CASE STUDY

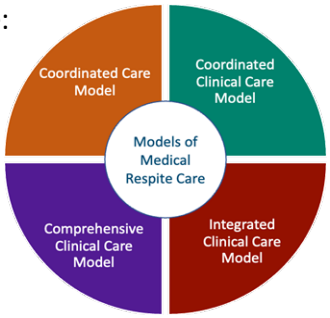
Models of Medical Respite Care: Program Examples

July 2023

Introduction

Medical respite care[1] (MRC) is defined as acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. While programs vary in size and structure, they are all guided by the Standards for Medical Respite Care Programs, and share the same fundamental elements: short-term residential care that allows people experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and supportive services.

The National Institute for Medical Respite Care (NIMRC) developed the Models of Medical Respite Care in response to the need for programs and policy makers to have clearer guidance on what constitutes medical respite care. MRC programs develop services in response to the needs of the community and clients[2], thus variability is expected. However, each program should include the same key components, and align their service delivery with one of the Models of Care. The Models describe what services the client has access to while in medical respite, and the differences in intensity, location, and delivery. The four models of MRC are:



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

To further demonstrate how medical respite programs respond to community needs within each Model of Care, a series of case studies has been developed to highlight three programs operating under each model. 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, unless a program specifically identified its participants by another word. **This document provides examples of how programs operate under each of NIMRC's four Models of Care by expanding on their individual staffing models, level and intensity of services provided, and partnerships with community organizations.**

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

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

Coordinated Care Model

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

Program 1: Brother Francis Shelter

Anchorage, Alaska

David Rittenberg, Sr. Director of Adult Homeless Services

Number of beds: 10
Length of Stay: 20 days
Referral Source: 3 major hospital systems
Funding Source: 3 hospital systems donate operating dollars annually

Inside the Brother Francis Shelter in Anchorage, Alaska is a 10-bed medical respite program that started as a 2-bed pilot in 2016 through Catholic Social Services. Medical respite was one of the first projects that all three local hospitals came together for collaboration. In the last calendar year, the program has logged 144 stays for 124 individuals. The average length of stay is roughly 20 days, a number identified by the referring provider. The maximum a client can spend in medical respite is 60 days. Senior Director of Adult Homeless Services, David Rittenberg, states that having the provider determine the length of stay at hospital discharge has been the biggest learning experience for the program. “We don’t have that medical expertise and we have big hearts, so putting that in the hands of the medical provider has helped us serve more people and turn beds over more.” The medical respite program can adjust the discharge date based on the referring provider's recommendations, and typically discharges respite clients to the shelter on site.

Partnerships with outside providers are essential to the operations of the medical respite program. Home-based services, such as wound care, physical therapy, IV antibiotics, and more can come into the program to provide care to clients if the referring hospital arranges them upon discharge. Respite staff work to get clients connected to primary care and basic needs services. The respite program can also help with **transportation** to appointments through the shelter van or use donation dollars to pay for taxis. Clients can securely store their own medications in their rooms and have minifridges for items such as insulin. Breakfast, lunch, and dinner for the program are purchased from a local vendor. All **meals** come prepared, as there is no kitchen on site. In a nearby building on the same campus, Catholic Social Services has recently opened a new Navigation Center where over 30 community organizations utilize the space to provide resources that any person experiencing homelessness, including medical respite clients, can access.

Speakers and other guests regularly come on site to talk to medical respite clients about topics relating to physical health and social and emotional wellbeing. Other recreational activities include lunch buy out days (such as pizza), movie watching, reading, group discussions, summer gardening, and in-house art and music groups. Occasionally the medical respite clients take trips to the

Anchorage Museum, the Alaska Native Heritage Center and have even gone to watch The Nutcracker live.

Staffing the medical respite program requires a program manager, a program coordinator, and support from the Brother Francis Shelter staff. The program manager and coordinator work processing referrals, intakes, and discharges. They also help clients with short-term issues by connecting them to outside resources. They assist clients in obtaining vital documents for identification cards, public assistance applications, medical resources and get them connected to Anchorage's Coordinated Entry System. Working hours for these staff positions are daytime only, and medical respite is supported by the general shelter staff on evenings/weekends. Medical respite is in a private wing connected to the main shelter and staff complete regular checks through the space each hour. However, due to the staffing model and the high level of privacy, individuals with active and more significant behavioral health or substance use challenges have proven to be difficult to serve well.

A piece of wisdom from David to new or developing medical respite programs is to wait 6 months to a year before starting academic research involving the program. Allowing your program time to learn and adjust is important. The respite pilot obtained IRB approval and started research close to day one, which locked them into a research model that they could not modify or change. As the program evolved, they realized changes must be made to navigate the program development process, which negatively affected the more rigid research design. Reserving the ability to remain flexible when designing and implementing a new program is vital for creating a sustainable model that best serves the community's needs.

Program 2: Gospel Center Rescue Mission Recuperative Care
Stockton, California
Sandra Maple-Deaver, Recuperative Care Program Director

Number of beds: 15 male beds; opening 7 bed women's facility
Length of Stay: 30-90 days
Referral Source: hospitals in San Joaquin County
Funding Source: Hospitals, Health Plans (CalAIM), DCHS

The Gospel Center Rescue Mission (GCRM), a shelter-based medical respite program, opened in 2008 in partnership with a local community medical center. Those admitted to the program are called 'students' because they come to respite to learn skills to better manage their wellbeing. The campus offers programming outside of shelter and medical respite, including a two-year men's program that has three phases, and New Life, a faith-based program for women and children. Medical respite students can sit in on program activities, an opportunity that a general shelter stay does not offer. Additionally, many transition out of medical respite into a long-term program offered by the Mission.

Medical Respite provides three **meals** a day from an on-site kitchen, with the evening meal open to the general public. Hospitals referring to medical respite are requested to schedule a primary care appointment for the individual and send 7 days of medication. Once accepted, students attend **clinical appointments** at the medical facility on campus and/or at a local clinic. They are also able to utilize the mobile clinic that comes on Thursdays or do a telehealth appointment with the campus doctor. A behavioral health care provider is on call, a psychiatrist is available at the campus clinic, and referrals can be made to other community providers or the local crisis center. Substance use needs can be met by enrolling in the campus New Life program or receiving a connection to a hospital detox or other community organization.

Essential components for the success of students in the program include coordination of transportation to appointments and medication management. **Transportation** is offered with the local health plan, which pays for transport to medical appointments for individuals with disabilities, or by utilizing one of GCRM's wheelchair accessible vans. They also have two 28 passenger buses that can be used for group outings. Staff manages medications by storing, locking, and logging upon dispensing. In the future, the Mission has hopes of renovating existing property to rebuild ADA accessible buildings to accommodate more individuals in medical respite and shelter spaces.

Case management is provided on site, including support by individuals with lived experience. In total, the respite program employs 7 **staff**: a director that oversees operations and solely manages referrals, a director assistant that also oversees operations, 4 full-time "house men," and a driver that facilitates transportation services. Referrals to medical respite are sent by local hospitals and clinics within the county, or clients can be admitted on a preventative basis if it is suspected they will soon end up in the hospital. Once a referral is received, the hospital patient is met with in person to discuss the program and have an opportunity to ask questions before coming to medical respite. This face-to-face meeting has decreased the number of no-shows and helped alleviate the fear of the unknown for people coming to respite. Medical respite is funded by hospitals, CalAIM (Medicaid), and the Department of Health Care Services.

Gospel Center Rescue Mission is the oldest operating low-barrier shelter in San Joaquin County (for over 82 years), and as the only recuperative care program in the county, they have provided over 100,000 beds in the past 13 years.

Program 3: Firehouse Ministries Respite Program

Birmingham, Alabama

Abby Poole, Medical Social Worker

Number of beds: 10
Length of Stay: 6 months
Referral Source: 5 local hospitals/walk-ins at emergency shelter
Funding Source: Grants

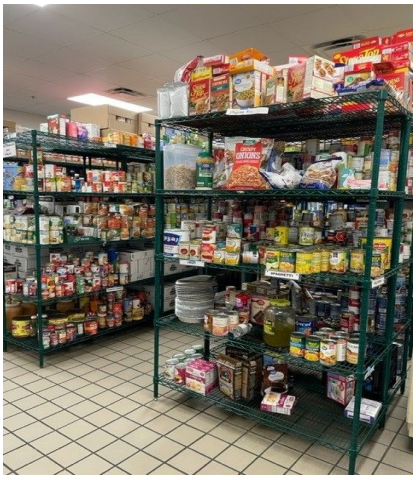
Within the Firehouse Ministries Emergency Shelter, a 10-bed medical respite program provides a safe place to heal for men in Birmingham, Alabama. The low-barrier shelter implements harm reduction practices, and sobriety is not required. Clients can leave the building but are expected to attend medical appointments and meet their case management goals. UAB Beacon Recovery comes on site to assist with outpatient substance use treatment services, such as medication assisted treatment (MAT). Staff prioritize meeting individuals where they are at and use motivational interviewing with those that are in pre-contemplation to address hesitancies and barriers related to participating in services offered. Cahaba Medical Care comes to the shelter once a week to provide **medical and behavioral health care**, prescription refills, and to facilitate ongoing care at their clinic after discharge.

Living space at Firehouse

Referrals to medical respite can come from local hospitals or internally through walks-in for the emergency shelter services. Medical Social Worker Abby Poole, who oversees medical respite, has worked in collaboration with shelter staff to help them become advocates for medical respite and identify clients that need connected to care. The unique placement of the program within the emergency shelter allows access to clients that might not have had an opportunity to receive the care they need. The Firehouse **staff** is a comprehensive team that includes shelter program assistants, peer specialists and case managers who can provide services to those in respite. Other staff supporting the program includes executive director, Nicole Boomhover, Val Green, assistant director of the shelter, a shelter coordinator, Rob Davis, and overnight security. Currently, medical respite is funded solely through grants.

On average, clients stay in medical respite for 6 months. During this time, **meals** are provided by volunteer groups through an on-site meal coordinator that works in the kitchen. Community organizations donate food to provide meals and snacks to any individual staying in the shelter. Two company vans provide **transportation** to outside appointments, and Senior Ride, through the United Way, and Birmingham On-Demand can be utilized as a backup resource. Organizations that come onsite to provide the men with

resources include Recovery Resource Center, Alethia House Mobile Health Unit and MAT group therapy/assessments, JBS Mental Health Authority, Volunteer Lawyers, and the UAB Health Clinic, who provides health education and check vitals every Wednesday. Clients are responsible for storing and taking their own **medications**, but staff provides locked storage for narcotics. InToto, a local creative arts organization, offers movement class (yoga/dance) and art therapy (poetry or art projects) in the shelter space, and NA meetings and Bible studies are also available for clients.



Kitchen Pantry at Firehouse

The **partnership** with Cahaba Medical has contributed immensely to the success of residents at Firehouse Medical Respite. Their providers review the medical records of referred patients and provide clinical insight about who is appropriate for respite. This allows transitions to happen quickly, and the accessibility to Cahaba's medical care has decreased the average length of stay from one year to 6 months. Assistant Director of Firehouse Shelter, Val Green, reports that a recent housing grant was awarded to the program specific to supporting respite clients transitioning into more permanent placement after discharge. "It can't be emphasized enough: our success is our ability to provide quality care, to a population facing significant barriers, with limited funds and resources."

Coordinated Clinical Care Model

The **Coordinated Clinical Care Model** focuses on individualized case management and provides basic onsite medical services. Additional services are offered through community connections and partnerships.

Program 1: Sojourner House Medical Respite
Oak Park, Illinois

Holly Rotman-Zaid, Director, Medical Respite

Number of beds: 3-5
Length of Stay: 3-6 months
Referral Source: Trinity Health (Loyola Medical, Gottlieb Hospital, and MacNeal Hospital)
Funding Source: Multiple funding sources; Main funder- MacNeal Hospital Foundation

Sojourner House provides medical respite care in Oak Park, Illinois, in partnership with MacNeal Hospital (part of Trinity Health Loyola Medicine) for clinical care, and Housing Forward for case management. Sojourner House is one of two medical respite facilities operating under Housing Forward, the other being the RISE Center of Cook County. In their fourth year of operation, the medical respite program resides within a large house divided into 5 apartment-style units. Respite rooms are single occupancy (3 studios and 2 larger one bedrooms), with each unit having its own bathroom. While men predominantly make up the census, women are also accepted, as well as small families.

The **staffing** required for operations includes medical respite director Holly Rotman-Zaid, a case manager split between Sojourner House and the RISE Center, 2 engagement specialists from 4-9pm, and an AmeriCorps volunteer that comes 1-2 times a week to engage with clients. The volunteer was also the fourth client to ever stay at Sojourner House. Clients have a large backyard for recreation, as well as a small community room to gather occasionally.

Community **partnerships** are vital for successful service delivery at the medical respite program. A local surplus food program packages up **meals** and delivers them twice a week. Clients are also able to go shopping off site or get items from the local food pantry. **Medical care** is provided once a week by MacNeal Hospital's Dr. Bareis, along with Housing Forward's community nurse, Arletta Curtis. They provide instructions to the client and nurse assists for a care plan during the rest of the week. Clients are referred out to local providers for behavioral health and substance use needs, and **transportation** is facilitated by using Uber Health Rides or disability bus passes. Sojourner House places an emphasis on being a low-barrier residence by meeting clients where they are at, keeping naloxone on hand, and not requiring sobriety for admission to medical respite.

In her interview, Holly stated one of the most effective professional training courses she's had was on Trauma Informed Care. The training began with a visual of the word trauma and an arrow pointing to the word kindness. This directly impacted her as a professional, as kindness in care is

prioritized at Sojourner House. "Our biggest success is that almost every person that leaves our program gives us a big bear hug and whispers in our ear 'You saved my life. Without you I'd be nowhere—I'd probably be dead on the street.' I think that's a huge component of what medical respite needs to be, whether it's a small program or a large one."

Program 2: Recoveryworks
Lakewood, Colorado

James Ginsburg, Executive Director

Number of beds: 7 individual rooms, 3 with bunk beds (13 total beds)
Length of Stay: 30 days
Referral Source: Hospital contracts: Lutheran Medical and University of Colorado Hospital
Funding Source: Lutheran Hospital has 2 paid beds; UC Health has 1

Living Space at RecoveryWorks

In Lakewood, Colorado RecoveryWorks is operating a low-barrier, harm reduction focused, medical respite program. Medical respite is housed on the second floor of a building that also offers a daytime drop-in center on the ground floor during the mornings and focused case management in the evenings. The medical respite program can accept any gender, various family dynamics, including caregivers, pets, and patients on oxygen. The second-floor location does require that individuals referred are ambulatory, but there is hope in the future that medical respite can occupy a ground floor space to be more accommodating.

The two referring hospitals pay for 3 total beds at a daily rate. RecoveryWorks has MOUs with mental health and primary care providers, the local FQHC, and is in negotiations with two other hospitals. Obtaining payment contracts for 7 beds would allow the medical respite program to be self-sustaining. Guests can also be referred to medical respite internally if they come through the day center and need care. The current length of stay is 30 days, but that can be extended if connections to more stable housing are in the works, or a slightly longer recovery time is needed. The current **staffing** model includes 2 FTE case managers, overnight staff, volunteers, a respite monitor in the evening, and a lead safety person during the day drop-in hours that is trained in crisis prevention, de-escalation, and trauma informed care. Volunteers do acupuncture on site, host substance use recovery groups, and clients can access the courtyard for recreation, hold barbeques, movie nights, and have an on-site garden. Once admitted to the medical respite program, guests are responsible for managing their own medications, but they can be locked away by staff if necessary. Three **clinical nursing** providers from Stride Community Health Center see respite guests

Participant of RecoveryWorks

once per week, and they are also available on an as needed basis. Follow up appointments are set by the hospital at discharge, so the medical respite program is generally only responsible for **coordinating** Lyft rides if public transit can't be utilized. Other on-site services include a weekly syringe exchange, a monthly DMV service that assists with obtaining IDs, and Benefits in Action, who comes to help guests with Social Security and county benefit applications.

Participant of RecoveryWorks

Meals are provided by a 3-year grant from Kaiser Permanente to help fund medical respite, a part of which is Project Angel Heart, who brings meals to the community. Kaiser paid for one year of their high quality, frozen meal delivery that is diet specific and can be tailored to the individual. Volunteers also coordinate family meals for all guests. Participants attending the drop-in center, and those in respite, get a light breakfast (bagels, eggs), and day staff prepares a basic lunch. There isn't an oven in the building, but there is access to a stovetop, microwave, and toaster.

One of the most unique **partnerships** RecoveryWorks has is with Jefferson Center for Mental Health, who placed an on-demand, behavioral health kiosk at the medical respite program. This computer allows guests to connect quickly with a provider, be triaged, and they then can be offered an immediate therapy session, with an out-patient follow up appointment scheduled. Being trauma informed is important for any medical respite program staff, and Executive Director James Ginsburg also emphasizes having staff that is diverse, including BIPOC, aged diversity, and having those with lived experience in homeless services and addiction.

Program 3: COTS Recuperative Care
Petaluma, California

Julia Gaines, COTS Senior Supportive Programs Manager

Number of beds: 8
Length of Stay: 4-6 weeks/90-day maximum
Referral Source: Providence Health and Kaiser Permanente
Funding Source: 2 referring hospitals provide annual flat rate, Health Plans (CalAIM),

Committee on the Shelterless (COTS) Recuperative Care center is located within a shelter in Petaluma, California. The main respite dorm offers six beds, with two of the beds located in a private room. Clients come to medical respite from Kaiser Permanente and Providence Medical Group, both of whom also fund the program annually. Respite is also funded through CalAIM reimbursement. Referring providers initially estimate a discharge date of 2 weeks, but the average length of stay is 4-6 weeks with a 90-day maximum. Roughly half of the medical respite clients discharge to the shelter after healing from their illness or injury.

Julia Gaines, Senior Supportive Programs Manager, works **collaboratively** with three recuperative care specialists that provide case management and health coordination, and a **nurse practitioner** that sees patients on site. Medical respite specific **staffing** is limited to daytime, evenings, and weekends, but the shelter provides overnight staffing for monitoring and emergencies. Clients are supported in managing their own medications by being provided with pill containers and locked storage. Respite clients receive three **meals** per day, prepared by an on-site chef, and food is received through donations and from local grocery stores. Lunch and dinner services are accessible to the entire community.

COTS operates as a low-barrier and harm-reduction focused program, and clients can leave the facility as long as they return in time for the 10pm to 6am curfew. Access to MAT and other substance use treatments, behavioral health care and primary health care is available through **partnerships with community providers.** Hospital discharge planners are responsible for scheduling follow up medical appointments, and medical respite staff assist with scheduling **transportation** through Medicaid, or they provide it with a company vehicle. Respite care specialists also refer clients to specialty services, such as Home Health, and organizations for seniors, veterans, and domestic violence programs. The program offers in-house recovery and life skills groups, art therapy four times a week, and has a library with recovery resources and games. Upon arriving at medical respite, clients are given a set of headphones so that they may watch television on their individual devices and are connected with a peer mentor to orient them to the respite program.

“What makes us COTS is that we go the extra mile and are focused on the solutions.” Julia went on to say that she is proud of the quality of care that staff provides for clients and their willingness to let them be themselves and work on their personal goals. The program is proud to be expanding into a new space later this year that will house 20 beds and offer 24/7 care. “The city and county are seeing the importance of our work, especially with the aging population.” Although there is a large number of older adults in the shelter, they are seeing progress being made towards permanent housing and a reduction in returns to the emergency room after leaving medical respite.

Watch a virtual site tour of COTS Recuperative Care here.

Integrated Clinical Care Model

The **Integrated Clinical Care Model** focuses on individualized case management and onsite clinical supports that address the acute health needs of program consumers. Additional services are offered through community connection and partnerships, especially in preparation for transition and discharge.

Program 1: Deborah Smith Walsh Recuperative Care Center
Lynn, Massachusetts

Gargi Cooper, FNP

Number of beds: 10
Length of Stay: 2-6 months
Referral Source: Massachusetts General Hospital, Lynn Community Health Center, street outreach
Funding Source: Medicaid, grants, contracts that pay per diem

On the second floor of the Massachusetts Coalition for the Homeless building, the Deborah Smith Walsh Recuperative Care Center has been providing medical respite care since 2017. Through close work with the Continuum of Care (COC) and community organizations, the respite program has housed an average of about 20 clients per year. Medical respite referrals are submitted by community hospitals, clinics, street outreach programs, or home visits that occur within the community. Clients are seen daily Monday through Friday as an outpatient billable service. Medical on-call services are available to support the residential team during off shifts and weekends. Multiple grants, including State Opioid Response (SOR) and SAMHSA, provide funding support for the medical staff. Residential services are provided by LifeBridge, a Northshore based shelter provider. The respite program is owned and operated by Lynn Community Health Center.

Medical Director Gargi Cooper, FNP, stated the medical respite staff prides themselves on being "dedicated to judgement free care, addressing barriers to wellness, and providing the highest quality health care to our cities most resilient population." The **respite outpatient clinic** serves as a walk-in clinic Monday through Friday, providing recovery services, case management and episodic and acute medical care. This level of care includes a harm reduction approach where clients can be assisted with getting connected to a detox facility while a bed is held for them. Upon arrival at medical respite, clients can receive Medication Assisted Treatment (Suboxone, Sublocade, Naltrexone), participate in AA/recovery groups or be connected to IOP. The walk-in services provide a shower program 3 days a week which helps with engagement and promoting wellness for clients living outside. The medical respite is **staffed** 24 hours a day by a program director, a case manager, an operations assistant and two direct support professionals on the evening and overnight shifts. The medical team is comprised of a team medical director, a physician's assistant, team nurse, medical assistant, two case managers, front desk/care coordinators, a part-time social worker, and a behavioral health/psychopharmacology clinician 8 hours a week.

Clients can receive medical, behavioral, and substance use services on site, but they are also connected to ongoing care with community providers. On-site nurses pre-pack medications for clients in a 7-day Mediplanner, where they are then locked and stored, but clients self-administer. Printed medication cards are also given at discharge to assist with ongoing medication management and support. The medical respite program has accepted individuals with acute and chronic medical diagnoses, those needing wound care, pre/post op care, individuals with cardiac and respiratory illnesses, treatment of Hepatitis-C, HIV, diabetes, recipients of cancer treatments, and provided support for end-of-life care.

Once arriving at medical respite, clients can only leave for scheduled medical or social service appointments. Guests can make an individual schedule with their case manager to support their needs, including going to the store, reconnecting with family members, and working with legal and social services to help navigate their housing goals. Recreation provided during the stay includes a living room area with a TV, art therapy, and games. Community dining helps foster social connections in the recuperative care center. Lynn Community Health Center provides behavioral health groups that respite clients are eligible to participate in. The medical respite program continues to work on much needed programming goals to incorporate physical activity on-site, such as chair yoga, and plans to partner with a local gym to establish wellness routines.

Local **partnerships** include maintaining connections with the clinical and behavioral health providers the clients come to respite formerly affiliated with, or new providers the clients are referred to. **Transportation** is provided by Mass Health (PT-1) and Uber Health (paid for by grant funds), to assist clients with rides to medical and social appointments. **Lunch and dinner** are provided by My Brother's Table, a local soup kitchen, and the medical respite program serves **breakfast** from food pantry donations. Clients can purchase their own groceries and use the kitchen on site but managing that creates difficulties from an equity perspective. Not all clients in medical respite have access to the same resources to acquire, purchase and/or prepare food.

Continuity of care is priority for post medical respite stays. Former clients can utilize the on-site walk-in clinic, and case managers and nurses do home visits post respite discharge. Community clinics are also hosted in housing units that individuals often move into. The Medical Outreach Program, which includes the medical team and outreach team, is located within the medical respite clinic. The medical team is currently in the process of obtaining a mobile van so that the outreach team can perform regular clinics at various housing units and encampments. Gargi believes a holistic care team and service options have contributed to the success of the program and the staff. "We are a great continuum of services- the same team is outreaching, at the walk-in clinic, at the shower program, at our local soup kitchen, and then providing care for folks as we move them through respite care. We are very innovative; we are constantly flexing our programing to support the community's needs, like starting a walk-in acupuncture detox program. With a lot of persistence and teamwork I am amazed by the number of people we can get into housing and whose lives transform from respite care. I am fortunate that our team also has a nice culture, which is excellent in a world of burnout."

Program 2: Center for Respite Care
Cincinnati, Ohio
Laurel Nelson, CEO

Number of beds: 10 double occupancy rooms
Length of Stay: 45-55 days
Referral Source: 5 local hospitals, Community programs, Other medical providers
Funding Source: Government grants & contracts, Healthcare organizations (FQHC & local hospitals), Grants & private donations

The Center for Respite Care is a 24-hour facility providing medical and nursing care to sick people experiencing homelessness in Cincinnati, Ohio. They are celebrating 20 years of operation in 2023. The Medical Recovery program has a maximum capacity of 20 (10 double occupancy rooms) and is located on the 3rd floor of a 10,000 square foot social services collaborative that houses five agencies. The program has a full medical suite with two exam rooms and a nurses' station. There are four private, full, all-gender bathrooms, a library with computer stations, a kitchenette (accessible to clients 24/7), dining area, and a common area for meetings, client activities and recreation. The Center staff implements, or facilitates outside partners, recreational activities such as arts and crafts, bingo, and brief outings to local parks or events. They also have a large group of regular volunteers that provide activities, as well as a financial planner who comes onsite as requested to educate clients on financial basics like setting up a bank account or budgeting. The local library and zoo have also held special presentations onsite for clients.

Clients can be referred to medical respite by any licensed medical provider. Referral sources include local hospitals, Federally Qualified Health Centers (FQHCs) limited health check locations within shelters, or nonprofit providers with medical service programming. Funding sources include government grants and contracts (Hamilton County Tax Levy, City of Cincinnati Human Services, Ohio Department of Health), healthcare organizations including hospitals and FQHCs, and various grants and private donations. Prior to COVID-19, the average length of stay was 45 days, but it has since increased approximately 10 days to account for barriers to placement.

Transportation is utilized in a variety of ways, mostly dependent on client capabilities. If able, clients are encouraged to utilize transportation benefits through their Managed Care Organization. Case management staff may provide transportation if the client is unable to use public transit. The Center also provides cab fare and/or bus passes from the city as needed. Clients are permitted to bring a limited amount of **food** into the unit for their own consumption. During the week, an in-house partner that operates a **feeding program** delivers breakfast and dinner. Weekday lunch and weekend breakfast is provided by Center staff who utilize donations from local organizations. On weekends, most meals are provided by volunteers who drop off food or share meals on site with clients.

The 24-hour **staffing model** includes one physician (provided in-kind from a local FQHC), four LPN's, one medical assistant, and five client care assistants. Additional staff includes two case managers, one program manager and one program director. The Center is also licensed by the State of Ohio as a Short Term Assisted Living Facility and manages the medical respite program in accordance with licensing regulations that dictate client to staff ratios throughout the 24-hour period. Clients receive care through **on- and off-site partners**. All clients are required to establish a "medical home" and utilize it for preventative healthcare during and after their medical respite stay. Behavioral health is accessed through Greater Cincinnati Behavior Health on or off site, and Ohio Addiction Services comes on site twice a week for group and individual counseling and substance use care. Harm reduction is a focus to the extent allowable by licensing. Specialized care, such as OT, PT, and RT primarily happens off site, but Home Healthcare utilizes the medical respite space.

Dr. Donovan, founding member of The Center

A therapy dog visits The Center once a week. Former clients who have successfully completed the program take turns facilitating a "Meet and Greet" group meeting where post-discharge resources are shared, as well as discussion around barriers that may be encountered to receiving services and how to overcome them. Clients also have direct access to programs and services that are provided by collaborative partners onsite (footcare, clothing, mental health assessments, cooking, and crafting/sewing).

CEO Laurel Nelson highlighted the education focus that The Center has developed within the medical respite program. Clients actively participate in creating an individualized case plan that requires goals for permanent housing placement, knowledge about the utilization of benefits, and personal health literary. "Personal Health Literacy is learning and understanding your health conditions, medications that may be required, and how to successfully engage in preventative medical care with a provider you know, and more importantly, trust." This works well for the client, as well as the local hospital systems, by reducing recidivism and increasing the use of "medical homes." Although they are a stand-alone program, the Center works with multiple healthcare systems, of which there are quite a few compared to other communities. As a primary partner in the collaborative, this makes the medical respite program unique, and contributes to their overall success clients.

Program 3: Shasta Community HOPE Medical Respite
Redding, California

Amber Middleton, Director of HOPE Program; Lesha Schaefer, Executive Director of Pathways to Housing

Number of beds: 15/scattered and fixed site
Length of Stay: Up to 8 weeks
Referral Source: Hospital, Clinics, Community programs
Funding Source: Health Plans (CalAIM), CommonSpirit Health, State/local grants

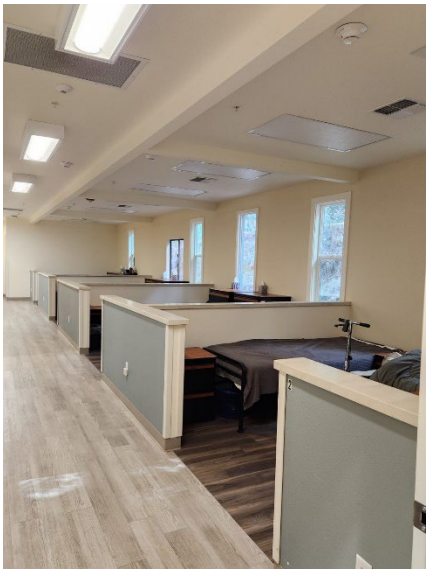
Medical respite clients coloring Easter eggs

Shasta Community HOPE Medical Respite Program operates in **partnership** with the Shasta Community Health Center, a Federally Qualified Health Center, and Pathways to Housing, a local non-profit in Redding, California. The program can serve up to 15 clients at a time. Medical Respite utilizes a standalone facility, The Hartman House, and three local hotels to provide scattered site locations. The average length of stay was around 4 weeks, but an increase in acuity has contributed to an increase of an 8-week average. Referrals are sent primarily from one hospital, but other local hospitals, rehabilitation facilities, the community Homeless Health Care Program, and other local providers can also connect individuals to respite care. Funding sources include CalAIM reimbursement, Common Spirit Health and state/local grants.

Amber Middleton, Program Director of HOPE Medical Respite, collaborates with **staff**, including a registered nurse (RN), medical director, 7 CalAIM coordinators (case management), a psychiatric nurse practitioner, care coordinators, drug and alcohol counselors, and a behavioral health consultant to provide comprehensive services to medical respite clients. The RN screens referrals, does in-person interviews for admission, and sets a discharge date at intake that can be adjusted based on recovery progress. At admission, clients are entered into CalAIM's Enhanced Care Management (ECM) to address clinical and non-clinical needs, which they can then continue with after discharge. Clients at both the Hartman House and scattered site locations receive medically tailored **meals** 7 days per week. The placement of the client depends on several factors. The hotel site can accommodate individuals with pets, couples, or those with higher behavioral health or substance use needs that might experience triggers from a communal living environment. HOPE focuses on meeting clients where they are at, places an emphasis on engagement with medical

Hartman House clinic space

care, and facilitates client access to case management, engagement activities and adherence to the policies of the program, such as a curfew.



Living space at Hartman House

Both program locations implement harm reduction practices, and clients can move between the two as their needs change. The medical director reviews safe practices, provides small harm reduction kits, and can prescribe, or connect clients to clinics for, medication to treat substance use disorder. **Transportation** through the Managed Care Organization is primarily used, but care coordinators also have two program vehicles, or can offer bus bases or taxi vouchers. Clients can receive medical and behavioral health care on-site, along with physical and occupational therapy. Medication is stored individually, and staff prioritizes education, teaching self-sufficiency, and can provide pill boxes or timers as needed.

Pathways to Housing, operated by Executive Director Lesha Schaefer, provides all the hospitality services. Their facility, The Hartman House, is an ADA compliant facility. It comes equipped with a commercial kitchen, clinic space, 15 individual beds with locking storage space, common areas for dining and watching television, shower and laundry facilities, a resident community room with internet and phone access, space for meeting with case workers, a garden space and backyard, and offers clothing and hygiene items. Healthy and nutritious **meals** are provided for lunch and dinner, along with a continental breakfast 7 days per week. Medical respite also offers engagement activities and celebrations for holidays and birthdays. Pathways to Housing provides a full kitchen staff and 24/7 onsite staff to assist clients with their needs. They also provide clients with a mailing address that can be utilized after they discharge from medical respite. Pathways to Housing implements the same hospitality services to the clients placed in motel sites. They deliver lunch and dinner 7 days per week and provide essentials such as hygiene items, clothing, and laundry services.

Garden space at Hartman House

HOPE's success in client care and operations is largely attributed to partnerships with Pathways to Housing and other community organizations. Director Amber Middleton explains that "Our patient feedback is continually that they feel seen and heard, and the ability to not have to worry about where they're going to stay while recovering has been a gift to them." Feedback practices are being revamped to collect data as efficiently and accurately as possible, most recently with the development of a Consumer Advisory Board to provide feedback on the medical respite program.

Comprehensive Clinical Care Model

The **Comprehensive Clinical Care Model** focuses on individualized case management and onsite clinical supports that address the health needs of program consumers. This model is also able to support more intensive medical needs and treatment onsite. Additional services are offered through community connection and partnerships, especially in preparation for transition and discharge.

Program 1: Edward Thomas House
Seattle, Washington

Hilary King, Medical Respite Manager

Number of beds: 34
Length of Stay: 3 weeks
Referral Source: any medical provider in King County
Funding Source: State/local government, hospitals, MCOs

Harborview Medical's Edward Thomas House is a Seattle-based medical respite program with a unique harm reduction focus. Clients receiving medical respite care can be active in substance use during their stay and have access to treatment options, including Methadone delivery that can be dosed on site, suboxone providers, recovery groups offered through the hospital, and connections to ongoing care. Medical Respite **staffing** includes Hilary King, medical respite manager, a medical director, psychiatrist, nurse practitioner, registered nurses, medical assistants, mental health practitioners, social workers, case managers, and mental health specialists. An overnight nurse and mental health specialist make clinical care available to clients 24 hours a day.

Any county medical provider can refer to medical respite as long as the individual has a need for daily nursing care. Single adults make up the majority of those referred to, and accepted into, the program, and the length of stay is decided during care plan development. Clients in medical respite can receive IV antibiotics, wound care, clinical support while completing outpatient chemotherapy and dialysis, and those on hospice can receive care until they are unable to complete activities of daily living independently. Edward Thomas House is funded through a contract with the Public Health Department, 6 participating hospitals that give an annual rate, Medicaid billing, and their primary hospital, Harborview Medical.

Three **meals** and a snack are delivered daily from a local catering company. Clients are assisted with scheduling **transportation** to outside appointments by utilizing Medicaid transit, and if that is not available, they are given bus tickets or a paid taxi by the medical respite program. Post-discharge appointments for primary, behavioral and specialty health care are made by medical case managers with providers from the referring hospital.

During the medical respite stay clients can utilize a community room for recreation and are offered wellness and art therapy groups. The facility itself is not locked down, and guests can come and go as they please as long as they adhere to the 9pm-7am curfew. If able, some choose to work or participate in other community activities. Being truly harm reduction focused means ensuring staff are firmly committed to the mission of the organization and that they remain flexible with clients in medical respite. Key takeaways from their 27 years in operation include allowing policies and procedures to be dynamic and evolve to best support the clients' needs and collaborating closely with staff to train and build skills in a harm reduction model of care. Hilary King explains that focusing on the things you can do and do well, and best utilizing resources that are available, has been vital to the success of the medical respite program.

Program 2: Greater Portland Health
Portland, Maine

Robert Fulton, MD

Number of beds: 15
Length of Stay: 2-6 weeks
Referral Source: Maine Medical Center
Funding Source: 2-year community benefits agreement

In October 2022 Greater Portland Health began a 15-bed medical respite pilot. The program has seen a steady increase in referrals and is approaching the need for a wait list for services. Maine Medical Center, a clinical partner, submits referrals to medical respite, and a collaborative care plan between clinical and social service staff is developed at intake. The current **staffing** model is nurse driven and includes Robert Fulton (MD), first and second shift nursing, overnight CRMA, a .5 FTE nurse practitioner, nurse clinical manager, two case managers at all times, a supervisor and director of social services, two homeless health partners, a .5 LCSW, and a part-time peer recovery specialist.

Acute clinical care can include long courses of IV antibiotics, chronic wound care, post-surgical and post-fracture care, dialysis support and general medical needs. Medications are held by staff and dispensed to clients during their stay. Medical respite clients can also participate in individual and group behavioral health therapy on site, be connected to chronic medical care services, such as dental care, receive Medication Assisted Treatment (including Methadone delivery from a local clinic), access the required Methadone group sessions on site, receive AA support via telehealth service, and access other social worker led groups.

Maine Medical Center and Preble Street are **partners** for the medical respite program. Homeless Health Partners employed through Maine Medical provide direct **transportation** for clients, or work with local agencies for MaineCare (Medicaid) recipients. Preble Street, a social services

organization, employs 24/7 case workers that manage the milieu and provide social services support for client-directed goals that include obtaining vital records and housing. The program itself operates as a closed-facility model, and individuals are accompanied to all community appointments, smoke breaks, and outside activities. A weekly community meeting is held for residents, along with social activities like bingo, art groups, trivia night, and movie night.

Client feedback is solicited at the weekly community meeting, any time through an on-site feedback box, and through a satisfaction survey given at discharge. Preble Street has a large **food pantry** that delivers a cold breakfast, two warm meals, and stocks the kitchenette for medical respite. Dr. Robert Fulton believes that despite some of the medical respite restrictions (clients cannot leave, visitor hours are limited, outside food can't be brought in), they have built strong relationships with the population. "A testament to that is we've had multiple patients return to the center, even ones that had pursued self-directed discharges, because they felt supported and heard." Implementing harm reduction practices and placing a priority on creating a person-centered environment has been key for success. In the future, Greater Portland Health wants to expand its referral avenues, create new programming, and possibly move into a bigger space with an outdoor area.

Watch a virtual site tour of Greater Portland Health here.

Program: Santa Clara Medical Respite
San Jose, California

Laurie Mello, RN

Number of beds: 20 occupied rooms
Length of Stay: 2-4 weeks
Referral Source: Hospitals, community organizations
Funding Source: County government, hospital, HRSA grant, Health Plans (CalAIM),

Santa Clara Medical Respite is entering its fourth year operating out of a motel setting. Prior to the COVID-19 pandemic, medical respite was located within a local shelter. The need for medically vulnerable patients to isolate caused the program to relocate, and they now share space with a temporary housing program for families until construction on their new facility is complete. Funding for the 20 medical respite beds comes from the county, under the local hospital system, a HRSA Health Care for the Homeless Grant, and since 2022, Medicaid reimbursements. Contracted hospitals in the county can refer clients, as well as the BHHP backpack program, and outpatient clinics needing client care for preventative screenings such as colonoscopies, outpatient oncology, and eye clinics.

Medical respite staff is on site from 8:30am-5:00pm, and motel staff is available half time, in the evenings and overnight. **Staff** consists of a program director, MD, a charge nurse that manages admissions, general RN, LVN as needed, two social workers, a twice a month psychiatrist,

community outreach worker/driver, substance use counselor three days per week, and a pharmacist two days per week. **Medical care** is provided through a mobile bus clinic once per week. The medical director recently stepped into the program director role, a position that is in the process of being filled. The pharmacist can provide specialty diabetic care, including management of in-arm glucose monitors and injected medications. Pill boxes are given at admission for medications to be self-managed, but the staff has capacity to do the prescription pick up and assist with managing medication as needed.

On average, medical respite cares for clients for 4 weeks. However, a 2–4-week window is sometimes given, and the program weighs the pros and cons of giving the discharge date at admission. Some oncology patients have been in the program for up to one year. A medical respite house meeting occurs every Friday and has been very beneficial for promoting inclusivity in such a secluded space. **Meals** for respite clients are separate from what the motel guests and other on-site programs receive, which poses a challenge to the staff and clients. The program driver picks up frozen meals, salads, sandwich items, snacks, and staple items (milk, cereal oatmeal, fruit, etc.) from the county hospital, and clients then use their in-room fridge and microwave for preparation and storage. Outside food is also permissible. Once a month a community member donates a hot meal through utilization of his taco food truck, Costco pizza, or hot dogs.

If the community health worker/driver is unable to **transport** clients, connections are made to insurance provided medical transport or taxi vouchers are given. A warm hand off to new primary and behavioral health care providers prior to discharge ensures continuity of care, or clients can continue with providers they see during their respite stay. A weekly “coffee chat” group is offered to facilitate a sense of community among participants. Harm reduction practices are implemented, but patient seclusion has made it difficult to manage a no on-site use policy and maintain client safety. Laurie Mello, RN, believes the best part of the program is their multidisciplinary approach and how clients can receive an array of services while in respite care. Being able to provide single rooms to oncology patients, and building services, like mandatory housekeeping twice a week, weekly pest spraying and weekly send out laundry service, has also been very successful.

The future vision for their new 30 bed space includes being able to provide palliative and end of life care, IV antibiotics, 24-hour clinical and non-clinical staff, and 7 days a week admission where patients don’t have to arrive by 3pm, a challenge the medical respite program is currently facing. The physical space will include a large kitchen and day room, an on-site clinic, a counseling space, an outdoor patio, and ample storage space.

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