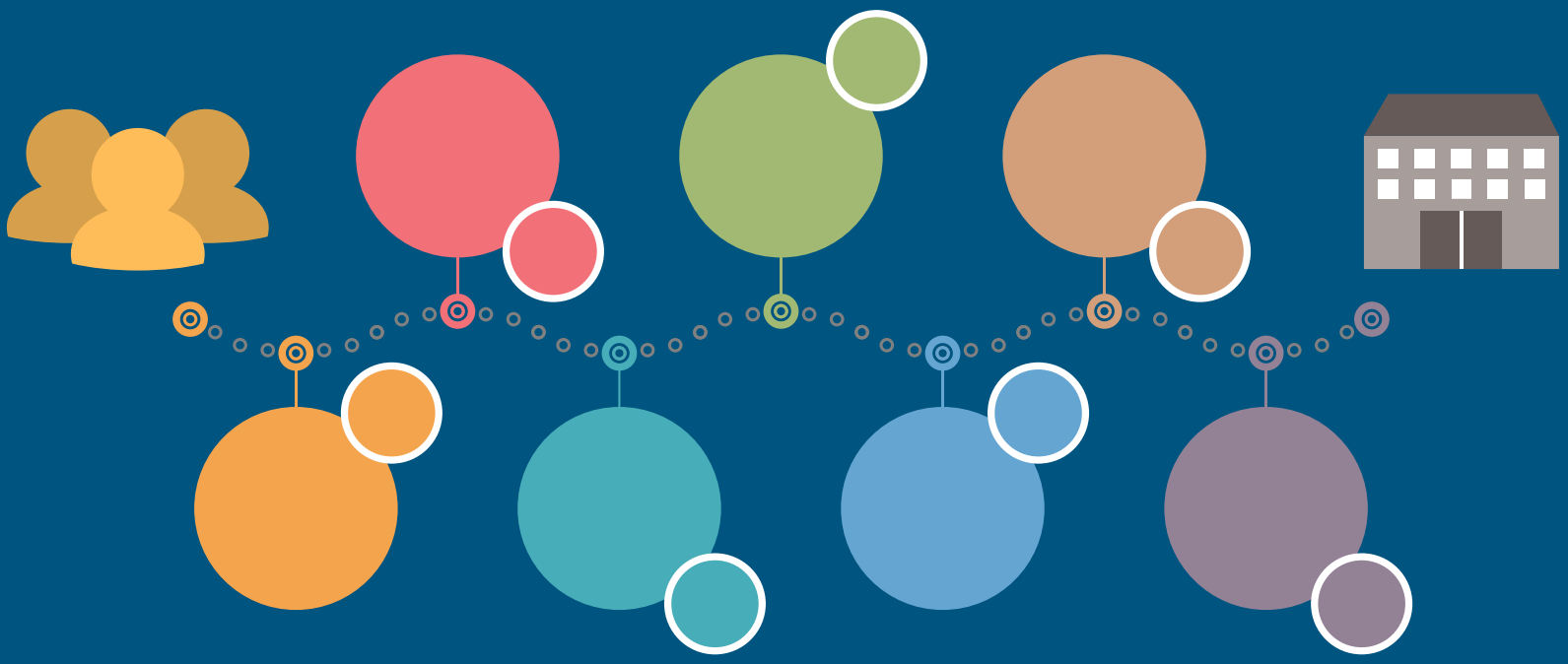
GUIDE

NATIONAL INSTITUTE *for* MEDICAL RESPITE CARE

Medical Respite Care Program Development Guide

2023



Introduction

A significant health event can precipitate becoming homeless, and those experiencing homelessness will have health conditions exacerbated (Treglia et al., 2019). These health conditions, combined with the chronic stress and trauma of homelessness, make recovery, health, and well-being difficult to achieve. Health care continues to shift to respond to society's needs and to provide more cost-effective care (National Institute for Medical Respite Care [NIMRC], 2019). The Affordable Care Act, and expansion of health insurance, allowed some states to offer increased health coverage, which positively impacted people experiencing homelessness. In addition to cost-effectiveness, there has also been a focus on quality outcomes and the need for more integrated community care (NIMRC, 2019). As hospitals are seeking shorter inpatient stays, they are also beginning to invest in effective community programs to decrease re-hospitalization and focusing on integrated and comprehensive home and community care. But what happens when there is no home to which the person can return, and/or place to receive the needed support to recover? The hospital discharge process often relies on the person having adequate resources (such as housing or social supports) to be able to follow through with discharge recommendations. People experiencing homelessness are often discharged with prescriptions for medication they cannot afford to get filled, and instructions for self-care—such as resting and drinking fluids—that cannot be followed due to limitations of shelters or living conditions. Providers of health care to people without homes have become increasingly aware of the need for alternatives to discharging patients to the streets or shelters where safety cannot be guaranteed and the basic facilities needed for successful recuperation are not consistently available.

All people, and especially those with an acute health condition, need extended access to a safe bed in which they can rest, adequate restroom facilities, nutritious food and clean water, secure storage and/or refrigeration for medications, assistance with dressing changes and general nursing care. All of these elements are necessary for successful health and quality of life outcomes. Optimally, everyone would have a home to return to after hospitalization and significant health events. However, medical respite can provide a dignified environment for a person experiencing homelessness to heal and be able to address medical needs.

Medical respite is a humane, evidence-based, and cost-effective approach to providing care for people experiencing homelessness. This document is intended to guide the establishment of a medical respite program that provides high quality care to people experiencing homelessness in communities across the country.

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Section 1: The Need for Medical Respite Care

Hospital Utilization and Homelessness

People experiencing homelessness (PEH) have higher hospitalization rates than the general population, including emergency department (ED) visits and inpatient admissions (Doran et al., 2013). Fazel et al. (2014) hypothesizes increased use of acute care by PEH could be attributed to several factors including:

- High prevalence of predisposing conditions;
- Communicable and non-communicable diseases;
- Unintentional injuries;
- Comorbid mental health and substance misuse; and
- Experiencing internal and external barriers to care that limits management of conditions as an outpatient.

Hwang et al. (2013) found that even with universal health care coverage, people experiencing homelessness continue to have higher rates of ED and hospital admissions, pointing to homelessness and lack of stable housing as a primary cause of increased hospital usage. This indicates the need to use housing as an intervention for improved health and recovery.

Discharge Planning

The challenge of quality and appropriate care is experienced by both people experiencing homelessness and their health care providers. People experiencing homelessness do not have available resources for recovery and health management. Hospitals caring for people who do not have a home are faced with a difficult dilemma of finding appropriate and safe discharge options. Hospitals must make the decision to discharge these patients to the street or shelter, where opportunities for recuperation are bleak, or allow them to stay in the hospital for an extended amount of time until they are fully stabilized. Extended hospitalization can be costly, and excess time spent in the hospital can be restrictive and increase exposure to other potential health issues.

Recovery without Housing

In lieu of a home, people experiencing homelessness are discharged to shelters or the street. However, emergency shelters generally provide night shelter only. Typically, guests arrive late in the afternoon, get a hot meal and a shower, and must leave the shelter early in the morning on the following day. For a variety of reasons many emergency shelters do not allow their guests to remain on the premises during the day. Some expect their clients[1] to be out looking for employment; others do not have the resources to staff their program during the day or use

[1] 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.

those hours to perform maintenance of the facility. Even for those who are not ill, there is considerable exhaustion associated with making it through a day without easy access to a bathroom, food, or a place to rest. Shelter staff may not be trained or feel equipped to manage significant health needs, and there are also individuals who do not use the shelter system and sleep outside. When a person experiencing homelessness is ill or recuperating, an overnight emergency shelter bed or sleeping on the streets is inadequate for recovery.

Affordable housing shortages exist in almost all communities within the US (National Low Income Housing Coalition [NLIHC], 2021). Combined with short hospital lengths of stays, discharge for a person experiencing homelessness to stable housing is very unlikely. Medical respite care provides a solution for these inequities by providing a stable, safe place to stay, rest, and recuperate. With housing temporarily addressed, outcomes of connection to primary care and benefits can be enhanced. Medical respite may also provide a pathway to stable housing.

Case Example

George is managing diabetes and depression, which is increasingly difficult while experiencing homelessness. George has an accident resulting in a leg fracture, but due to previous hospital experiences where his needs were ignored and he was treated poorly, he avoids seeking care until he is in excruciating pain and unable to walk. George seeks out care at the Emergency Department (ED) at his local hospital and is admitted for a short inpatient stay. He is treated and ready for discharge after 2 days of care.

Without medical respite care:	With medical respite care:
George returns to the emergency shelter where he is only able to rest his leg after 5 p.m., and is required to leave daily by 6:30 a.m. Two weeks after his discharge, George returns to the ED due to swelling and pain in his fractured leg. His diabetes and being unable to rest has contributed to poor healing in his leg, and he is hospitalized again, this time for longer, to prevent his leg from worsening. George reports increasing depression due to ongoing pain from his leg and feeling unable to prevent his health conditions from worsening.	George is discharged from the hospital to the local medical respite program where he is able to rest his leg throughout the day. The RN provides daily checks to ensure his leg and fracture are healing and provides support for his diabetes management. As a result of the positive relationships he develops with staff at the respite program, George is agreeable to establishing with a primary care provider (PCP) at the local health center for long-term follow-up for his leg and diabetes. George feels healthy and strong enough to leave the medical respite after 4 weeks, and in that time he attended his first PCP appointment, received a referral for and scheduled his first physical therapy appointment, and identified a case manager to navigate the housing process in his community.

Medical Respite Care

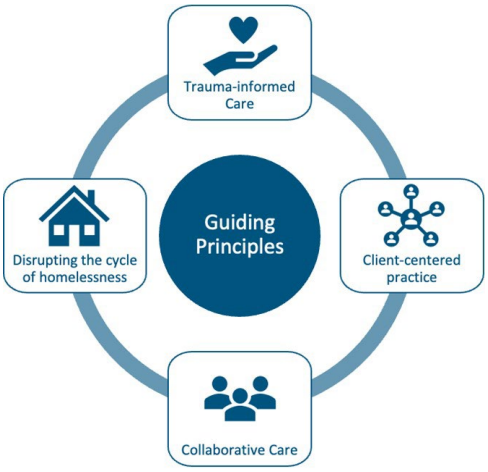
Medical respite programs are a humane and dignified approach to recuperative care for people experiencing homelessness (PEH). Medical respite care is defined as **"acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in shelter or on the streets, but who are not sick enough to be in a hospital"** (National Institute for Medical Respite Care [NIMRC], 2021). The terms "medical respite" and "recuperative care" are used interchangeably. Medical respite care fills a service gap between hospital and shelter, providing a safe place to recover by ensuring basic needs are met. This also allows the person experiencing homelessness to focus on their health by attending appointments, managing medications, and connecting with specialty care. Programs also support recovery by offering case management, connection to benefits, enabling services[2], and mental health care.

Medical respite care has been found to have several positive outcomes, including:

- Decreased hospitalization and readmissions;
- Increased use of community-based health services;
- Overall decreased healthcare costs;
- Reduction in gaps in services; and
- Improved quality of life and health outcomes for clients (NIMRC, 2021).

These outcomes have resulted in many communities establishing a medical respite care (MRC) program; at the publication of this document, there are over 140 MRC programs across the US (NIMRC, 2022a). Due to the growing need and positive impact of MRC, programs are continually being developed across the country.

The steps outlined in this document are in alignment with the *Standards for Medical Respite Care Programs* (NIMRC, 2021b) and grounded in the *Guiding Principles for Medical Respite Care* (NIMRC, 2023) to ensure quality and comprehensive care and positively impact health outcomes. Additionally, supplemental resources available from NIMRC that go into more depth on each step are linked throughout this document.



[2] Non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach (Health Resources and Services Administration [HRSA], 2021).

The Standards for Medical Respite Care Programs

The *Standards for Medical Respite Care Programs* (the Standards) provide a framework for implementing quality medical respite care. Since many medical respite programs are diverse and reflect the needs of their specific community, the Standards ensure consistency on key components of respite programs, and the quality of care for people experiencing homelessness (NIMRC, 2021b). Although a new medical respite program may not initially meet the Standards, it serves as a guide for developing a high-quality program.

Each Standard has specific criteria detailing how it can be met, which is a useful tool throughout the program design process. The full document can be accessed here: https://nimrc.org/standards-for-medical-respite-programs/

Developing programs may also want to review the Organizational Self-Assessment Tool, which is a check-list format to help organize and identify if each of the criteria has been met.

The Standards for Medical Respite Care Programs are:

1. Medical respite program provides safe and quality accommodations.

2. Medical respite program provides quality environmental services.

3. Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings.

4. Medical respite program administers high quality post-acute clinical care.

5. Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services.

6. Medical respite program facilitates safe and appropriate care transitions out of medical respite care.

7. Medical respite care personnel are equipped to address the needs of people experiencing homelessness.

8. Medical respite care is driven by quality improvement.

Section 2: Planning and Developing a Medical Respite Care Program

The Program Development Process

Each community is unique in its needs and resources and may adopt a different approach to program planning. Numerous factors such as cost, client needs, community support, or lack thereof play a role in designing a program. The information that follows is intended to be used by communities and organizations that are interested in designing a medical respite program, and describes the basic steps involved in program planning. Providers initiating medical respite programs may include homeless service providers, hospitals, community health centers[3], or a combination of interested community partners. The steps should be used as general guidance, with the understanding that each community has individual needs that will influence the planning process.

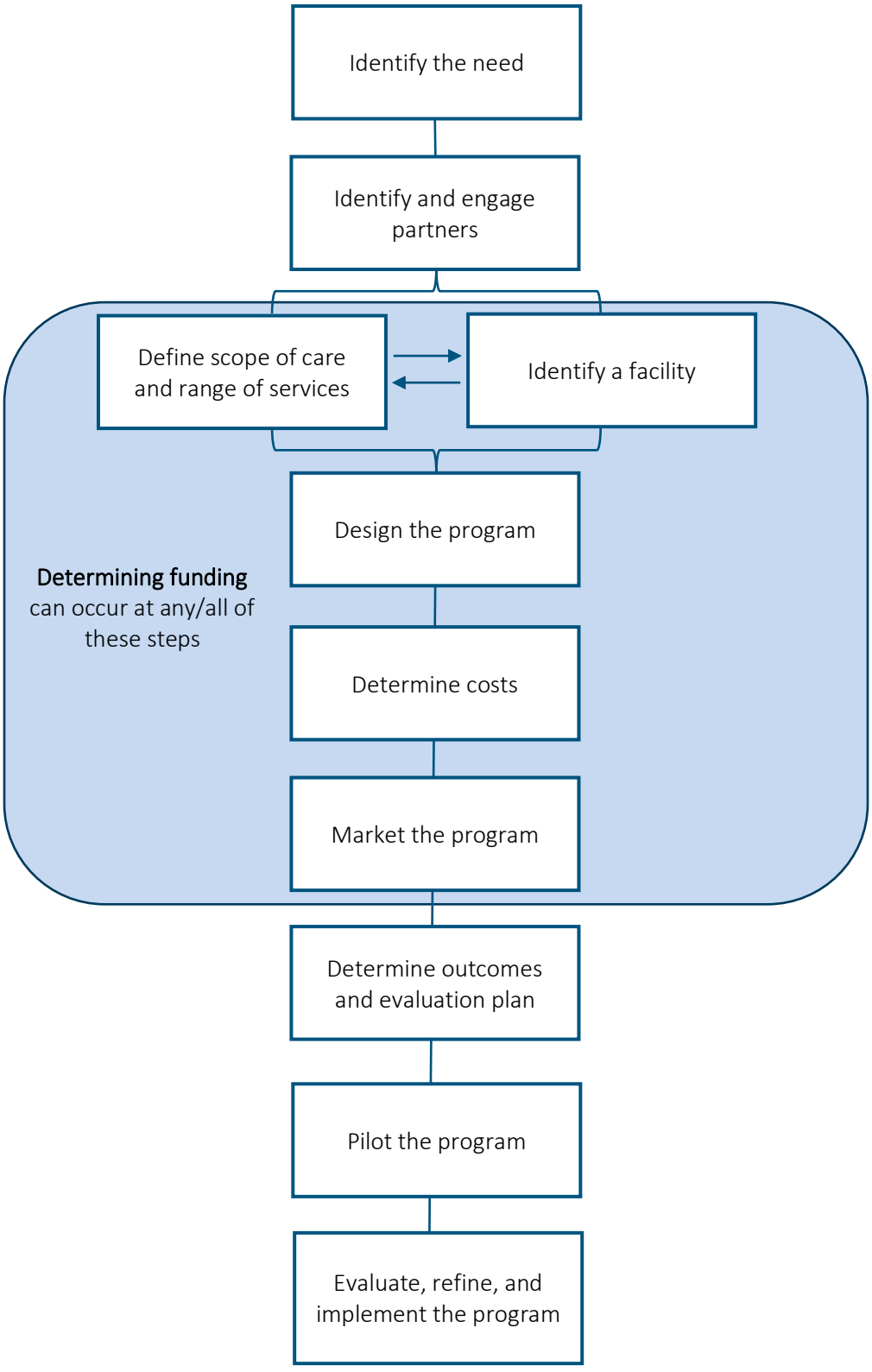
Figure 1 depicts the steps of the program development process. Each of these steps are discussed in detail in this section.

Pilot Programs

Although a full-scale medical respite program may be the initial goal, in many cases it is not realistic due to lack of resources or funding. Instead, it may be more feasible for organizations to implement a pilot program that will operate on a smaller scale. Pilot programs have the opportunity to demonstrate positive outcomes for clients and communities. The establishment of the pilot program will follow the same steps outlined in this document, and by doing so will be able to easily scale up if the structure and steps have been thoroughly completed.

[3] Non-profit, community-based organizations that provide comprehensive, low- or no-cost health care to underserved populations. Also referred to as "health centers." They are funded and regulated through HRSA at the U.S. Department of Health and Human Services (HHS). NHCHC, 2021

FIGURE 1: MEDICAL RESPITE CARE PROGRAM DEVELOPMENT PROCESS



Identifying the Need

Often the starting point in program planning is the identification of a need or a problem. In the case of medical respite care, the need is often presented by the frequency with which people experiencing homelessness utilize high-cost in-patient hospital services, and by the dilemma and moral injury faced by discharge planners responsible for finding a safe discharge environment. Though the primary need might seem evident, planners will still benefit from a formal needs assessment. In many cases, data will reveal needs that are much more complex than anticipated. The needs assessment identifies key partners, existing resources, and prioritizes the clinical and care coordination services to be provided. Understanding the magnitude and complexity of a community's need is an important foundation for the program planning process. Further, the needs assessment can help articulate the consequences of not having the medical respite program available in the community.

A needs assessment can be defined as "a method to identify current conditions and desired services or outcomes" (Substance Abuse and Mental Health Administration [SAMHSA], 2020). The medical respite program planners can complete multiple needs assessments to gather necessary data to establish the need for a respite program in their community. Needs assessments may directly target those who would be most impacted by a medical respite program including clients, hospital discharge planners, shelter providers, community health centers, and Continuums of Care. This data collection may occur through qualitative methods, such as interviews, surveys, and focus groups, or quantitative methods, such as hospital data regarding admissions/discharges, type of diagnoses treated for people experiencing homelessness in hospital or community health settings, etc.

A needs assessment may also include gathering secondary data, such as information collected by medical respite programs in other similar communities, broad hospital records of admissions/discharges, Community Health Needs Assessments, public health registries, or published literature regarding the health needs of those experiencing homelessness.

Other helpful data to collect includes information regarding the consequences of not having a particular intervention. Some consequences of not having appropriate recuperative options for people without homes include:

- Planned procedures may be delayed or cancelled without a set, safe place to recover.
- Without a secure location in which to recuperate, individuals have difficulty following the treatment plan or discharge recommendations.
- The person's inability to follow the recommended treatment, due to the environment, may then result in complications and emergencies, which in turn results in higher use of the hospital emergency room and increased costs to the medical system.
- Clients and providers are both frustrated and dissatisfied when medical treatment seems ineffective due to incomplete recuperation.

- There is limited continuity of care when clients are discharged without support or direct connection to community providers.

The information gathered from a needs assessment is consolidated to identify priority needs, the extent of the problem in the community, and potential solutions. This information can be presented to partners, funders, community members and partners, and will guide the rest of the program development process.

Identifying and Engaging Partners

It is crucial to involve representatives of all potential partners or collaborators from the earliest planning stages. Partners or collaborators are individuals or organizations who have an interest, personal or professional, in the topic (Guise et al., 2013). It is important to be inclusive of a variety of perspectives and be centered around the needs and voices of community members experiencing homelessness throughout the program development process. Having a planning group of key partners and collaborators is extremely beneficial for a multitude of reasons. For example, members of the planning group will likely include hospital administrators who can access data for a needs assessment. Another advantage of involving other community members—whether from hospitals or local government—is the opportunity to encourage support for the project, which could conceivably result in additional resources and/or funding. Most importantly, including community members experiencing homelessness in the planning groups ensures that the developed program reflects the needs of clients. Partners and collaborators can be approached for participation in several steps of the program planning process. Prior to beginning the development of the program, it is helpful to identify the steps of the process where input will be necessary. Not all partners or collaborators have to participate in all components of the process; instead, program planners may opt to identify smaller work groups for each individual step.

A planning group for medical respite services should include:

- Top-level decision makers in the operating organization (executive director, board members);
- Front-line providers and practitioners who will be involved in program implementation;
- Clients or people with lived experience of homelessness;
- Representatives of hospitals or other entities that may be involved in referring to the respite program;
- Other community members, such as staff from shelters, meal sites or other homeless services programs;
- People with expertise in behavioral health care and substance use treatment.

The program planners should determine how various partners or collaborators should participate. They can be involved by:

- Planning and implementation of the respite program;
- Giving feedback to the proposed plan or program;
- Sharing knowledge and expertise;
- Marketing the program and developing strategic partnerships;
- Funding.

In the initial planning stages, a short-term planning group may convene regularly to identify answers to broader questions and to gather multiple perspectives on establishing a medical respite program. This group may transition to an identified advisory board or leadership team for the final stages of development and implementation.

Regardless of the extent of participation, the partner engagement process should (Eldredge et al., 2016):

- Be collaborative;
- Reflect the diverse opinions and experiences of participants;
- Be respectful of the expertise, values, perspectives, contributions, and confidentiality of the community and;
- Acknowledge personal and institutional histories and power dynamics.

When multiple partners or entities are involved in planning and implementing the program, clear expectations should be established regarding the nature of the collaborations. The roles of each contributor are essential and should be considered during the planning process to utilize the group's time most effectively and build on each other's strengths.

All of the information gathered from the needs assessment(s) and partner convenings will help the planning group determine the most appropriate model to meet the community's needs. It will also guide the group in planning program elements such as the scope of medical care, range of services, staffing, and facility. If the planning group is a combination of different partners, collaborators, and community groups, it is important that at the end of the planning process an operating agency or group is determined for the medical respite facility. Determining who will oversee the coordination of engaged entities is essential in ensuring the program runs safely and effectively.

Concurrent Steps of the Program Development Process

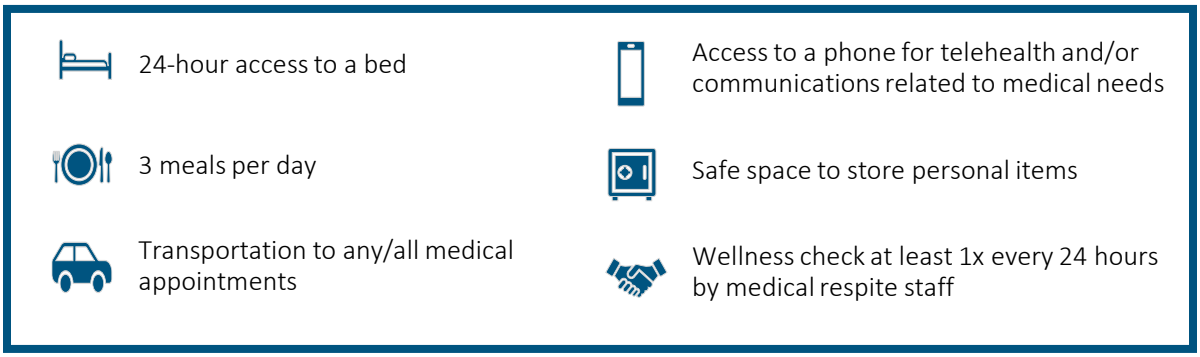
The next several steps in the medical respite program development process [*Defining Scope and Range of Services*, *Identifying a Facility*, *Determining Costs*, and *Determining Funding*] are intertwined. Although they are linearly presented within this document, working through each component will influence, or be influenced by, another element. For example, a community may have a building available to be re-purposed into a medical respite program. Having identified the facility, the scope of services will be determined by the size of the facility and the ability to support individuals with various medical and mobility needs. Programs may have an initial investment and need to develop the program within the boundaries of this amount, while others may design their services and then seek funding for their building and services. Each community will need to approach this process based on their resources and needs assessment. These steps of the process will be informed by, and build on, the Needs Assessment and Partner Engagement process.

Defining Scope of Care and Range of Services

People experiencing homelessness have high rates of chronic and acute health conditions, both as a result of, and exacerbated by, a lack of housing (Fazel et al., 2014). Ideally, the scope of clinical services offered should reflect the health problems identified in the needs assessment and be specific to the community. However, the scope of medical care that can be provided also depends on available community resources. Multiple factors, including the needs assessment, resources, funding, and existing or potential partnerships will determine the range of health conditions that can be safely and successfully treated within the medical respite setting.

There are several key components that are essential to every medical respite care program depicted in Figure 2. Beyond that, the services provided within medical respite can be divided into two categories: Clinical Care and Enabling Services.

FIGURE 2 – KEY COMPONENTS OF ALL MEDICAL RESPITE CARE PROGRAMS



Clinical Services

To ensure recuperation from illness and injury, medical respite programs must provide access to an adequate level of clinical care. Standard 4 of The Standards for Medical Respite Care Programs states "Medical respite program administers high quality post-acute clinical care." Medical respite programs need qualified personnel to assess baseline health at intake, make ongoing reassessments to determine whether clinical interventions are effective, and determine readiness for program discharge (NIMRC, 2021b). Importantly, this can be accomplished using internal medical respite personnel or through formalized partnerships with medical providers in the community (for instance, HRSA-funded health centers).

Clinical services should be determined by the health priorities identified in the needs assessment, input from key partners, the capacity of the facility, and a staffing structure that is sustainable. Due to the high prevalence of co-occurring mental health diagnoses, chronic medical conditions, substance use disorders, and cognitive impairment among PEH, programs should consider how they will provide integrated care to address these needs (Fazel et al., 2014; Jego et al., 2018; Topolevec-Vranic et al., 2017). Strategies may include having behavioral health providers on staff or developing a process for direct referrals to access mental health and substance use services in the community (NIMRC, 2022b). Table 1 provides examples of common

clinical services offered within medical respite.

Beyond the management of acute conditions, medical respite programs can offer other medical support services that may be inhibited by a lack of housing, such as a place to complete colonoscopy preparation, a course of IV antibiotics, and/or support during chemotherapy and radiation treatments.

The clinical staffing model will determine the type of care that can be provided, from basic care for minor injuries, to complex and specialized services such as palliative care. Ideally, the clinical care provided would be entirely based on the needs of the community, however, budget and facility restrictions may dictate the types of services that can be implemented.

Enabling Services

The Standards for Medical Respite Care Programs, Standard 5 states "Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services" (NIMRC, 2021b). The connection between a person's health status and their social resources (e.g., housing, income, nutritious foods, etc.) is well established. To prevent exacerbation of acute medical issues, and promote health and recovery, programs will also want to offer enabling services such as case management and care coordination. These services help prepare clients for transition from the respite program and support continuity of care by connecting them to needed community services. Case management and care coordination assists clients with applying for benefits and housing, connecting to primary care, obtaining medications, and more. Table 1 provides examples of common enabling services offered within medical respite.

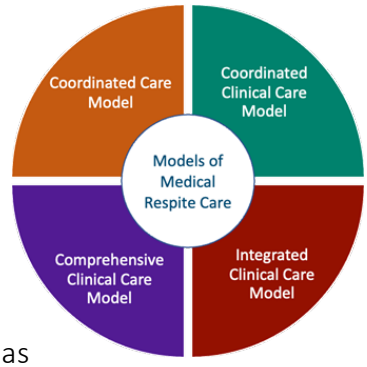
Enabling services within medical respite focus on addressing the various barriers that impact health and quality of life. Care coordination focuses directly on engagement in health services and addressing the social needs that impact a person's ability to care for their health. Case management in medical respite programs differs from other settings in that there is an intentional emphasis on connection to primary care, attending medical appointments, and accessing health resources, such as prescriptions or medical supplies.

Additionally, community partnerships will be essential in providing a sufficient range of enabling services, and medical respite programs should coordinate with existing entities that already provide specific programs/services (such as SOAR programs for Social Security Income or Coordinated Entry for housing). The majority of medical respite programs have a case manager on staff to addresses care coordination and enabling service needs (NIMRC, 2022a). The scope of the case manager or care coordinator's role will vary based on the medical respite program's internal resources and goals, as well as existing services in the community.

TABLE 1: FREQUENTLY INCLUDED CLINICAL & ENABLING SERVICES WITHIN MEDICAL RESPITE PROGRAMS

Clinical Services	Enabling Services
• Vital sign monitoring. • Management of acute conditions. • Management of chronic conditions. • Medication management (education, instruction). • Care coordination with specialists. • Mental health screening and intervention. • Substance use screening and treatment. • Escorts and support to attend appointments. • Advocacy and support for clients' health needs. • Health education.	• Care coordination to connect to primary care, attend medical appointments, and complete follow-up. • Connection to benefits programs such as food stamps. • Initiation of, or connection to, income, such as Social Security or supported employment programs. • Navigation or connection to Coordinated Entry and housing programs in the community. • Peer supports. • Reconnecting to family and other support systems. • Leisure and recreational activities.

Models of Medical Respite Care

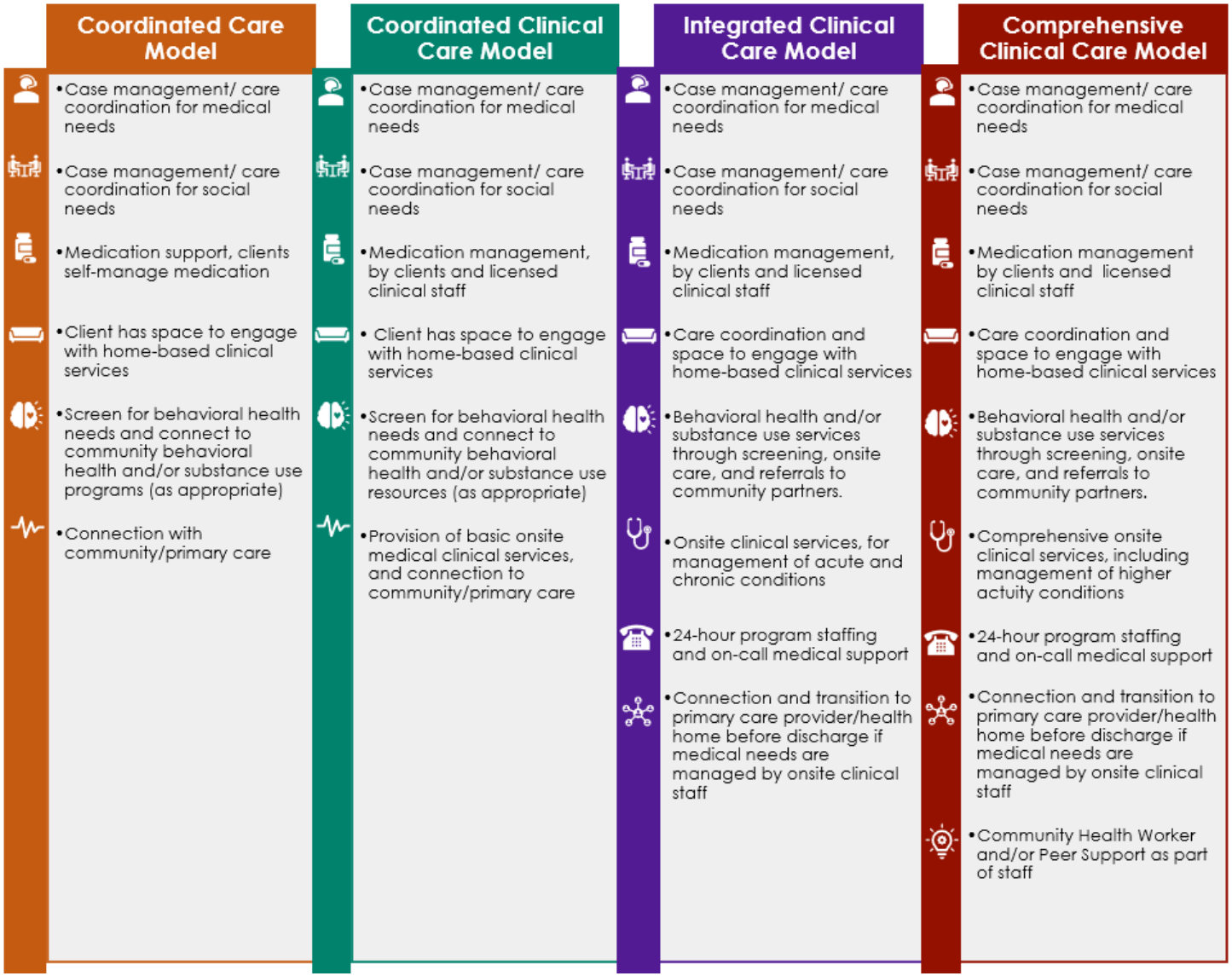


The *Models of Medical Respite Care* provide an overview/description of various program structures and approaches for delivering services within medical respite settings. The Models of Medical Respite Care fall on a spectrum where the intensity of onsite clinical services increases. The four models are briefly described in Figure 3, and a more in-depth description of each model is available in the publication *Models of Medical Respite Care*.

It is important to note that there is not one "best" model of care. Instead, the ideal model is the one that is responsive to the community's need and will be sustainable. Programs may opt to start with a lower intensity of clinical services as part of their pilot program, and then increase the number and types of services offered as they establish consistent partnerships and expand funding sources.

The Models of Medical Respite Care are not prescriptive, and programs may choose to offer additional services, again dependent on existing community resources and needs. Considerations for determining the staffing model for a program will be discussed in *Designing the Program*.

FIGURE 3 – BRIEF DESCRIPTION OF THE MODELS OF MEDICAL RESPITE CARE



Connecting with Primary Care Providers

In addition to facilitating or providing clinical care within medical respite, another essential goal is for clients to establish an ongoing relationship with a primary care provider (PCP) if they do not already have one. In many communities the ideal place for PEH to access PCP services is through the local health center or Health Care for the Homeless[4] (HCH) program. If the medical respite program is operated by the health center or HCH, then the transition to ongoing care at the clinic will be relatively seamless. However, medical respite programs not operated by a health center should reach out and establish a relationship. In some communities there may be only one health center, and in other larger communities there may be several to develop relationships with. Health centers may also become a referral source into the medical respite program for pre-operative care, colonoscopy prep or other procedures.

This publication *Health Centers Improve Outcomes with Medical Respite Care* can provide more information for HCH programs regarding establishing and/or partnering with medical respite care programs.

Considerations for Developing High Quality Care and Services

Quality Care

Regardless of the program model and scope of clinical services, medical respite programs should ensure that they are able to obtain and retain adequate staffing and medical equipment to sustain the level of clinical care offered. Programs may opt to start small with the potential to grow as positive outcomes are demonstrated and more funding is secured. It may be tempting to design the "perfect" program that meets all needs identified in the needs assessment process, however, it is more important to ensure the respite program can deliver a high quality of care. Thus, prioritizing where to invest resources may be necessary. Program planners should identify specific, measurable goals of the respite program in order to determine the initial scope of services that will be provided.

Standards 4 and 5 detail criteria for quality clinical and support services within medical respite. Providing quality care also necessitates adequate staff training and supervision, resources and equipment, and a safe and clean facility. Finally, medical respite programs will benefit from learning about, and implementing, trauma informed care in their programs and services. All medical respite program services should be based in trauma-informed principles and practices.

[4] HCH programs are a part of the community health center program authorized under Section 330 of the Public Health Service Act. HCH programs fall within the "special populations" category of health centers that are required to predominantly serve people experiencing homelessness.

For more on trauma-informed care please review these resources:

- Trauma-Informed Care in Medical Respite Online Course
- Trauma-Informed Organizational Toolkit
- Trauma-Informed Care Webinar series

Evidence-Informed Care

When determining the scope of services, planners should also aim to implement evidence-informed interventions. Evidence-informed interventions use the best available research and practice knowledge to guide program design and implementation. Research and clinical guidelines for people experiencing homelessness can be limited and presents a challenge for providers. However, assumptions and decisions on what services will be offered should not be based primarily on opinion, but also on the evidence that is available and clinical expertise. This may include reviewing relevant literature on interventions for people experiencing homelessness and engaging with providers who already work with this population to determine best practices.

Identifying a Facility

The previous section focused on what services will be offered within the medical respite program – this section is devoted to ***where*** those services will be provided. As depicted in the program development model, defining the scope and range of services and identifying the facility may happen simultaneously. In some cases, communities may have a building or facility already available, and the scope of services will be designed to fit the space. Alternatively, programs may identify services first, and seek a building that can meet those needs. The type of facility will be dependent on several factors aside from clinical services being implemented, including the spaces available in the community and the funding needed to acquire and maintain the space.

In determining the type of facility needed, consideration should be given to physical accessibility, safety/security, and the space required to complete the identified clinical services. Facilities should be able to provide basic needs to clients, specifically meals, beds, space to rest during the day, and access to restrooms. Attention also needs to be paid to the location. Access to public transportation and other services and resources is important, especially for those in the final stages of recuperation who are ready to be discharged.

Local and state regulations must also be considered, as there may be licensing or zoning regulations that prohibit particular medical respite models. Every community has different zoning regulations for types of facilities and services that can be rendered in particular locations. It is essential that all state and local regulations be thoroughly researched, considered, and followed. Licensing and regulations related to the delivery of clinical services are covered in *Designing the Program*. Although there are no national licensing guidelines or regulatory bodies for medical respite, it is also important that the facility allows for fidelity to the *Standards for Medical Respite Care Programs* to provide high quality and safe care. Facilities overall should be in good condition and able to be thoroughly cleaned and sanitized.

Finally, program planners will have to evaluate the cost involved with each type of facility, and if they will be building, rehabbing, or modifying physical structures to meet guidelines and clinical care needs. Although older structures may have a lower cost for purchasing, the cost to remodel the facility to meet accessibility guidelines may be significant. When determining the best type of facility, programs will also need to consider how the building supports:

- Intended population
- Accessibility
- Safety and security
- Location
- Intended onsite services

Potential Facility Types

There are a variety of ways medical respite facilities can be structured. They vary depending upon the communities' and populations' needs, available space, and funding. This is where a pilot program may be most beneficial to demonstrate the need and effectiveness of medical respite before a larger investment in a space. For example, starting with a few beds within a shelter may be easier and less costly than developing a stand-alone facility. Some of the identified approaches may serve either as a pilot model toward the development of a more comprehensive program or can be used in conjunction with a stand-alone medical respite program. Initial outcomes from the programs that are not in free standing buildings may be able to generate the support and funding needed to develop a separate stand-alone facility. Table 2 (on page 24) outlines medical respite facility types and the benefits and challenges of each.

Freestanding Medical Respite Facility

Freestanding programs provide the highest-level of autonomy for delivering medical respite care services. In this model, generally one organization owns and operates the program in a separate leased or purchased facility that is designed specifically for medical respite services. The nature of a freestanding program affords the ability to control policies and procedures—including admissions, length of stay, the delivery of care, discharge planning, and health and safety guidelines. This creates an opportunity to design a program that is best suited to the needs of the people served in that community. Freestanding programs provide the conditions for delivering a higher level of medical care. This includes staffing models like 24-hour nursing care, and treatments like IV antibiotics. While a freestanding facility offers the highest level of autonomy, it can also be the most expensive facility type to maintain. As the entire space is designed specifically for medical respite services, the program must plan for all of the building maintenance costs, rent or mortgage, utilities, laundry services, janitorial services, etc.

Shelter-Based Facility

Many stand-alone respite programs begin within a shelter. Starting a respite program in this way allows the program to demonstrate the need for services and establish ongoing relationships within the community. Once the program is established, outcome measures can be used to demonstrate to hospitals and other partners the quality of care provided and the impact of the program on their clients.

There are numerous configurations within the shelter-based model, varying primarily in the intensity and comprehensiveness of medical and other services offered, as well as differences in who employs the staff. Like other models, it is responsive to hospitals and health centers looking for ways to support their clients who have no place to go to recover.

Shelters may be the primary organization developing the medical respite program in response to a community need. These programs will have specific space designated as the medical respite program, or medical respite beds, and will directly hire or contract the staff needed to provide

the clinical and supportive services. Staffing models may be a combination in which the shelter employs the care coordinators and case managers but contracts or collaborates with another organization for clinical and medical services. The care coordinators and/or case managers may also facilitate access to primary care.

Another format of a shelter-based medical respite program could be a collaboration between the shelter and the local health center. In these situations, shelters have set aside areas within their facilities for medical respite units where guests have access to nursing care and other supports, while the health center provides the management of admissions, respite, and clinical services. This model is similar to a freestanding respite unit, with the exception that the facility and beds are still provided by an existing shelter, and there are other shelter guests and activities taking place in the vicinity.

The intensity of clinical care provided within the shelter will vary depending on the space and relationship with community medical providers. However, shelters are often motivated to support a dedicated medical respite space, as they are frequently serving individuals in their shelter who would benefit from the additional support, oversight, and resources provided by a medical respite bed.

Motel/Hotel Vouchers

Some communities utilize motel or hotel rooms for respite care, either directly renting rooms as needed, or collaborating with other organizations to operate voucher programs. In this approach, the health and social services staff make "home" visits to the motels/hotels. Transportation is a key service that is provided for clients so that they can attend any needed follow-up appointments. Arrangements must also be made for providing meals and/or assuring that there are cooking facilities available. This can sometimes be accomplished through collaborative agreements with local meal programs such as Meals-on-Wheels.

Clients placed in motels or hotels need to be ambulatory, able to care for themselves, and require less medical oversight, as staff will likely not be onsite 24/7. In these instances, programs also need to ensure clear emergency procedures are in place and that clients are able to follow these procedures. This approach works relatively well for families and prevents separation during times of stress caused by health problems. Motel and hotels were also used extensively during the height of the COVID-19 pandemic when shelters and congregate facilities closed due to safety and concerns of transmission (NHCHC, 2020a).

Nursing Home, Skilled Nursing Facility (SNF), and Assisted Living Facility(ALF)

Nursing home facilities may be an essential part of the continuum of health care for people experiencing homelessness. For those who have temporarily lost the ability to perform activities of daily living (ADLs) due to a medical condition or acute injury, a Nursing Home or SNF may provide the opportunity to progress and regain ADL capacity. Once that level of independence with ADLs has been obtained, a client can continue their healing at a medical respite program. It

is important to note that nursing homes/ALFs/SNFs are not interchangeable with respite, and the ability to perform ADLs is the key difference. The issue brief *Barriers to Accessing Higher Levels of Care: Implications for Medical Respite Programs* provides an overview of the key differences between the levels of care and recommendations for ways these entities can more actively work together.

A medical respite program may have beds within a nursing home or SNF. This model is similar to the shelter model in which the program will operate the beds and provide care to the clients, but utilize the facility space (e.g., beds, meals). The clients of the medical respite program will not receive the SNF or nursing home clinical services. The medical respite program will provide the care coordination and connection to clinical and behavioral health services needed. Programs can also use a similar model within an assisted living facility. There are also some cases when the medical respite program may be required by their local government to be designated as an assisted living facility. In these instances, the program provides medical respite care (not a higher level of care) but meets the established regulatory guidelines for an assisted living program.

Transitional Housing or Recovery Program

These programs are generally located within a transitional housing facility or residential treatment center, where the program allows clients to stay for prolonged lengths of time. In this structure, clients have access to supports and services through the transitional housing or recovery program, with the medical respite staff focused on care coordination and medical needs. Clients will likely be with others not within the medical respite program and may also have to comply with additional facility rules to be eligible for their services. These programs may offer an additional pathway to housing and prevent a transition back into homelessness or shelter services.

Multiple Facilities / Scattered Site

For many established programs there are not enough beds to meet the community need for respite. For this reason, some medical respite programs have learned to complement the respite beds available in their stand-alone respite facility with respite beds in a shelter. Clients may be able to stay in a shelter bed while waiting for space in the medical respite facility. Inversely, clients may step down to shelter-based program as their health stabilizes, and then continue to transition to a regular bed in the shelter while waiting for housing. This is advantageous for programs because it facilitates timely discharge and frees up beds within freestanding programs. Programs may also supplement with motel/hotel rooms to accommodate families or couples, or those with isolation needs.

TABLE 2. FACILITY TYPE AND CONSIDERATIONS

Facility Type	Benefits	Drawbacks & Considerations
Free Standing	• Able to design space to implement clinical services. • On-site staff. • Can have private clinical spaces for care. • Control quality of physical environment. • Control admission criteria, policies, and procedures.	• Requires higher operating costs to run and maintain an independent building. • May need to rehabilitate an older or existing building. • Knowledge and compliance of local and state zoning laws and regulations.
Shelter or Shelter-based	• Minimizes costs of building, rehabbing, and maintaining a building. • May be co-located with other services (such as an onsite health center, case management, etc.). • May already have existing structure to provide regular needs (meals, laundry). • Eases transition from respite into shelter setting at discharge. • Expertise in providing shelter services to people experiencing homelessness. • Likely already serving individuals who need medical respite care.	• Respite program staff and administrators may need to comply with shelter rules that may conflict with preferred service delivery (e.g., harm reduction). • May not be able to provide private space to respite clients. • May not be able to accommodate all clinical services desired to be offered. • Less autonomy over decisions regarding the building, structural or programmatic changes. • May have to follow shelter policies, procedures, and admissions criteria (versus developing its own).
Apartments or Motel Rooms	• Does not require an independent building or structure and could operate within structures already existing in the community. • Ensures a private space or shared space is only between 1-2 clients. • Cost of program can be specific to the number of people referred. • Effective for families or people with a contagious illness requiring a separate space.	• May have difficulty negotiating access to rooms due to stigma regarding people experiencing homelessness. • Limited to no control over quality and upkeep of facility. • Scattered site and location may make it more difficult to engage with clients regularly. • A strategy to provide services, such as meals and transportation, will have to be developed.

Facility Type	Benefits	Drawbacks & Considerations
Assisted Living Facility, Nursing home, or Skilled Nursing Facility	• Facilities can accommodate a range of medical and clinical services. • Facilities will be accessible for varying ranges of mobility. • Minimizes costs of operating a stand-alone building and/or clinical staff. • Accommodations will be semi-private or private and include meals, laundry services, etc.	• May have a limited number of beds that can be reserved for medical respite. • May have limitations on diagnoses that will be accepted; may choose not to accept people with mental health diagnoses or symptoms, who have active substance use, or are on medication assisted treatment. • Staff may not be trained in trauma-informed care or best practices for people experiencing homelessness. • May have restrictions on client's leaving the building, limiting their ability to engage in outside services.
Transitional Housing or Substance Use Programs	• Limited costs to operating building/facility. • Can provide a direct transfer from medical respite into housing or a program for longer-term housing or care. • May provide additional services as part of the facility (such as case management or mental health services).	• Limited to no control over the accessibility, quality, or cleanliness of the building/facility. • May have to comply with program's regulations (e.g., requiring sobriety) which can limit some clients from being accepted. • Will require coordination between medical respite and facility staff, and onsite visits by the medical respite staff.

Considerations for All Medical Respite Facility Types

Facility Designation

The designation of the medical respite program will depend on the facility where it is housed, which guides the local regulations, zoning, and licensing that programs must follow. As noted at the beginning of this section, there is not one regulatory body to oversee medical respite programs and facilities. Therefore, programs will need to identify and adhere to their local regulations, some of which depend on the type of facility and its designation, along with who is providing the services. The Standards for Medical Respite Programs are applicable to all programs. Standards 1 and 2 focus specifically on the physical environment of the program.

Many medical respite programs that do not exist within other entities (such as a recovery program) will opt to be designated as an emergency shelter, and thus considered part of the shelter and housing continuum for people experiencing homelessness. These programs should follow the recommendations for providing emergency shelter services in addition to the *Standards for Medical Respite Care Programs*. The recommendations from the United States Interagency Council on Homelessness include:

- Provide dignity and respect for every person seeking or needing shelter;
- Divert people from the homelessness service system when possible. (This is especially critical if the person is newly experiencing homelessness because of their hospitalization or medical event);
- Adopt a Housing First approach and create low-barrier access to emergency shelters;
- Equip emergency shelters to serve as a platform for housing access.

Programs that are part of a health center or HCH scope of service will also follow HRSA facility requirements. Programs can review the HRSA Compliance Manual for those requirements.

As noted earlier, programs may be required to be designated as an assisted living facility (ALF). This will be dependent on state requirements and its regulatory bodies. Programs within transitional housing or recovery programs will have similar regulations based on their program designation and source of funding.

Ability to Provide Trauma-Informed Care

Each type of facility will have advantages and limitations when establishing a trauma-informed environment. More congregate spaces may increase social interaction but will have fewer private spaces for clients to complete ADLs or meet with providers. Facilities that offer individual rooms increase a client's privacy but may create difficulty engaging clients outside of required services. When developing the facility there are many considerations regarding color, furniture choice, and structure of the space.
Program developers can review the following to learn more about providing a trauma-informed environment:

- Trauma-Informed Care in Medical Respite Online Course
- Trauma-Informed Environment Webinar
- Trauma-Informed Environment Checklist

ADA Accessibility

Any program that is providing services is required to meet applicable ADA[5] guidelines. This is required regardless of source of funding or non-profit status (Department of Justice, 2010). Program planners should refer to the *Guidance on the 2010 ADA Standards for Accessible Design* (Department of Justice, 2010) to identify how facilities and programs should be structured for accessibility. The ADA National Network is a good resource in providing support, technical assistance, and recommendations for accessibility. It should also be noted that accessibility extends beyond physical access. It is also inclusive of accessible communication and ensuring non-discriminatory practices for any person with a disability, including physical diagnoses, cognitive disorders, traumatic brain injury, and mental health and substance use disorders.

Evolution of Programs

Regardless of which facility type an organization initially chooses, it may be a steppingstone to a more extensive program development later on. Some of the information necessary for planning an actual freestanding respite care unit may not be available immediately but can be gathered during the implementation of an intermediate approach, such as use of motel/hotel vouchers or collaboration with a shelter. Concerned communities across the country have developed a variety of innovative respite care programs, ranging from collaborative models that share space and services, to freestanding full-service medical respite units. There is no one model that works best for every community given the differences in client needs as well as available resources. Partner engagement from the community can be a vital resource in finding a facility and creating a medical respite program. Creativity and compassion are key to generating such resources.

[5] **Americans with Disabilities Act – ADA:** A person has a disability under the ADA if the person has

1. A physical or mental impairment that substantially limits one or more major life activities, e.g. someone with bi-polar disorder, diabetes or addiction to alcohol; or
2. A history of an impairment that substantially limited one or more major life activities, e.g. someone who has a history of cancer; or someone in recovery from illegal use of drugs; or
3. Been regarded as having such an impairment, e.g. someone who has a family member who has HIV, so is assumed to have HIV as well and face discrimination as a result, or someone who is perceived to have a disability and is treated negatively based on the assumption of disability.

Major life activities include, but are not limited to: walking, seeing, caring for oneself, learning, working, thinking, communicating and also the operation of bodily functions, such as neurological and brain functions (ADA, 2019).

Designing the Program

Designing the program occurs once the scope of services and facility have been determined. This process puts together the "nuts and bolts" of the program. Designing the program includes identifying staffing, provision of non-clinical services, and program operations.

Staffing

Staffing decisions can be made once the type of facility and clinical and enabling services are identified. The staffing of each program will be unique, based on partnerships and resources, and the services that will be on- versus off-site. However, in order to be in alignment with the *Standards for Medical Respite Care*, each program should aim to include staff that are licensed and/or trained to:

- Conduct screenings and manage referrals and the admissions process;
- Provide care coordination while in the medical respite program, including connection to primary care and enabling services;
- Conduct wellness checks and respond to emergency situations;
- Maintain a safe and clean facility.

Based on the scope and range of services and available resources, clinical and enabling service providers may be direct staff of the medical respite program or contracted through a partner agency such as a hospital, shelter, home health service, or health center. If the medical respite program is a collaboration among several existing programs or agencies, then a lead agency should be determined that will provide administrative oversight and human resources management to employees.

The type of staffing and services provided should be determined by the needs of clients (e.g., if the program is serving those with more complex medical needs, onsite clinical services will be necessary), funding, and partnerships available. Staffing models should be sustainable and be able to compensate staff appropriately for their expertise and job roles. Table 3 provides examples of how different facilities can be staffed. Details of personnel and titles will be specific to each program.

The publication, *Potentials Skills and Staffing of Medical Respite Care* includes in-depth considerations for developing staffing for medical respite programs by each Model of Care.

TABLE 3: EXAMPLES OF MEDICAL RESPITE STAFFING MODELS

Facility Type	Clinical Services	Enabling Services	Environmental Services	Safety & Monitoring
Free Standing Facility	Providers may be located on site and offer routine clinical services within dedicated spaces or in client rooms as appropriate. Providers may be direct staff of the medical respite program or contracted by partner agencies. If onsite clinical services are not available, transportation must be provided for medical appointments.	Providers should be accessible onsite to meet with clients and provide supportive services. Providers may be direct staff of the medical respite program or contracted by partner agencies.	Cleaning and environmental services staff should either be directly hired by the medical respite program or contracted through an outside company.	24-hour staffing is recommended, with personnel trained to follow emergency response procedures. If 24-hour staffing is not available, staff should complete check-ins with clients at least once every 24 hours.
Nursing Home / ALF / SNF	Onsite clinical services should be provided by the facility staff while clients are utilizing a medical respite bed. Partnership may be needed for behavioral health and/or substance use treatment.	Onsite enabling services may be provided by the facility staff. If not available through the facility, the medical respite program should provide enabling services directly or through a partner agency. This may be beneficial if onsite staff is not equipped to specifically address social work/case management needs of clients.	Environmental services will be provided as part of routine care and maintenance of the facility.	Facilities will likely provide 24-hour staffing and personnel will be trained to respond to emergency situations. Assisted living facilities may not provide 24-hour staffing, in which case emergency procedures should be clearly communicated to clients.

Facility Type	Clinical Services	Enabling Services	Environmental Services	Safety & Monitoring
Shelter-based/ Homeless shelter	Onsite clinical services may be provided if an appropriate and private space is available. Providers may be direct staff of the medical respite program that work within the site, contracted by partner agencies, or be a part of home health services. Shelters may be co-located within a health center or HCH site. HCH mobile clinics may also come to the shelter site. If onsite clinical services are not available, transportation must be available to medical appointments.	Providers should be accessible onsite to meet with clients and provide supportive services. Enabling service providers may be staff of the shelter setting and follow clients if they transition from the medical respite program to a shelter bed. If not available through the shelter, providers should be employed by the medical respite program or contracted through other partner agencies.	Environmental services will likely be provided as part of routine care and maintenance of the shelter. Additional environmental procedures may need to be in place if onsite clinical services are provided (e.g., hazardous materials disposal).	24-hour staffing and trained personnel will most likely be direct providers of the shelter facility. Additional emergency procedures and training may need to be in place for the medical respite beds/floor.

Facility Type	Clinical Services	Enabling Services	Environmental Services	Safety & Monitoring
Motels/ Hotels/ Short-term apartments	Clinical providers visit clients regularly at their room/ apartment. Providers may be employed by the medical respite program, contracted through other partner agencies, or via home health. Transportation is provided to primary care and other medical appointments.	Case managers visit clients regularly at their room/ apartment. Providers should be employed by the medical respite program or contracted through other partner agencies.	Facility operators should provide the needed cleaning and environmental services as part of a contract with the facility. Laundry facilities should be available onsite with monetary support for clients to access and use.	24 staffing may not be available in motel or apartment-based services, although it is recommended if possible. There should be a clear plan for responding to emergencies and clients should have access to phones to call for emergency services. There should be a medical respite provider or staff member checking in with clients at least once every 24 hours.
Transitional housing and Substance use programs	RN or other medical providers visit clients regularly at their transitional housing program. Providers may be employed by the medical respite program or contracted through other partner agencies. Transportation is provided to primary care and other medical appointments.	Case managers visit clients regularly at their transitional housing program. Providers should be employed by the medical respite program or contracted through other partner agencies.	Environmental services will be provided as part of routine care and maintenance of the transitional housing program. Support to access laundry facilities if none onsite.	Facilities will likely provide 24-hour staffing and personnel will be trained to respond to emergency situations. If the facility does not provide 24-hour staffing, emergency procedures should be clearly communicated to clients.

Non-Clinical Services

Programs will need to consider the logistics of providing access to 24-hour care and having clients living onsite, regardless of the facility type. This includes how meals will be provided, client transportation, and laundry services.

Meals

All medical respite clients should have access to three meals a day. How meals are provided will be dependent on the facility structure and capabilities, however, all meals should be provided onsite.

Meals prepared by staff within the medical respite facility should follow local and state regulations regarding food preparation and industrial kitchen standards. These meals should also be nutritious and healthy options should be provided to medical respite clients. Programs that are located within shelters may opt to use the meal services provided by the shelter, if onsite.

Programs can also choose to have a kitchen space for clients to prepare their own meals and store food. These spaces should be accessible and have adequate space to accommodate the number of participants within the medical respite program. Programs should provide the necessary supplies to maintain cleanliness within the kitchen space (e.g., dish soap, paper towels), as well as routine professional cleaning. Alternative meal options should be available to those unable to prepare their own meals. Programs should also assist clients in mitigating barriers to food access, such as applying for food stamps, accessing food pantry services, or supplying clients with groceries.

If onsite meal preparation is not available, programs should contract with meal delivery or service programs. Programs such as Meals on Wheels or other similar services can provide regular meals to medical respite clients. Clients should have a way to safely store or reheat food if they are not able to eat immediately (e.g., if all meals are delivered in the morning), and clean their dining spaces. Ideally, meals will provide clients with choice, be reflective of client preferences and culture, and be accommodating to different dietary needs.

If the medical respite program is located within a facility that does not provide or allow onsite food (e.g., some shelters do not allow food storage or provide meals within the building), a policy and strategy should be developed to ensure medical respite clients have access to meals. There are many reasons why it might be difficult for a medical respite client to leave the building for meals. Thus, accommodations should be made to allow for onsite meals and to minimize issues between respite clients and staff.

Transportation

Medical respite clients should have access to transportation for necessary medical and follow-up appointments. Programs can assist clients by offering transportation through a variety of methods. Programs may opt to purchase a vehicle for transportation, such as an accessible van.

They may also help clients navigate various ride services or systems (such as mobility services through public transit) and provide the needed funds to use the ride services. Programs may also facilitate the use of independent ride share programs, such as Uber or Lyft, and again, should provide the needed funds to use these services. Even if primary care and routine clinical services are available onsite, medical respite clients may need transportation to specialty care and follow-up appointments. Medical respite programs should inquire with local hospitals regarding available ride programs within the community. Depending on the location of the respite program, public transportation may not be available, or have routes to the resources that clients will need to access.

Laundry

Medical respite clients should be provided clean linens upon admission to the program. Additionally, they should have access to laundry services to wash clothing and personal belongings, along with being able to routinely clean bedding. Access to laundry can be facilitated in several ways. Programs may opt to have onsite laundry facilities that are accessible to clients. Those with onsite laundry facilities could also identify specific staff who will carry out laundry services on behalf of clients, with set schedules for laundry to be completed and returned to clients. Washers and dryers selected for onsite use should be those that are built to sustain a high volume of use, as well as bulky items, such as blankets. Alternatively, programs who do not have onsite laundry facilities may opt to contract with a laundry service or provide clients with prefilled cards to use at a nearby laundromat. If using a nearby laundromat, accommodations should be made to support clients who may have difficulty accessing the laundromat or need assistance to transport their items. Programs may also have a combination of services, including onsite laundry facilities for personal items and a contract with a service for program supplies, such as bedding and towels.

Program Operations

Regulations & Licensing

Programs must make sure that they comply with laws governing regulations and licensing on the federal, state, and local levels. There is currently no overarching regulatory body or licensing category for medical respite programs. Alignment with the Standards for Medical Respite Care will help to ensure quality services are delivered, but is not a substitution for local and state regulations. As noted in *Identifying the Facility*, the designation of the program and facility will inform which state and local regulations should be followed.

Applicable regulations are dependent on the scope of services, facility, staffing, and how other services are provided. Examples of different entities that will regulate aspects of the program include:

- State Board of Pharmacy: Regulates how medications are stored within the facility;

- Local Health Department: Regulates food preparation and distribution, management of infectious diseases, etc.;
- Local Building Codes: Specifies what aspects of the facility need to be in place for the building to be safe and usable;
- Insurers: May dictate how other services are provided (such as transportation) and facility requirements.

Programs will also need to be designed so that providers can comply with local licensing laws. This may include supervision and who providers report to, required licenses for services, and what interventions can be done onsite at the program. All staff providing services within the medical respite setting should also meet appropriate licensing and certification guidelines to deliver services within their job role.

Funders of the program, and the entity for overseeing the overall services, may also determine which regulations are applicable. For example, a program whose clinical staff is provided by the funding hospital will have to follow hospital regulations for providing community-based care. Similarly, a program staffed or operated by a health center must be included in the grantee's Scope of Project to assure Federal Torts Claims Act (FTCA) protection and reimbursement rates for health care services provided to patients with Medicaid. Programs that are billing for services through Medicare, Medicaid, and Managed Care Organizations will also need to comply with affiliated guidelines.

Following local and state regulations ensures that the care provided within the medical respite program is safe for clients and staff. It may seem overwhelming to identify and follow regulations and guidelines. This is where partners are valuable as a resource to provide guidance and make necessary connections. Beyond partners, it will be helpful to program developers to engage with community partners who may be providing similar services (e.g., local shelters) for guidance on regulations. Hospital and health center administrators may also be a good resource to for identifying and following regulations, and staff licensing procedures. Program developers should also connect with their local health department for guidance and resources.

Policies & Procedures

The medical respite program should have policies and procedures that encompass operations of the medical respite program, admissions/discharges, and provision of care. The program's policies and procedures will be dictated by local and state guidelines and regulations, type of facility, type of care provided, and mission and values of the program. The *Standards for Medical Respite Care Programs* identify specific policies and procedures that should be in place to provide quality care. Policies are the "what," while the procedures are the "how-to" of the organization. Table 4 provides examples of some policies and procedures that should be in place for safe operation of a medical respite program.

TABLE 4: EXAMPLES OF MEDICAL RESPITE PROGRAM POLICIES & PROCEDURES

Operations	• Response to life-threatening emergencies. • Fire safety standards. • Basic first aid. • The handling of alcohol, illegal drugs, and unauthorized prescription drugs found onsite. • The handling of weapons. • Prevention and response plan for staff and client safety. • Pest control. • Cleaning and disinfecting of premises and equipment.
Admissions and Discharge	• Admission criteria and screening. • Written code of conduct for clients. • Admission agreement for clients. • Discharge criteria for a planned transition from the medical respite program. • Discharge criteria for early or unplanned discharge from the medical respite program.
Care and Services Provided during the Medical Respite Stay	• Documentation of care coordination and clinical encounters. • Scheduling and implementing activities, groups, and services within the medical respite program. • Process for referring to, or connecting with, external partners to address health and/or enabling service needs. • Staff roles and job descriptions.

Much like following local and state regulations, it will be helpful for program planners to engage with partners and resources that already implement similar services. Medical facilities will have working knowledge and policies in place regarding clinical care, while shelters will likely have policies regarding cleaning, emergency response, and 24-hour management. These can be used as models to adapt and modify to meet the needs, capabilities, and values of the medical respite program. Any existing or adapted policies and procedures should be reviewed to ensure there are not any inherent biases, and that they align with the program's mission.

Client Engagement in the Program Design Process

Ideally, the planning groups informing the medical respite program development process will include clients and those with lived experience. The design of the program, from operations to policies, benefits from client engagement and feedback. It is important to be inclusive of the needs and priorities of those who will be or could benefit from the medical respite program. This feedback can inform the facility selection, services and structure of the facility, how services are accessed and delivered, and what additional activities may be onsite. Inclusion of client voice can both improve the quality of the program and prevent issues that may occur once the program is open. For example, clients might identify that the space designated for beds does not have enough room for them to store their belongings and bring the insight that program participants will not have an alternative location for storage during a medical respite stay. This information could influence the program in redesigning the sleeping/personal space or adding additional storage lockers and units.

The following resource is useful for intentionally developing client engagement in the program development process:

- *From Recuperation to Life-Long Leadership: Consumer Governance in Medical Respite*

Designing the Program Summary

Designing the medical respite program is a complex activity, but it is essential to ensure that the program is equipped to provide high quality care when it opens. Program planners should not hesitate to reach out to partners, community resources, existing medical respite programs, and NIMRC for support and examples to assist in this process.

Determining Costs

Determining the costs of a medical respite program is an important step in preparing to approach funders and ensuring the long-term viability of the designed program. Estimated costs should include the amounts needed to develop, launch, and maintain the program.

Start-up costs are what is needed to build and open the program. Start-up costs include things like purchasing a building, completing renovations, and obtaining equipment (such as blood pressure cuffs and computers) and supplies (such as linens and office supplies). Each program's start-up costs will be unique depending on existing resources, the type of facility, and the scope of services. Determining start-up costs will help planners understand the initial capital needed to create and launch the program.

Ongoing costs are what is needed to keep the program open and operating. Having an accurate estimate of ongoing costs is important *before* the program opens to ensure the proposed model is sustainable, and to identify consistent funding sources. These expenses will include salary and benefits for staff, upkeep and maintenance of medical equipment, the purchase of medical supplies, maintenance and upkeep of the respite facility/space, meals, transportation, etc. Similar to start-up costs, ongoing program costs will be dependent on numerous variables such as the scope of services, staffing structure, partnerships, and the facility.

Partners can be a useful resource in the cost-estimation and budgeting process. Administrators from shelters and health centers may be able to provide information regarding costs of equipment, building maintenance, insurance, and staff salaries. Planners may wish to consider appointing partners with experience in developing and maintaining large-scale program budgets as board members or advisory council participants. Accuracy in determining program costs is essential for ensuring sustainability and the implementation of consistent, high-quality services for clients. Being thorough at this stage of the process will support the next critical step of securing funding.

Programs can utilize the *Medical Respite Budget Tool* to help determine their start-up and ongoing costs. Please review the *Budget Tool: A Guide for Use* first to understand and most effectively use the Budget Tool.

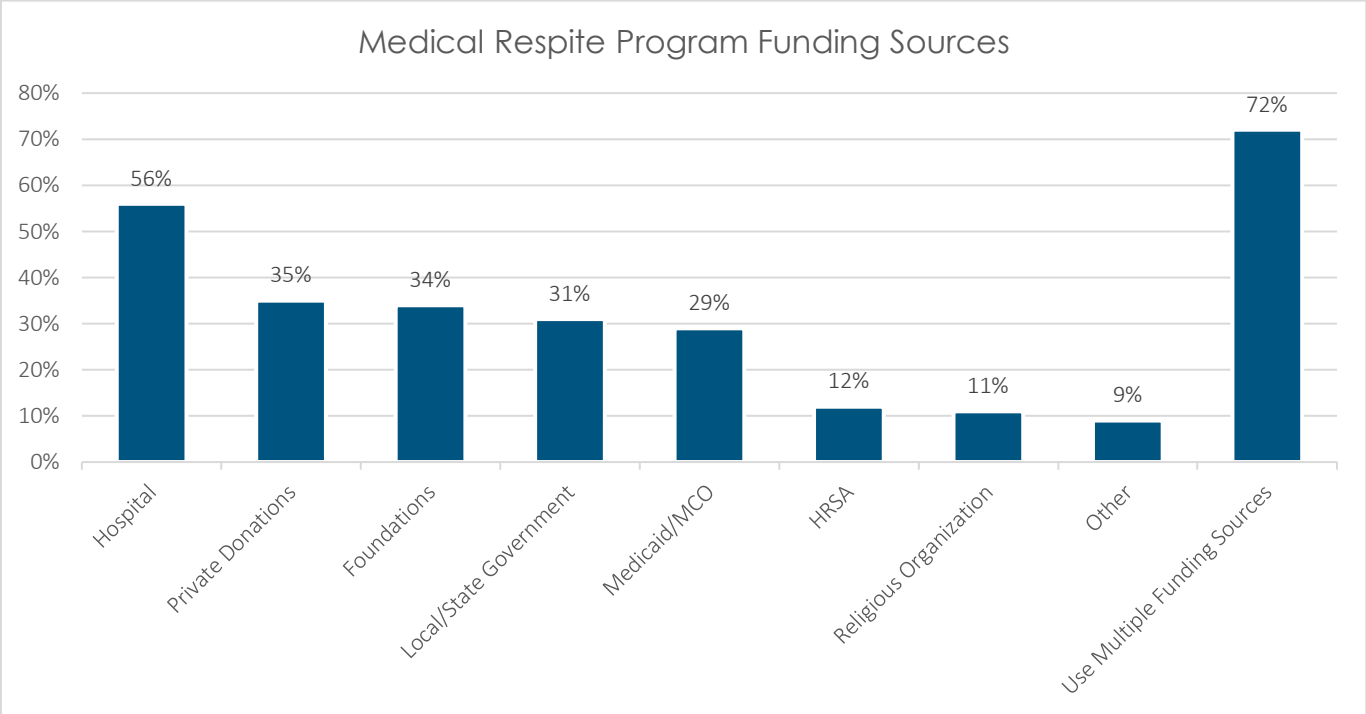
Funding

Most medical respite programs use more than one funding source to meet all program expenses (see Table 5). Determining how to fund a program can seem daunting; however, making the case for medical respite to funders has become easier given the increasing amount of evidence that shows positive health and cost outcomes (NIMRC, 2021a). Hospitals, insurers, and health care systems are increasingly focusing on interventions that improve care, reduce costs, and promote positive outcomes—a strategy known as the "Triple Aim" approach to health care that is promoted by the Institute for Healthcare Improvement. Medical respite programs are well-positioned to align their services with these larger goals to demonstrate their value and to negotiate appropriate financing.

This section outlines the common funding sources used by medical respite programs—noting the benefits and challenges to each type of funding—and outlines how to "make the business case" to funders. Note that policies regarding reimbursements and funding opportunities are rapidly evolving, so new financing approaches may emerge. More detailed information about the key funding sources is included below.

Before programs approach potential funders, a detailed cost analysis must be completed that identifies start-up costs and ongoing operational expenses, as covered in the previous section. This analysis will support the financing negotiations and ensure programs are strongly positioned to receive adequate funding to provide high-quality services.

TABLE 5: NUMBER OF MEDICAL RESPITE PROGRAMS USING EACH FUNDING SOURCE



Source: State of Medical Respite Care

Hospitals

Hospitals are often the primary referral source for medical respite programs, and they benefit directly from these placements as they contribute to shorter lengths of stay, reduced readmission rates, and safe discharge venues. Thus, seeking funding from hospitals is often a good starting point. Importantly, the Hospital Readmission Reduction Program established by the Centers for Medicare and Medicaid Services (CMS) aims to reduce avoidable readmissions by linking payment to quality of care (CMS, 2020).

There are five ways in which a medical respite program might receive funding from a hospital.

1. Per diem rate: A contract may be "payment per referral daily rate" in which the hospital pays a daily rate for each person referred while they are at the respite facility.
2. Flat case rate: A "payment per referral flat rate" is where the hospital pays a one-time payment for each person referred. In these cases, the medical respite program is guaranteed financial coverage for each individual referred.
3. One-time payments: An annual grant or payment from hospitals, in which programs receive a one-time, annual payment. This funding approach guarantees a predictable amount of funding each year.
4. Reserved beds: A hospital partner reserves a specific number of beds.
5. Community benefits funds: Non-profit hospitals are required to conduct community health needs assessments and dedicate a portion of funds to meeting those needs, which could include medical respite care for hospital patients experiencing homelessness.

When approaching hospitals for funding, program planners should identify which hospitals in their community are likely to refer patients to their program. These hospitals likely have participated in the partner and needs assessment process, although there may be additional hospital organizations (such as state hospital associations) that may be willing to fund the program that have not been involved in the process thus far.

Keeping a record of hospital costs that were avoided due to the program's intervention is also a good way to demonstrate value and the hospital's return on investment (ROI). This information makes a stronger case for continued/increased support in the next year. ROI data for one hospital can also be used to seek support from other hospitals, or to pursue other types of funding.

Benefits of Hospital Funding	Challenges of Hospital Funding
• A funding relationship with a hospital is mutually beneficial. • Hospitals may be more focused on the needs of the local community. • Medical respite may be seen as a tangible way to meet hospital goals (e.g., reducing ED readmissions). • Provides flexible funding that often does not require extensive administrative capacity or the purchase of specific software/ electronic health record (EHR).	• Funding may not be sustainable over time, or will require annual renegotiation. • Funding may not be able to cover the total cost of program operations. • Demonstrating the benefit may require data collection and analysis. • It may be jeopardized when specific hospital champions for the program leave the organization.

For further information regarding hospital funding and medical respite please see:

- *FAQs: Contracts with Hospitals*
- *Hospital Community Benefit Funds: Resources for the HCH Community*

Medicaid and Medicaid Managed Care Organizations

Medicaid is the primary health insurance coverage available to people experiencing homelessness in both Medicaid expansion and non-expansion states (NHCHC, 2020b), though Medicaid enrollment only extends to 21% of this population in states that have not yet expanded eligibility. Hence, pursuing Medicaid reimbursements may be most advantageous for programs located in expansion states. Engaging with state Medicaid agencies and/or Medicaid Managed Care Organizations (MCOs) is a promising way to establish sustainable funding. Medicaid systems have a direct interest in decreasing hospital stays, reducing overall costs of care, and focusing on quality of care measures (NHCHC, 2016). "Value-based payments," payments that are tied to defined health outcomes, are increasingly common in incentivizing specific results. There may be options to receive payments directly from state Medicaid systems (possibly under a fee-for-service model), though working directly with one or more MCOs may be a more common way to begin paying for services under Medicaid.

Medical respite programs may be established by, or in collaboration with, a community health center that has added recuperative care to its scope of service. Under this arrangement, many of the health care services provided during a medical respite stay could be billable under the health center's Medicaid reimbursement rate. For more information on health center partnerships, see the HRSA section below.

Other pathways for securing MCO reimbursements that are somewhat similar to hospital funding:

1. **Per diem rate:** The MCO pays a daily rate for each person referred while they are at the respite facility; a contract may be "payment per referral daily rate" .
2. **Capitated per-member-per-month (PMPM) rate:** The MCO pays a standardized monthly payment to the program.
3. **Monthly payments:** The MCO pays a monthly payment to the medical respite program to reserve a designated number of beds for their members.
4. **Flat case rate:** The MCO pays a one-time payment for each person admitted to the program, regardless of the length of stay.

Medicaid and/or MCO funding for medical respite care programs is currently an area experiencing significant growth, and brings unique benefits and challenges compared to grant funding:

Benefits of Medicaid/MCO Funding	Challenges of Medicaid/MCO Funding
• More sustainable funding arrangement. • Allows greater integration of medical respite into the larger health system. • May allow broader access to health care service utilization across the system to conduct better evaluations of outcomes. • Brings greater recognition of medical respite care as a standard component of care.	• Establishing a contract with a MCO may require entry into specific electronic health records, the purchase of equipment, and training of staff. • MCOs may also require additional information or activities from the medical respite program, such as submitting additional data on program/client outcomes and/or participating in case conferences. • Contracting with multiple MCOs can be administratively burdensome and yield disparities in payments and/or requirements between plans. • Plans also may require prior authorizations or other service utilization controls that may pose delays or barriers to prompt care.

For further information regarding funding through Medicaid and Managed Care Organizations please see:

- *Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care* (publication)
- *Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care* (webinar)
- *Medical Respite Care Online Course: Relationships with MCO's*

Local and State Government

Funding from local and state governments for medical respite care can vary widely by program, and is often dependent on individual community circumstances, availability of resources, or the type of facility. Engaging with HUD-funded Continuums of Care (CoCs) and/or the broader homelessness services sector may also identify partnership and funding opportunities, especially to help pay for beds, facility costs, or other expenses that other funding streams may not allow. The following are strategies to obtain state or local funding for medical respite:

- Embed the program in the local/county public health department.
- Embed the program in a municipal/state department of family services/human services/social services.
- Locate the program in a homeless shelter and identify homelessness services funds to support the residential component, which may be overseen by the CoC.

Programs seeking local or state governmental funding should involve relevant decision makers in the partner engagement and planning process to both identify potential funding sources and generate buy-in.

Benefits of Local/State Funding	Challenges of Local/State Funding
• Often flexible funding able to be used for many types of program costs. • Can fill gaps where other funding sources cannot be used. • May be motivated to address local/community needs.	• May be short-term and/or dependent on availability of ongoing resources. • May also depend on presence of local champion who may leave their position. • May be less available in less-resourced areas.

For more information on medical respite program and CoC engagement:

- *Expanding Options for Health Care Within Homelessness Services: CoC Partnerships with Medical Respite Care Programs*

Private Donations & Foundations

Funding from private sources (individual or corporate donations, in-kind contributions, or national or local foundation grants) is extremely valuable and may offer greater flexibility than is possible with public grants. Private and foundation funding may only be available for a specific period of time, often to cover start-up costs, and then have requirements for identifying other sources for ongoing funding thereafter. Those who are less experienced in managing private or foundation funding may want to work with more experienced community partners to identify opportunities for, and manage, funds.

During the application process, it will be beneficial for programs to have a clear outline of how services will be implemented and evidence to support projected outcomes. Grant amounts from local, private or foundation sources may be small or large, and local organizations may have a more vested interest in funding programs that will benefit their immediate community and make a valuable contribution to the program.

Benefits of Private/Foundation Funding	Challenges of Private/Foundation Funding
• Often greater flexibility than publicly funded grants. • Local partners may be highly committed to investing in the community.	• May be one-time only. • May only be available for a very limited timeframe. • May require completion of a lengthy grant application.

HRSA *(U.S. Department of Health and Human Services/ Health Resources and Services Administration)*

Medical respite programs operated by community health centers should consider using health center funds to support medical respite care services. In 2002, "recuperative care services" was added to Section 330 of the Public Health Service Act 42 USCS § 254b (the authorizing statute for the HRSA Health Center Program) as an "additional health service" that health centers are permitted to offer using their Health Center grants. If the medical respite program is added into the health center's scope of service, then HRSA grant funds can be used to cover health services (such as medical visits) that occur with the medical respite program.

Note: Although HRSA health center funds can cover the cost of health services and some supportive services, these funds do not cover costs associated with providing and maintaining the residential component of a medical respite program. Therefore, health centers that wish to operate a medical respite program often work collaboratively with a shelter or other housing-based program to balance program costs.

Benefits of HRSA Funding	Challenges of HRSA Funding
• A more sustainable funding stream. • Allows integration with the services of a larger health center and brings an administrative infrastructure (billing, human resources, etc.). • Increases integration and accessibility of clinical/medical services within program.	• Health centers are required to meet numerous requirements to be approved for funding and have a high degree of compliance activities. • Requires programs to be operated by, or in partnership with, a health center. • Will require additional funding source(s) to cover room and board costs.

More information on health center funding can be found at:

- https://bphc.hrsa.gov/about-health-centers/how-become-health-center

More information on Health Centers and Operating Medical Respite:

- *Health Centers Improve Health Outcomes with Medical Respite Care*

Making the Business Case for Funding

Making the business case for funding medical respite services starts with the ethical position that "it's the right thing to do." It should be obvious that discharging a person who has recently undergone surgery to the streets is *not* the right thing to do. Strengthen the ethical position with a needs assessment and other data to show how medical respite care can be beneficial to patients admitted into the program, the broader community, and funders. As described above, utilize NIMRC's *Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care* to help create a business case that focuses on the following aspects of care:

1) **Reducing hospital readmissions, length of inpatient stays, and emergency department visits.** Overall, medical respite programs have reduced the number of days a person experiencing homeless spends in the hospital due to the lack of a safe discharge location. Medical respite programs have also been found to reduce readmission rates following discharge from the hospital and reduce emergency room visits. When clients have a safe place to recover, connect with needed community services, and address underlying or complicating conditions, readmission rates to the ED or hospital are also greatly reduced.
2) **Shifting health system engagement from emergency services to community services.** Studies found that clients who have a medical respite stay were more likely to be connected to, and engage with, outpatient and community services, including primary care and behavioral health care. Often, utilization of community-based care was also found to increase after a medical respite stay.
3) **Reducing gaps in services.** Medical respite programs have been found to connect clients with essential services including Medicaid coverage, income (such as Social Security Income), and connection to housing services and programs. Medical respite provides an opportunity to address the intensive social service needs that cannot be addressed while in the hospital.
4) **Improving quality of life and recovery for clients.** Medical respite provides a place to meet basic needs and offers security, allowing clients to be able to focus on recovery and health management. Clients have reported positive outcomes from a medical respite stay, including increased feelings of safety and wellness.

When approaching funders, have an established method for data collection and analysis to demonstrate ongoing impacts and make the case for continued funding. Focus on the outcomes most relevant to the funder you are engaging, and specifically show how medical respite positively and directly impacts those outcomes. Have the estimated the amount of funding needed available, as funders may be unaware of the costs to start up and maintain a respite program. Having a specific "ask" demonstrates that the program has been well planned and helps to further the conversation towards an ultimate funding agreement.

For information on general financing approaches, see:

- *Medical Respite Care Programs & the IHI Triple Aim Framework*
- *Medical Respite Care: Financing Approaches*

Marketing the Program

Marketing the medical respite program is the step of the process where programs planners can begin to share details with potential partners. Throughout the program development process planners have built relationships with entities through needs assessments, planning meetings, and by seeking funding. Once the program or program plan is fully developed, marketing the program can serve several purposes, including:

- Soliciting organizations/entities to refer to the medical respite program;
- Informing clients of the role of medical respite and services offered;
- Raising awareness of the need for medical respite in the community and the issues facing people experiencing homelessness;
- Promoting the program to new and established funding sources; and
- Bringing awareness of the program to the community, which can generate additional partnerships, volunteers, and other supports.

There are several ways a medical respite program can be marketed. However, most new programs are operating on limited funds and budgets, so establishing a feasible marketing plan is essential. Developing methods for marketing is another opportunity to engage partners and those who may be able to donate time or services to launch marketing initiatives. Materials developed can include brochures or flyers, webpages, emails, social media pages or accounts, and presentations at community and board meetings. Any marketing materials should include key program information, such as:

- Mission and values;
- Contact information;
- Services provided;
- Admissions criteria; and
- Clear definitions of medical respite care.

Since the medical respite program is new and may not be known to some community entities, planners will likely need to do outreach to make others aware the program is established and ready to serve clients. Targets of marketing outreach may be discharge planners from hospitals, medical directors and board members of local hospitals, directors of local health centers, and directors and board members from local shelters. Although some of these entities may have been engaged throughout the process, sharing marketing materials will allow them to promote the program with their contacts and staff, further building awareness within the community..

The scope of marketing should match the space and readiness of the medical respite program. If the program is fully staffed with 10 beds available, the program should be widely marketed to begin admissions and care. If the program is still in development, is a smaller pilot program, or only looking for a specific resource, then marketing will be more targeted to specific entities that can address the immediate needs. If a pilot program is going to be operating 2-4 beds, marketing will more likely be targeted to 1-2 sources for referrals to prevent the program from being

overwhelmed. The respite program should never market or offer more services than they are capable of implementing. In order to receive referrals and maintain positive relationships with community partners, the respite program will need to be accessible and responsive, while maintaining their established scope of services. The more successful outcomes the program can demonstrate, the more support they will likely gain in their community.

It may be helpful to include or use the following in the development of marketing materials:

- *Models of Medical Respite Care*
- *State of Medical Respite Care*
- *Defining Characteristics of Medical Respite Care*
- *Executive Summary of the Medical Respite Literature Review*

Collecting Data and Evaluating the Program

Once the program has been designed and moves towards opening, program planners will need to determine a plan for program evaluation and collecting outcomes. Program evaluation and outcomes are what demonstrate that the medical respite program is effective, addresses the community's needs, and provides quality care.

Program evaluation is the opportunity to assess the operations and outcomes of the program. The program evaluation process informs quality improvement activities, identifies areas of strengths, and gives an opportunity to adjust aspects of the program that may not be functioning as intended. The evaluation process will likely include the collection of data that reflects program and client outcomes.

Programs will want to determine the initial outcomes they would like to track; establishing outcomes and methods for collecting data are much easier in early program stages than attempting to find data and information retroactively. Prioritizing outcomes helps establish consistent methods for which data variables will be captured and how data collection methods can be integrated into the routines of the program.

There are several outcomes that could potentially be collected. New programs do not need to focus on collecting all possible data but should instead focus on a few initial and key outcomes. The outcomes for each program will be determined by information required from funders, capacity of the program, information requested by priority partners and regulatory bodies, and what the program has determined will demonstrate effectiveness of their services.

NIMRC recommends medical respite outcomes from three major categories:

- Health outcomes;
- Social outcomes;
- Program outcomes.

Within each of these three categories, there are several listed potential outcomes that programs may determine to track, with recommended outcome measures, variables, and considerations. It is suggested that programs review *Outcome Measures and Data Collection: Recommendations for Medical Respite Programs* and *Identifying Outcomes for Medical Respite Care Programs* for specific details and guidance. It is important to determine outcomes that are actually measurable and can be tracked easily and consistently by the program staff.

Regardless of what outcomes are determined, programs will need to develop a plan for collecting the necessary data. Some electronic medical record (EMR) programs offer methods to easily search, record, and generate reports on information collected in the client's chart. Using the EMR for data collection is a streamlined way to gather necessary information, as it will be routinely entered into the chart by key staff and offers the needed security to protect personal health information (PHI). Similarly, programs that have access to a Homeless Management Information System (HMIS) can integrate medical respite outcomes into their preexisting HMIS

process. If the program is not using an EMR, HMIS, or other centralized ways of gathering data, planners will have to be more creative in developing their own tracking systems (e.g., a spreadsheet). If this is the case, the program will need to establish a plan to ensure their process is HIPAA (Health Insurance Portability and Accountability Act) compliant, or that all information is de-identified to protect the privacy of client. The program will also need to identify staff that are responsible for routinely updating the tracking system and how to keep the information secure (e.g., requiring a password to access the content).

Another component of data planning is determining at what point data will be collected during a client's stay at the medical respite program. One common example of a systematic approach is to align data collection with the admissions and discharge processes. This helps to ensure that data collection is formalized, streamlined, and captures data that can be calculated as a meaningful outcome. Programs will need to consider their structure, capacity, and resources before determining which process is appropriate.

Depending on the staff available and experience of the program planners, it will be useful to engage with partners who are experienced in data collection and outcomes. Partners with experience in data collection and analysis may be from hospitals or academic programs. Working with these entities from early program stages will help ensure the data collection process is feasible and sustainable and will identify the information needed to address the targeted outcomes. Additionally, programs may also consider community partners (e.g., hospitals, health centers, housing programs) that can help track outcomes that aren't available internally (e.g., emergency department visits, primary care appointments). This type of partnership can be extremely valuable, although it will require contractual agreements to ensure appropriate parameters are set around data sharing.

The outcomes identified by medical respite programs can be used in several ways. First, they may help the program meet guidelines for existing funding. They can also help the program demonstrate effectiveness to gain additional funding and community support. Beyond funding, outcomes are important in determining how the program is working and if it is meeting the needs of those it is intending to serve. In the program's initial or pilot year, it will be beneficial to check in more frequently on outcomes (e.g., quarterly) to identify any barriers to care, and to see if the program is on track. Identifying any problems early on will make it easier to resolve them, modify the program in response, and discuss with partners.

The following resources are recommended for more information on outcomes and evaluation:

- *Outcome Measures and Data Collection: Recommendations for Medical Respite Programs*
- *Identifying Outcomes for Medical Respite Care Programs*
- Online Course: Demonstrating Quality in Medical Respite Care: The Importance of Data

Section 3: Considerations for Implementation and Growth of the Program

Implementing a medical respite program is an exciting opportunity for communities to increase the quality and spectrum of care available to those experiencing homelessness. Program planners and partners will want to see the program's success to gain further support and capacity for growth. Many considerations and potential issues have been presented throughout this guide. This section adds a few additional considerations as programs move towards opening or expanding from a pilot.

Maintaining the Identified Philosophy and Culture of the Program

During the program development process, planners are encouraged to learn about, and implement, evidence-informed, trauma-informed, and harm reduction practices to guide the medical respite program. However, those planning the program are not necessarily the same people that will be providing services. Medical respite staff that are hired may come from programs or have experiences where philosophies differ than the respite program's. Planners and program administrators should be prepared to provide training to staff, both as a group, and during staff supervision, on important philosophies of care and specific strategies to implement. Providers unfamiliar with trauma-informed care will need time to complete training and to discuss ways to implement it within their settings. Planners and administrators need to ensure staff have allotted time to complete training and have access to resources to support these practices. Using the *Guiding Principles for Medical Respite Care* can support a program in identifying their mission and understanding the essential elements of providing medical respite care.

The Medical Respite Online Course *Trauma-Informed Care in Medical Respite* can be utilized by all program staff as training and support for implementing trauma-informed practices.

Review and Modifications to Policies and Procedures

It is hard for any program to anticipate all challenges and needs before opening. Programs should anticipate the need to review procedures and policies frequently throughout the initial year of the operations. These reviews should include feedback from staff, clients, and community partners to identify areas for improvement. This feedback can also help to identify improvements to processes, resulting in better outcomes for clients. Reviews of policies and procedures can come through anonymous feedback forms, staff meetings, and planning meetings. These meetings will also provide an opportunity for staff to coordinate and grow as a team as they navigate the challenges and successes of respite together.

Managing Inappropriate Referrals

Due to a lack of resources in continuums of care and health services experienced by many communities, it is likely a medical respite program will be encouraged to admit clients whose needs are beyond the scope of care provided by the program. New programs may be tempted to admit these referrals in order to fill beds, promote positive relationships with referrers, and appease partners. Programs may also feel compelled to help the client when it appears there is no other option available. Although medical respite care requires flexibility, medical respite programs should aim to be consistent with their admission criteria for several reasons. First, of utmost importance, is client and staff safety. A person who requires a higher level of assistance and care than what is provided in medical respite will not be able to safely reside in the respite program. Staff will likely attempt to assist the client in their care, but without adequate training and equipment, injury can occur to both staff and clients. Second, taking on clients with higher needs may violate certain licenses acquired by medical respite care, such as dispensing medications. This can place the facility and its providers at risk. Finally, from an advocacy standpoint, if the medical respite program accepts inappropriate referrals, this decreases the pressure on other facilities to provide appropriate care. A skilled nursing facility that refuses to take people experiencing homelessness, or who have a history of substance use, will only continue that pattern if there is no longer pressure to do so and medical respite care is filling that gap. Medical respite programs can track the number of referrals received for clients requiring a higher level of care and use that to advocate for the need to expand skilled nursing facilities or health coverage in their community.

Responding to Changing and Evolving Health Needs

The medical respite program and its services will be developed in response to the needs of the community and clients. However, programs should be equipped to grow or modify the clinical services being provided as the needs of the community change. This has been exemplified by the COVID-19 pandemic, in which medical respite programs had to respond and modify their care for the safety of their clients. In some cases, programs had to transition into being isolation and quarantine sites for those with positive symptoms of COVID. Hopefully this significant challenge is not one that will occur again soon, however, it demonstrates the flexibility of medical respite programs. Programs can be equipped to respond to a community crisis and should be prepared to work with their community to adjust services as is safe and necessary. Programs may opt to re-complete a needs assessment with hospitals and health centers in their community to ensure services being provided continue to be responsive to community needs. Doing so will also help the program identify ways in which they can expand, such as offering beds for pre-operative or procedural care (e.g., colonoscopy prep) or for stabilization to prevent hospitalization (e.g., management of diabetes).

Responding to Changes in Health Care

Medical respite programs will also need to stay engaged with changes to health care policies and the climate in their area. Significant changes may have large implications for medical respite programs in their funding and service delivery. National, local, and state policies will all impact how health care is delivered in a community, whether it is through increased funding for certain types of services, or regulations on care. Programs will need to stay engaged and aware of policy changes that could both support and hinder their delivery of services. Keeping up to date with, and understanding these implications, can be complicated. This is another instance in which engaging with community partners will be beneficial to understand what is changing and what the intended or potential effects are. Programs can also stay informed through the National Institute for Medical Respite Care and the Respite Care Providers Network.

Conclusion

The growth of medical respite care programs across the country indicates the continued need for more robust and comprehensive health services for people experiencing homelessness. However, it also indicates the growing concern of communities and health systems establishing high quality and alternative discharge options to promote health and recovery. Those who have come together to design and implement a medical respite program are pursuing an evidence-based and humane solution to the country's current health and housing crisis. Medical respite program planners join a network of those committed to providing quality and safe care for those experiencing homelessness that are in need of a safe space to recover, in turn benefiting their communities and the people that live within them.

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