GUIDE

Housing and the Medical Respite Care Program:
A Practical Guide to Navigating the Homelessness Response System

August 2023

Introduction

Medical respite care (MRC) is an essential part of the health care and homelessness response system's continuum for unhoused community members. Medical respite care is defined as acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, 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 (the Standards) and share the same fundamental element: 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 other supportive services.

Within the Standards, Standard 5 states, "Medical respite program assists in health care coordination, provides wraparound services, and facilitates access to comprehensive support services." Additionally, Standard 6 states, "Medical respite program facilitates safe and appropriate care transitions out of medical respite care." Unfortunately, there are challenges in meeting and exceeding these two standards due to a significant lack of affordable housing that meets the needs of various community members within the United States (US), and the complexity of the homelessness response system and housing process to access available housing.

In response to this challenge, the National Institute for Medical Respite Care (NIMRC) has developed this guide to support medical respite care programs with:

- Foundation information surrounding the Homelessness Response System (HRS)
- Housing and Social Service Discharge Planning Resources

It is important to note, **it is not** the sole responsibility of the Medical Respite Care Program to end homelessness in their community. However, **it is** the MRC Program's role and responsibility to support clients[1] in making meaningful progress toward their housing goals and resolving homelessness with clients when possible. While MRC programs may not have control over housing availability, they are **uniquely positioned to advocate for housing justice** in their community.

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.

Foundation Information

What is the Continuum of Care (CoC)?
A CoC, defined by Housing and Urban Development (HUD) in the interim rule, at the macro level, is designed to:

- Promote communitywide commitment to the goal of **ending homelessness**;
- Provide **funding for efforts** by nonprofit providers, States, and local governments to quickly rehouse individuals and families experiencing homelessness, while **minimizing the trauma and dislocation** caused to individuals through experiencing homelessness;
- **Promote access** to and effective utilization of mainstream programs by individuals and families experiencing homelessness;
- **Optimize self-sufficiency** among those experiencing homelessness.

CoC's are also referred to as the **geographical location** covered by a CoC Program, and the **body of people that participate in homeless services within** that **geographic area.** It is also notable that the Continuum of Care can be referred to, and look different, in every community. Alternative names include the CoC, Balance of State, the Local Lead, Lead Agency, Coalition, Collaborative Applicant, and Homelessness Response System. For an example of geographic boundaries, please see Figure 1 and Figure 2, the Texas Continuum's of Care, shared from Texas Homeless Network (THN) and the Colorado Balance of State Continuum, shared from the Colorado Coalition for the Homeless (CCH). To find your local CoC, contact see the HUD Exchange link here.

Figure 1: THN Texas Continuums of Care (CoC)

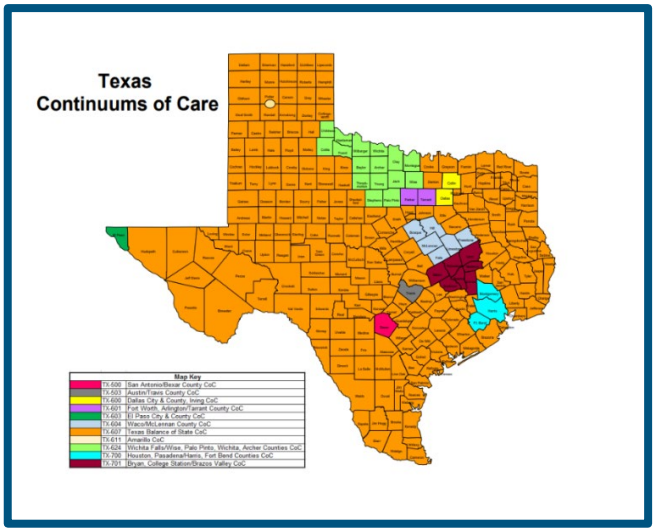
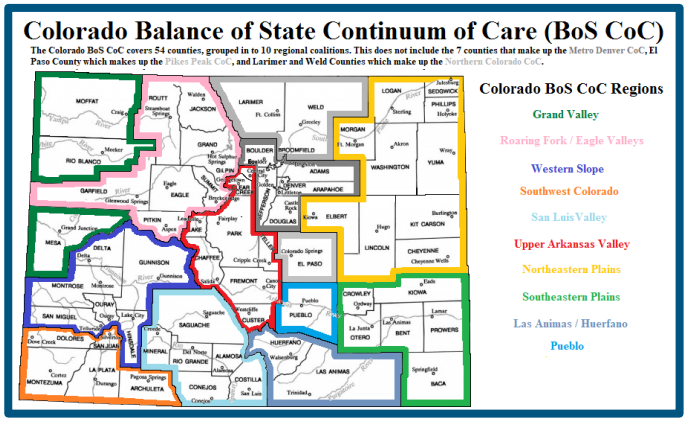


Figure 2: Colorado Balance of State Continuum of Care (BoS CoC)



How is Homelessness defined by HUD?
HUD defines homelessness through four categories: (1) Literal Homelessness (2) Imminent Risk of Homelessness (3) Homeless under other Federal statutes and (4) Fleeing/Attempting to Flee Domestic Violence (DV). Within the HUD category (1) Literal Homelessness definition resides a second definition: Chronic Homelessness. For more information about how HUD defines homelessness, see Figure 3 below, and reference HUD: Homeless Definitions. Following that, Figure 4 contains additional important terms and definitions. It's important to note the current primary focus nationally is on categories one and four, but local prioritization can be community specific.

Figure 3: HUD Definitions of Homelessness

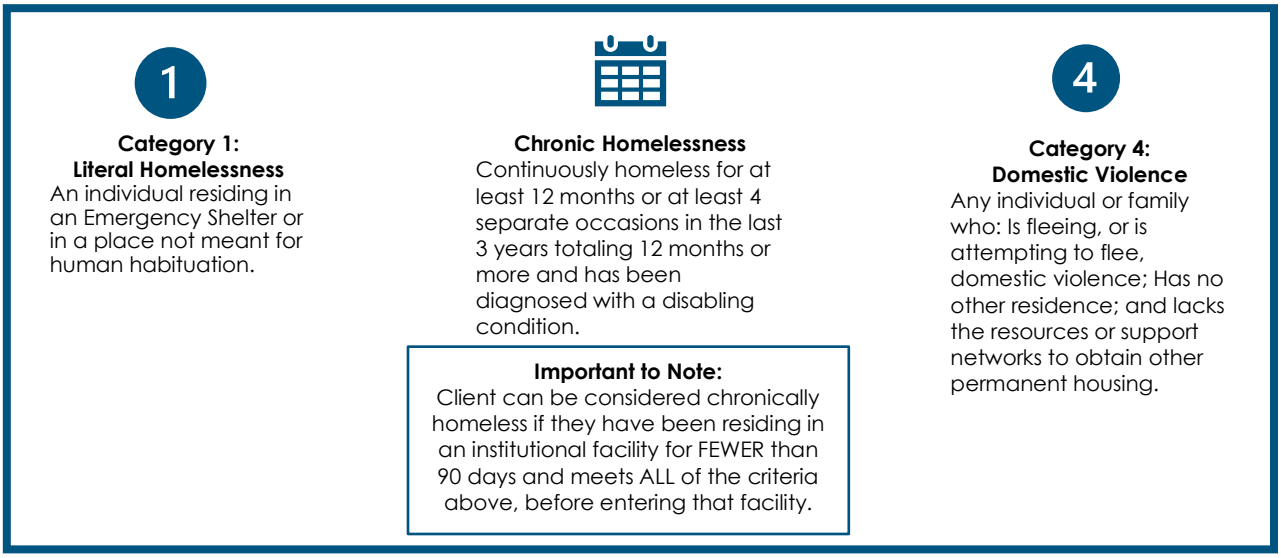


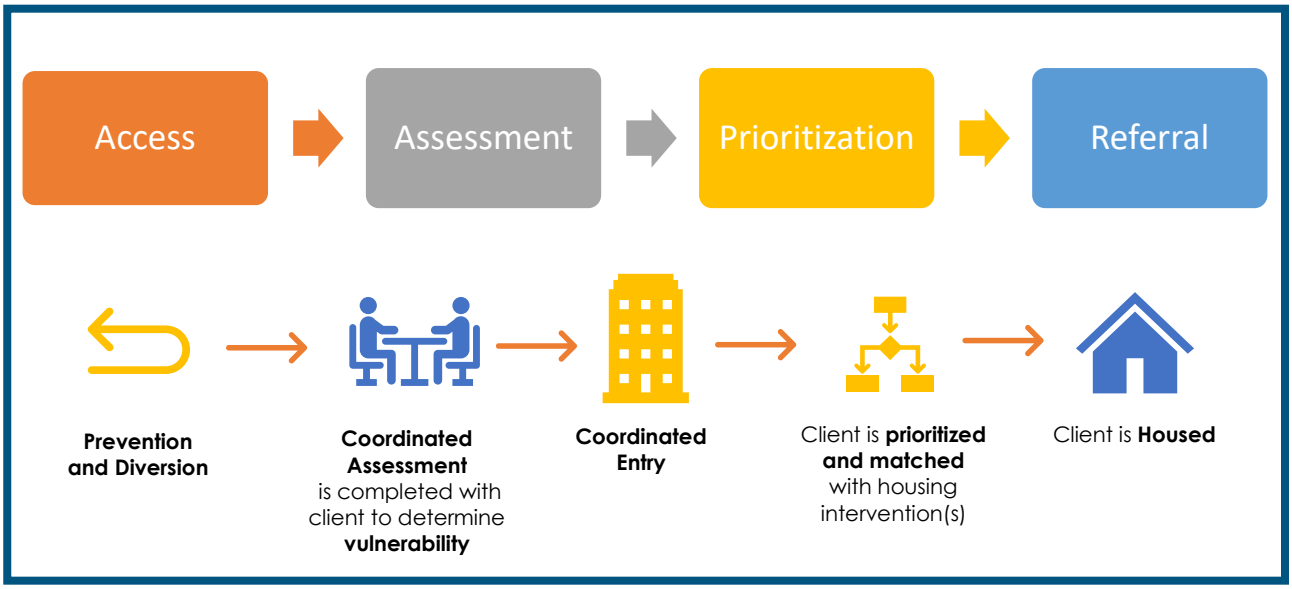
Figure 4: HUD Terms to Know

HUD Terms to know		
Term	**Definition**	**Resource to learn more**
Prevention	Prevention is the intervention utilized when a client is at imminent risk of losing housing. In this situation, the community member is not yet experiencing homelessness.	NAEH: Prevention and Diversion
Diversion	Diversion is the intervention utilized when a client is requesting shelter. In this situation, the community member is at the "front door" of the system.	NAEH: Prevention and Diversion
Housing First	Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible — and providing services as needed. The basic underlying principle of Housing First is that people are better able to move forward with their lives **if they are first housed.**	NAEH: Housing First
Rapid Rehousing (RRH)	RRH provides **short-term** rental assistance and services. The goals are to help people obtain housing quickly, increase self-sufficiency, and stay housed.	NAEH: RRH
Permanent Supportive Housing (PSH)	PSH is a **long-term** intervention that combines affordable housing assistance with voluntary support services to address the needs of community members experiencing chronic homelessness.	NAEH: PSH
Coordinated Entry (CE)	The Interim Rule defines Coordinated Entry as a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals.	HUD: Interim Rule
Coordinated Assessment (CA)	The Coordinated Assessment is a comprehensive and standardized assessment tool utilized to assess vulnerability. *Example: VI-SPDAT or Austin Priority Index (API)*	HUD: Interim Rule
Homeless Management Information System (HMIS)	A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals, families, and persons at risk of homelessness.	HUD: Interim Rule

What are the core elements of Coordinated Entry?

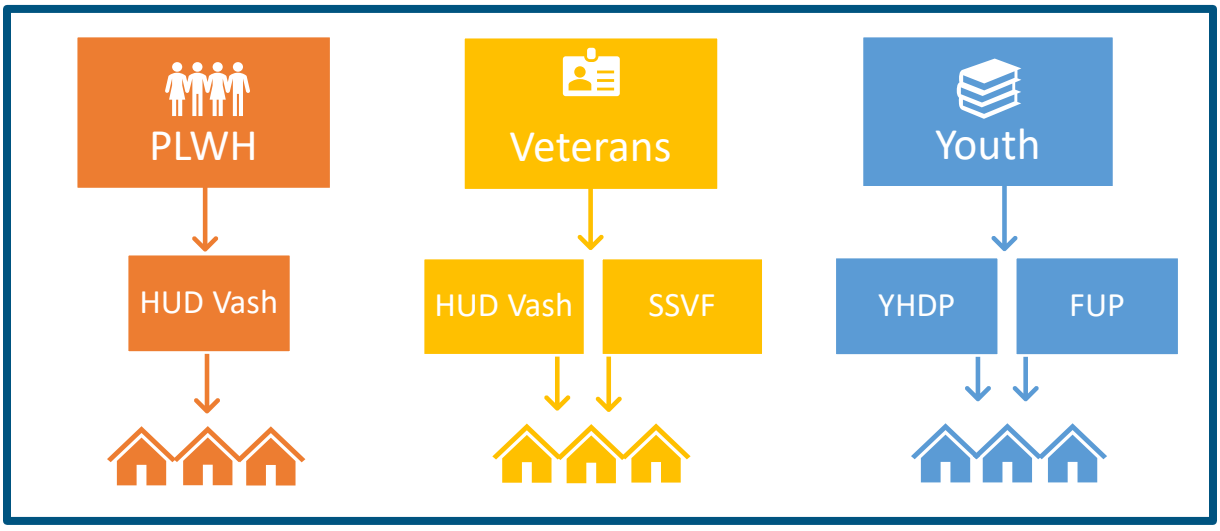
The four core elements of Coordinated Entry (CE) are: Access, Assessment, Prioritization, and Referral. In Figure 5 below, the CE Core Elements are paired with a linear model to represent the process the community member navigates to receive housing within the Homelessness Response System (HRS). Figure 5 is intended to be a high-level macro view of the CE Core Elements process. It is important to note that there are many moving parts and steps in between each of the listed markers, and often the process is not as linear as depicted in Figure 5. For more information on the Coordinated Entry Core Elements, please visit this document.

Figure 5: Coordinated Entry Core Elements



What additional community programs are there?

There may be additional funding and programs for approved subpopulations within communities. For example, there may be Housing Opportunities for Persons With AIDS (HOPWA), for People Living With HIV/AIDS (PLWH), HUD-Veterans Affairs Supportive Housing (HUD-VASH), Support Services for Veteran Families (SSVF) for Veterans, and Youth Demonstration Project (YHDP) or Family Unification Program (FUP) vouchers for Youth and Young Adults (YYA). These programs are typically managed by a variety of entities, such as the local Public Housing Authority (PHA), Veterans Affairs (VA) or local government. However, these programs are often facilitated in partnership with the CoC. With that, information needed for connection to those programs should be captured in the Coordinated Assessment process. For more information about these resources, please contact your local CoC.



What other Housing resources exist outside of the Homelessness Response System?

A notable resource adjacent to the Homelessness Response System under HUD is the Public Housing Authority (PHA). The PHA operates affordable housing and other federal housing programs that include, but are not limited to, the housing choice voucher (HCV). The PHA maintains different eligibility and income limits and can have different access points than the Homelessness Response System. However, it is strongly recommended that every community member experiencing homelessness connect with every eligible housing option available to them, including the local PHA. This recommendation is made as each system has capacity that fluctuates, and their allocated resources become available at different rates.

Housing and Social Service Discharge Planning Resources

Establishing Housing Discharge Resources
After gaining a foundational understanding of the homelessness response system, it is important for each program to identify what housing resources may exist in their community and establish processes and procedures for connecting community members to those resources. This connection is important, not only to meet the Standards for MRC, but also to support community members in disrupting, and potentially ending, the cycle of homelessness. Within this section programs can find examples of resources communities have created, questions to consider, and templates to establish resources for their program.

Examples of Community Resource Guides
Community resource guides are a space in which support services and resources are captured and shared widely. They are often created to be a one stop shop for community members, and can come in all shapes, sizes, formats, and platforms. Some examples of community resource guides can be found in Figure 6.

Figure 6: Examples of Community Resource Guides

Questions to Consider
It's highly encouraged that before diving into creating community resource guides, programs consider the following questions:

- What community resource guides already exist?
- What community resource guides have discharge planners at the hospital or CoC partners established?
- How are these resources being shared or accessed?
- Would these groups be open to sharing these resources for MRC program use and/or adaptation?
- What are the recommendations, changes, and/or feedback people with lived expertise have surrounding community resource guides?

Depending on the answers to the questions above, MRC programs may need to create or adapt resource guides to best support their clients. The templates below can assist in the creation and/or adaptation of resources geared toward housing and discharge planning. Figure 7, *Housing Discharge Planning Checklist,* is intended to be used by programs to support their discharge planning process. Figure 8, the *Adaptable Community Resource Guide,* is intended to be used by programs as a starting point for those in need of developing or modifying resources to aid with accessing community supports as part of the discharge planning process.

Figure 7: Housing Discharge Planning Checklist

Housing Discharge Planning Checklist

Item	Status	Comments
Have you attempted diversion or prevention with the client?	☐Yes ☐No ☐In Progress	
Have you discussed and shared resources on discharge placement options (e.g., local emergency night shelter, day centers, transportation)?	☐Yes ☐No ☐In Progress	
Has the client been connected to the Homelessness Response System (HRS) and received a Coordinated Assessment (CA)?	☐Yes ☐No ☐In Progress	
Is the client on all eligible community and public housing waitlists?	☐Yes ☐No ☐In Progress	
Has the client been connected with their vital documents?	☐Yes ☐No ☐In Progress	
Does the client have a housing case manager with access to HMIS? [2]	☐Yes ☐No ☐In Progress	
Have you supported the client in documenting their homelessness status prior to admission? [3]	☐Yes ☐No ☐In Progress	
If applicable, has the client started the SOAR process?	☐Yes ☐No ☐In Progress	
If the client is being discharged back to unsheltered homelessness, has their location and contact information been documented both internally and in HMIS?	☐Yes ☐No ☐In Progress	

2 It is important to make sure each client discharging the MRC program is connected with a housing case manager with HMIS access as this person can scan and save vital information into the clients HMIS account to be stored (i.e. contact information, location, vital documents, and more).
3 For more information on documenting homelessness status prior to admission please refer to HUD Recordkeeping and Recordkeeping Requirements for Chronic Status

Figure 8: Adaptable Community Resource Guide

Community Resource Guide

Emergency Shelters

Emergency Shelter	Population Served	Health Care Connection	Employment Connection	SOAR Assistance	Mail Access	Computer Access	Laundry and Hygiene Resources	Location and Contact
Example: Shelter A	*Men*	*X*	*X*	*X*	*X*	*X*	*X*	*101 Emergency Shelter Way Georgetown, Texas 78628 Phone: 111-101-1111*

Drop-in Centers

Drop-in Centers	Population Served	Health Care Connection	Coordinated Assessments	SOAR Assistance	Food Pantry or Meals	Meals	Laundry and Hygiene Resources	Location and Contact
Example: Drop-in A	*Men and Women*	*X*	*X*	*X*	*X*	*X*	*X*	*202 Drop-in Center Way Georgetown, Texas 78628 Phone: 111-101-1111*

Additional Support Services

Service Provider	Population Served	Housing Assistance	Legal Assistance	Benefits	Food Pantry	Healthcare Access	Case Management	Location and Contact
Example: Service Provider A	*Women*	*X*	*X*	*X*	*X*	*X*	*X*	*303 Service Provider Way Georgetown, Texas 78628 Phone: 111-101-1111*

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