medical clinical services, within scope of license (of clinical staff), and as indicated by discharge instructions and clinical care plan

- Chronic condition management
 - Medical management and treatment
 - Self-management education
 - Monitoring and support to complete intensive outpatient medical treatment, such as:
 - Dialysis
 - Chemotherapy
- 4. Connection and transition to primary care provider/health home before discharge if medical needs are managed by onsite clinical staff**
- 5. Medication management, which may include:**
- Medication reconciliation at admission to the program
 - Storage of medications by designated MRC staff, or safe and secure space for clients to store medications
 - Dispensing of medication by designated MRC staff
 - Prescription of medications by qualified MRC clinical staff (as needed)
 - Client self-administers medications, but may receive support for administration by qualified clinical staff
 - Education and skill development to self-manage and administer medications
 - Identification and implementation of strategies to support independence in medication management
- 6. Behavioral health services, which may include:**
- Screening and assessment for mental health and substance use conditions
 - Ongoing individual behavioral health therapy
 - Connection and transition to long-term community behavioral health supports?
 - Referral and transition to community-based substance use treatment, including recovery, harm reduction, and/or medication assisted treatment (MAT) programs
 - Psychoeducation (group and individual)
 - Harm reduction education, equipment, and services
 - Recovery-focused group education
 - Mental health promotion and well-being group education

7. 24-hour program staffing and on-call medical support

- Access to a medical call line to address immediate medical needs and assess the need for emergency department care

8. Care coordination with home health and home-based clinical care services (if services are not provided by onsite medical/clinical team)**9. Client has space to engage with home-based clinical services not offered onsite (e.g. home health, home nursing care, physical therapy, speech, occupational therapy)**

Comprehensive Clinical Care Model

The **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:

1. Individualized case management and care coordination for medical needs which may include:

- Conducting an individual needs assessment and developing a care plan
- Connection to Primary Care Provider (PCP)/health home
- Connection to home health (as indicated/referred)
- Coordination of medical appointments, including arranging transportation, and support and accompaniment to appointments
- Connection to pharmacies and support to navigate pharmacies to access medications
- Support to access durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed)
- Specialty care coordination and connection
- Insurance navigation

2. Individualized case management and care coordination for social needs which may include:

- Identifying clients' eligibility for community resources and services
- Identifying resources needed to transition into housing (e.g. documentation/identification, income)
- Completion of case management and supportive services onsite as applicable (e.g. MRC case manager can complete coordinated entry intake process)
- Connection to community case management services for services not available onsite and to prepare for discharge
- Developing discharge and transition plans
- Facilitating connection to, and coordinating with, any pre-existing case management supports

3. Community health worker and/or peer support

4. Comprehensive clinical services, which may include:

- Daily evaluation (or as indicated by plan) by clinical provider
- Provision of medical clinical services, within scope of license (of clinical staff), and as indicated by discharge instructions and MRC clinical care plan
- Chronic condition management
 - Medical management and treatment
 - Self-management education
- Monitoring and support to complete intensive outpatient medical treatment, such as:
 - Dialysis
 - Chemotherapy
- IV based treatment (e.g. antibiotics)
- Palliative and hospice care
- Rehabilitation services (e.g. physical therapy, occupational therapy)
- Connection and transition to primary care provider/health home before discharge

5. Medication management, which may include:

- Medication reconciliation at admission to the program
- Storage of medications by designated MRC staff or safe and secure space for clients to store medications
- Dispensing of medication by designated MRC staff
- Prescription of medications by qualified MRC clinical staff
- Client self-administers medications, but may receive support for administration from qualified clinical staff
- Education and skill development to self-manage and administer medications
- Identification and implementation of strategies to support independence in medication management

6. Behavioral health which may include:

- Screening and assessment for mental health and substance use conditions
- Ongoing individual behavioral health therapy
- Assessment of need for, and prescription of, psychiatric medications

- Prescription for medication assisted treatment
- Connection and transition to long-term community behavioral health supports
- Referral and transition to community-based substance use treatment, including recovery, harm reduction, and/or medication assisted treatment (MAT) programs
- Psychoeducation (group and individual)
- Harm reduction education, equipment, and services
- Recovery-focused group education
- Mental health promotion and well-being group education

7. 24-hour program staffing

- Staff is trained to address and monitor those with high level medical needs (such as clients receiving hospice care) **OR**
- Includes 24-hour onsite clinical staff

8. On-call medical support, which can include:

- Access to a medical call line to address immediate medical needs and assess the need for emergency department care that may be above the scope of 24-hour onsite staff

9. Care coordination with home health and home-based clinical care services (if services are not provided by onsite medical/clinical team)

10. Client has space to engage with home-based clinical services not offered onsite (e.g. home health, home nursing care, physical therapy, speech, occupational therapy; hospice or palliative care teams)

Models of Medical Respite Care

Coordinated Care Model	Coordinated Clinical Care Model	Integrated Clinical Care Model	Comprehensive Clinical Care Model
 <ul style="list-style-type: none"> • Case management/ care coordination for medical needs 	 <ul style="list-style-type: none"> • Case management/ care coordination for medical needs 	 <ul style="list-style-type: none"> • Case management/ care coordination for medical needs 	 <ul style="list-style-type: none"> • Case management/ care coordination for medical needs
 <ul style="list-style-type: none"> • Case management/ care coordination for social needs 	 <ul style="list-style-type: none"> • Case management/ care coordination for social needs 	 <ul style="list-style-type: none"> • Case management/ care coordination for social needs 	 <ul style="list-style-type: none"> • Case management/ care coordination for social needs
 <ul style="list-style-type: none"> • Medication support, clients self-manage medication 	 <ul style="list-style-type: none"> • Medication management, by clients and licensed clinical staff 	 <ul style="list-style-type: none"> • Medication management, by clients and licensed clinical staff 	 <ul style="list-style-type: none"> • Medication management by clients and licensed clinical staff
 <ul style="list-style-type: none"> • Client has space to engage with home-based clinical services 	 <ul style="list-style-type: none"> • Client has space to engage with home-based clinical services 	 <ul style="list-style-type: none"> • Care coordination and space to engage with home-based clinical services 	 <ul style="list-style-type: none"> • Care coordination and space to engage with home-based clinical services
 <ul style="list-style-type: none"> • Screen for behavioral health needs and connect to community behavioral health and/or substance use programs (as appropriate) 	 <ul style="list-style-type: none"> • Screen for behavioral health needs and connect to community behavioral health and/or substance use resources (as appropriate) 	 <ul style="list-style-type: none"> • Behavioral health and/or substance use services through screening, onsite care, and referrals to community partners. 	 <ul style="list-style-type: none"> • Behavioral health and/or substance use services through screening, onsite care, and referrals to community partners.
 <ul style="list-style-type: none"> • Connection with community/primary care 	 <ul style="list-style-type: none"> • Provision of basic onsite medical clinical services, and connection to community/primary care 	 <ul style="list-style-type: none"> • Onsite clinical services, for management of acute and chronic conditions 	 <ul style="list-style-type: none"> • Comprehensive onsite clinical services, including management of higher acuity conditions
		 <ul style="list-style-type: none"> • 24-hour program staffing and on-call medical support 	 <ul style="list-style-type: none"> • 24-hour program staffing and on-call medical support
		 <ul style="list-style-type: none"> • Connection and transition to primary care provider/health home before discharge 	 <ul style="list-style-type: none"> • Connection and transition to primary care provider/health home before discharge
			 <ul style="list-style-type: none"> • Community Health Worker and/or Peer Support as part of staff

Additional Resources

The following resources are recommended to assist programs in implementing the Models of Medical Respite Care:

[The Framework for Medical Respite Care](#)

[Guiding Principles for Medical Respite Care](#)

[Standards for MRC Programs](#)

[Potential Skills and Staffing of Medical Respite Care](#)

[Medical Respite Budget Tool](#) + [Budget Tool Guidance](#)

[Medication Support and Medical Respite Care: A Guide for Programs](#)

[Medical Respite Organizational Self-Assessment Tool](#) – [\(PDF version\)](#)

All resources can be found at www.nimrc.org and NIMRC is available for technical assistance and program support – [contact us here](#).



Development of this resource was supported
by the California Health Care Foundation