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Introduction

Medical respite care¹ (MRC) is defined as acute and post-acute care for people experiencing homelessness (PEH) 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 guided by the [Standards for Medical Respite Care Programs](#) and share the same fundamental elements: short-term residential care that allows PEH the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services.

The Models of Medical Respite Care have been established by the National Institute for Medical Respite Care (NIMRC) in response to the need of programs and policy makers to have clearer guidance on what constitutes medical respite care. This document serves as a framework to describe MRC programs and the various services that may be offered within the program. Each program design is in response to community and client (patient) needs, thus variability is expected. However, the models may be used to determine the types and intensity of clinical, case management, and care coordination services that can be expected within each MRC setting.

The four models of MRC are:

- [Coordinated Care Model](#)
- [Coordinated Clinical Care Model](#)
- [Integrated Clinical Care Model](#)
- [Comprehensive Clinical Care Model](#)

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

Key Components of All Models

Although each program and model may differ, all programs should include:



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 (clinical or non-clinical)

Coordinated Care Model

This model includes:

- Case management/care coordination for medical appointments
- Connection to Primary Care Provider (PCP)/health home
- Connection to health home (as indicated/referred)
- Medication support:
 - Safe and secure space for individuals/clients to store medications.
 - Medications are accessible to the MRC client 24/7
 - The MRC client is responsible for self-administering all medications.
 - The MRC staff supports client in accessing all prescribed medications (e.g. ensuring hospital discharges client with medications; accessing local pharmacies).
- Referral to community case management services (e.g. housing navigation, community case management)
- Client has space to engage with home-based clinical services (e.g. home health, home nursing care, physical therapy, speech, occupational therapy)

Coordinated Clinical Care Model

This model includes:

- Case management/care coordination for medical appointments
- Connection to Primary Care Provider (PCP)/health home
- Care coordination with home health and home-based clinical care services
- Connection to community behavioral health and/or substance use program
- Provision of basic onsite medical clinical services within scope of license and as indicated by discharge instructions
- Medication management supervised by licensed clinical staff which may include:
 - Storage of medications by qualified MRC clinical staff
 - Dispensing or administration of medication by qualified MRC clinical staff
 - Medication reconciliation
 - Medication monitoring, in which qualified clinical staff store medications but the client self-administers medications
 - Education and skill development to self-manage and administer medications
 - Identification and implementation of strategies to support independence in medication management
- Referral to community case management services (e.g. housing navigation, community case management)
- Client has space to engage with home-based clinical services (e.g. home health, home nursing care, physical therapy, speech, occupational therapy)

Integrated Clinical Care Model

This model includes:

- Onsite case management/care coordination
 - Medical appointments
 - Referral to community case management services
 - Completion of case management and supportive services onsite as applicable (e.g. MRC case manager can complete coordinated entry intake process)
- Connection and transition to primary care provider/health home before discharge
- Onsite clinical services include:
 - Daily evaluation (or as indicated by plan) by clinical provider
 - Provision of medical clinical services within scope of license and as indicated by discharge instructions and clinical care plan
 - Medication management which may include:
 - Storage of medications by qualified MRC clinical staff
 - Client should have 24-hour access to medications even if stored by program staff
 - Dispensing or administration of medication
 - Medication reconciliation
 - Medication monitoring
 - Education and skill development to self-manage and administer medications
 - Identification and implementation of strategies to support independence in medication management
 - Chronic condition management
 - Medical management and treatment
 - Self-management education
 - Monitoring and support to complete intensive outpatient medical treatment, such as:
 - Dialysis
 - Chemotherapy
 - Behavioral health
 - Screening & assessment

- Ongoing behavioral health care and therapy
- Connection and transition to long-term community behavioral health
- Substance use treatment
 - Recovery-focused individual therapy
 - Recovery-focused group education
 - Referral and transition to community-based recovery programs
- Group education
- 24-hour program staffing
- On-call medical support
- Care coordination with home health and home-based clinical care services (if services are not provided by onsite medical/clinical team)
- 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

This model includes:

- Onsite case management/care coordination
 - Medical appointments
 - Referral to community case management services
 - Completion of case management and supportive services onsite as applicable (e.g. MRC case manager can complete coordinated entry intake process)
- Connection and transition to primary care provider/health home before discharge
- Community health worker and/or peer support
 - Escort to community medical and case management appointments
- Comprehensive Clinical services include:
 - Daily evaluation (or as indicated by plan) by clinical provider
 - Provision of medical clinical services within scope of license and as indicated by discharge instructions and MRC clinical care plan
 - Medication management which may include:
 - Storage of medications by qualified MRC clinical staff
 - Client should have 24 hour access to medications even if stored by program staff
 - Dispensing or administration of medication
 - Medication reconciliation
 - Medication monitoring
 - Education and skill development to self-manage and administer medications
 - Identification and implementation of strategies to support independence in medication management
 - 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
- Behavioral health
 - Screening & assessment
 - Ongoing behavioral health care and therapy
 - Connection and transition to long-term community behavioral health
 - Assessment of need for and prescription of psychiatric medications and controlled substances (e.g. methadone or suboxone)
- Substance use treatment
 - Prescription of medications to address substance use/client desire for abstinence
 - Recovery-focused individual therapy
 - Recovery-focused group education
 - Referral and transition to community-based recovery programs
- Rehabilitation services (e.g. physical therapy, occupational therapy)
- Group education
- 24-hour program staffing
 - Staffing is trained to address and monitor those with high level medical needs (such as clients receiving hospice care)
- On-call medical support
- Care coordination with home health and home-based clinical care services (if services are not provided by onsite medical/clinical team)
- 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)