

GUIDE

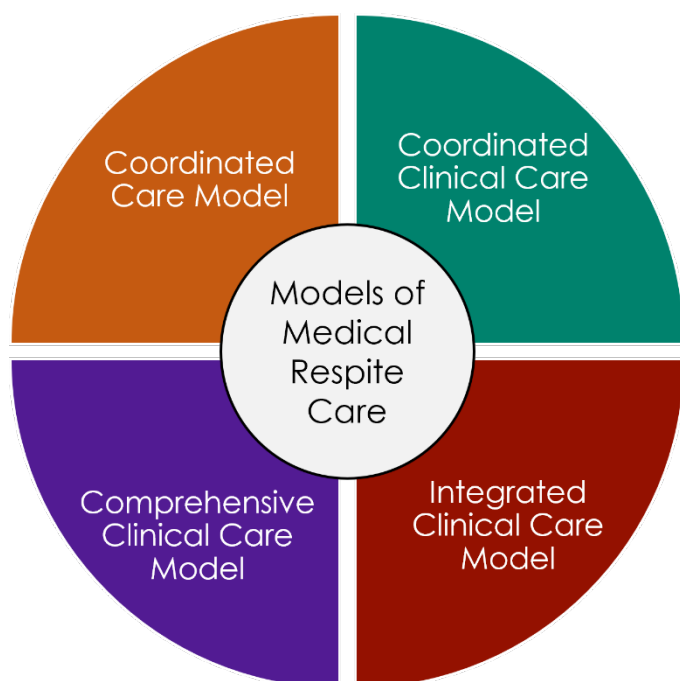
NATIONAL
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Potential Skills and Staffing of Medical Respite Care



Introduction

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



In addition to the Standards and Guiding Principles, the National Institute for Medical Respite Care (NIMRC) developed the **Models of Medical Respite Care** (Models of Care) in response to the need for programs and policymakers to have clearer guidance on what constitutes medical respite care. The **Models of Medical Respite Care** may be used to determine the scope of clinical care that can be safely and effectively provided onsite or through direct access. The Models of Care are structured to describe what services the client² has access to while in the medical respite program, which may be provided through [collaborations and partnerships](#) between two or more organizations. Regardless of which **Model of Care** programs identify as, every program should include the same **key components** and access to **program services**.

This document is a guide to the various skills and staffing needed to implement the **Models of Medical Respite Care**. This includes the distinct type and intensity of clinical services available in each medical respite care setting, offered through onsite services and/or community partnerships.

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

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

Medical Respite Service Delivery

The essential goal of medical respite care is to provide a safe place to heal and recover. Programs must also ensure that connecting clients to health care services is a top priority. All program Models, at a minimum, should include the **key components** described in [Figure 1](#), and should facilitate access to the **program services** described in [Figure 2](#). The location, intensity, and delivery of services vary by each Model and inform the acuity and types of conditions that can safely be served within the medical respite program.

Figure 1: Key Components of Medical Respite Programs

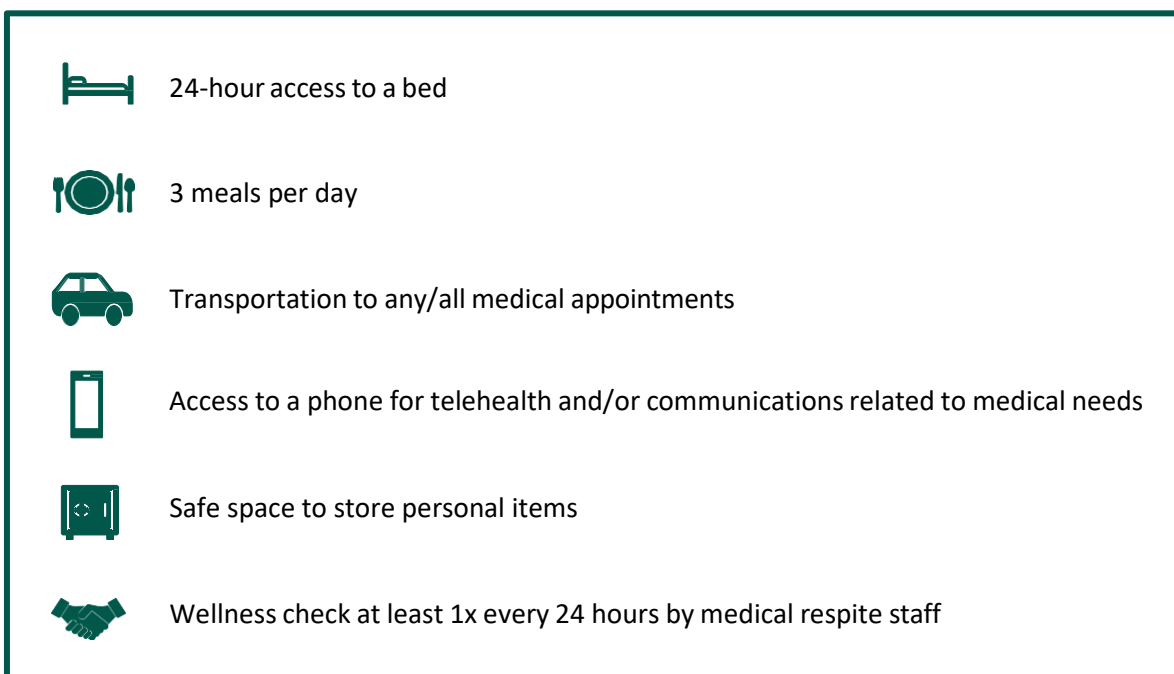


Figure 2: Medical Respite Program Services



Appendix A provides detailed descriptions of the Medical Respite **Program Services**.

Application of this Document

Intention

This document provides an overview of the staffing skills needed to implement each of the [Models of Medical Respite Care](#). The suggested staffing roles reflect the skills needed to provide the essential services, along with the clinical, behavioral health, and medication support services provided within each Model. However, this document does not reflect the staff needed for other program operations (such as maintenance) or additional services provided beyond the Model of Care (such as recreational therapy). This document can be used as a supplemental guide once programs identify which Model of Care is most applicable to the services they offer, to then provide suggestions regarding the staff needed to support those services. It can also serve as a guide for expansion when programs are seeking to change their Model of Care or increase their services and staffing.

Licensure and Scope of Practice

Programs will also need to ensure that the scope of practice and licensure of staff meet local guidelines and that all medical respite care program staff only perform skills for which they are experienced and/or licensed under state and federal laws and agencies. Programs and organizations should reference and contact their state licensure boards for specific details regarding the scope of practice and supervision requirements for licensed and certified roles.

Staffing Structure and Ratios

Multiple types of providers or staff can fulfill the skills needed to implement each Model. The staffing for each program will also be determined by the facility design, the number of clients served, and the types and acuity of conditions and comorbidities addressed by the program, along with specific state licensure guidelines. Because these factors will be variable for each program, a specific number of staff per model is not included as a recommendation. Regardless of the number of staff and/or partnerships utilized, programs should ensure that care provided is high-quality and meets the [Standards for Medical Respite Care](#).

Use of Partnerships

The skills and staff roles within medical respite care programs may be provided through formal partnerships, collaboration with community providers, or the staff may be directly employed by the MRC program. Programs may utilize different staffing structures to implement their chosen Model. The Key Components and Program Services may be delivered through collaborations and partnerships involving two or more organizations. Partnerships are crucial for all Models, as they often enable clients to more easily access existing community programs and reduce service duplication. Engaging and connecting with partners can facilitate smoother transitions from MRC to the community and aid in the development of community-based and natural support systems. The operating organization of a medical respite program may use two different levels of partnership to connect clients to or provide services. For more information on partnerships, see the Models of Medical Respite Care. For more information on Partnerships with Organizations, see [Appendix B](#).

Essential Skills for All Staff

To achieve the primary goal of medical respite care, providing a safe place to heal, recover, and connect to health care services, every program staff member should have foundational skills, including:

- Knowledge and training to implement trauma-informed care principles
- De-escalation training and crisis prevention strategies
- Person-centered care
- Demonstrate the necessary attitudes, knowledge, skills, willingness, and self-awareness to deliver culturally competent services in multicultural situations
- Understand and address systemic and policy contributors to homelessness
- Knowledge of, and adherence to, health information privacy and HIPAA regulations
- Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) training
- Assist clients with establishing goals focused on maximizing functioning within the community and decreasing the need for emergent care
- Motivational interviewing, including listening to the client's individual stories to help better respond to real needs and values
- Construct and maintain professional boundaries
- Communicate efficiently, actively listen, and cultivate empathy in situations with unpredictable dynamics
- Facilitation of shared decision-making between the client and staff

See Standard 7 of the [Standards for Medical Respite Care Programs](#) for more information.

For a list of recommended staff training and resources, see [Medical Respite Staff Training & Resource Recommendations](#).

Coordinated Care Model

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

Skills and Expertise

Although a staff member's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are needed to safely provide services within the Coordinated Care model.

ADMISSIONS SCREENING and INTAKE

- Extensive knowledge of, and adherence to, program admissions criteria.
- Communicate and hold clear boundaries.
- Comprehensively screen referrals, including review of supplemental health information, and assess each client's acuity, program requirements/criteria, and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within the medical respite program.
- Orient each client to the medical respite facility and program, including admission agreements, to optimize retention in the program.
- Maintain positive and collaborative relationships with hospitals, referring entities, and other partners/community providers.
- Communicate to and ensure referral sources/external agencies are aware of the referral process.

Coordinated Care Potential Staffing

- Case Manager
- Community Health Worker
- Peer Support Specialist
- Social Worker (LMSW/LCSW/LCPC)

CARE PLANNING and COORDINATION

- Establish goals with each client.
- Conduct an individual needs assessment that identifies medical, behavioral health, case management, and care coordination needs.
- Develop a care plan based on the goals of each client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections with appropriate providers (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with each client, in collaboration with the client's health care providers.

CASE MANAGEMENT

- Identify case management and supportive service needs, including eligibility for community resources and supports needed for housing transition.
- Provide resources for local and community-based organizations and complete referral processes for services, including community case management, Coordinated Entry, etc.
- Coordinate with pre-existing case managers and facilitate ongoing case management supports as needed.

- Support each client in identifying, discussing, and pursuing immediate and long-term needs related to Social Determinants of Health (SDOH), such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits, etc.
- Support each client in identifying and removing barriers to immediate and long-term needs related to SDOH.
- Provide each client with education tailored to the individual's learning style, education, and/or reading level, and that is sensitive to the culture of the individual.
- Support each client in obtaining vital documents such as identification, social security cards, etc.
- Support each client if/when behavioral concerns arise to maximize client retention in the program.
- Develop rapport with each client and offer hope through one's own life experience by using personal stories in a conscious, deliberate, and professional way in the service of helping another, when appropriate.

HEALTH NAVIGATION and HEALTH SELF-MANAGEMENT

- Assist each client with prescription management to fill/refill medications or connect them to resources that can support access to needed medications.
- Connect each client to primary care and community health care providers based on individual needs.
- Assist each client with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport each client to scheduled appointments or assist with scheduling outside transportation services.
- Assist each client in planning for and navigating post-medical respite transportation needs.
- Assist each client in developing awareness of the need for treatment services and use motivational interviewing and a client-centered approach to address any concerns or motivations impacting engagement in health services, such as attending appointments or completing discharge recommendations.
- Support each client in improving health literacy.
- Identify and address external barriers to receiving and engaging in services; provide advocacy when clients are receiving substandard care, request needed referrals, and navigate intake processes.
- Facilitate each client's access to durable medical equipment (DME) and medical supplies, such as wound care, oxygen, and incontinence supplies, as needed.
- Assist each client with obtaining insurance and/or understanding benefits and provide education on navigating their plan.
- Ensure each client can safely store their medications, including ensuring storage is secure, and the client has access to all needed medications.
- Support self-administration of medications and ongoing client progress towards self-management of medications.
- Coordinate with and ensure each client has space in the program to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy), ensure providers arrive as scheduled, and that the client is at the program when providers arrive.

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Address and/or support each client in responding to delays, paperwork needed, or other barriers to attending appointments or receiving home health services.
- Support the navigation process of accessing services or navigating referral systems for additional health needs.

CLINICAL CARE

- Case conference and communicate with program staff and community-based medical providers.
- Provide each client with 24-hour access to on-call medical support (through partnerships or community providers).
- Provide education to each client on how to utilize after-hours medical care or on-call medical support.
- Review with clients their providers' recommendations on when to contact the on-call staff to address immediate medical needs vs. emergency department care.

BEHAVIORAL HEALTH

- Use mental health first aid and trauma-informed de-escalation strategies to address or prevent client escalation or distress.
- Help each client identify, understand, and combat stigma and discrimination associated with mental illness, substance use, and/or homelessness, and develop strategies to reduce self-stigma.
- Ask about any behavioral health needs and facilitate connection or reconnection to community behavioral health services.
- Connect each client with needed resources (e.g., harm reduction supplies, recovery support groups) and coordinate with community organizations to increase access to those services.
- Facilitate scheduling of new appointments and/or accessing community behavioral health services.
- Refer each client to community behavioral health, recovery, and/or harm reduction programs and facilitate transition planning, as needed.
- Address stigmatizing practices by reviewing admission criteria to determine if clients with behavioral health conditions are being excluded based on diagnosis alone.

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.

Skills and Expertise

Although a staff member's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are needed to safely provide services within the Coordinated Clinical Care model.

ADMISSIONS SCREENING and INTAKE

- Extensive knowledge of, and adherence to, program admissions criteria.
- Communicate and hold clear boundaries.
- Comprehensively screen referrals, including review of supplemental health information, and assess each client's acuity, program requirements/criteria, and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within the medical respite program.
- Orient each client to the medical respite facility and program, including admission agreements, to optimize retention in the program.
- Maintain positive and collaborative relationships with hospitals, referring entities, and other partners/community providers.
- Communicate to and ensure referral sources/external agencies are aware of the referral process.

Coordinated Clinical Care Potential Staffing

- Nurse (RN/LVN/LPN)
- Case Manager
- Community Health Worker
- Peer Support Specialist
- Social Worker (LMSW/LCSW/LCPC)

CARE PLANNING and COORDINATION

- Establish goals with each client.
- Conduct an individual needs assessment that identifies medical, behavioral health, case management, and care coordination needs.
- Develop a care plan based on the goals of each client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections with appropriate providers (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with each client, in collaboration with the client's health care providers.

CASE MANAGEMENT

- Identify case management and supportive service needs, including eligibility for community resources and supports needed for housing transition.
- Provide resources for local and community-based organizations and complete referral processes for services, including community case management, Coordinated Entry, etc.

- Coordinate with pre-existing case management and facilitate ongoing case management supports as needed.
- Support each client in identifying, discussing, and pursuing immediate and long-term needs related to Social Determinants of Health (SDOH), such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits, etc.
- Support each client in identifying and removing barriers to immediate and long-term needs related to SDOH.
- Provide each client with an education tailored to the individual's learning style, education, and/or reading level, and that is sensitive to the culture of the individual.
- Support each client in obtaining vital documents such as identification, social security cards, etc.
- Support each client if/when behavioral concerns arise to maximize client retention in the program.
- Develop rapport with each client and offer hope through one's own life experience by using personal stories in a conscious, deliberate, and professional way in the service of helping another, when appropriate.

HEALTH NAVIGATION and HEALTH SELF-MANAGEMENT

- Assist each client with prescription management to fill/refill medications or connect them to resources that can support access to needed medications.
- Connect each client to primary care and community health care providers based on individual needs.
- Assist each client with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport each client to scheduled appointments or assist with scheduling outside transportation services.
- Assist each client in planning for and navigating post-respite transportation needs.
- Assist each client in developing awareness of the need for treatment services and use motivational interviewing and a client-centered approach to address any concerns or motivations impacting engagement in health services, such as attending appointments or completing discharge recommendations.
- Support each client in improving health literacy.
- Identify and address external barriers to receiving and engaging in services; provide advocacy when clients are receiving substandard care, request needed referrals, and navigate intake processes.
- Facilitate each client's access to durable medical equipment (DME) and medical supplies, such as wound care, oxygen, and incontinence supplies, as needed.
- Assist each client with obtaining insurance and/or understanding benefits and provide education on how to navigate their plan.
- Ensure each client can safely store their medications, including ensuring storage is secure, and the client has access to all needed medications.
- Support self-administration of medications and ongoing client progress towards self-management of medications.

- Coordinate with and ensure each client has space in the program to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy), ensure providers arrive as scheduled, and that the client is at the program when providers arrive.
- Facilitate communication with prescribing providers and support each client in discussions regarding their tolerance of medications and adherence to the medication regimen.

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Address and/or support each client in responding to delays, paperwork needed, or other barriers to attending appointments or receiving home health services.
- Screen for additional health needs, communicate with the prescribing provider any need for referrals, and support the navigation process of accessing those services.

CLINICAL CARE

- Case conference and communicate with program staff and community-based medical providers.
- Provide each client with 24-hour access to staff and/or on-call medical support (internally or through partnerships).
- Provide education to each client on how to utilize after-hours medical care or on-call medical support.
- Provide each client with guidelines and education on when to contact the on-call staff to address immediate medical needs vs. emergency department care.
- Provide clinical care within the scope and license of staff, as indicated by care plans, and within limits of appropriate case load size.
- Educate each client on medication administration and management, overall health management, and condition monitoring.
- Provide medication management within the scope of license, and per medication guidelines or state regulations, which can include storing, dispensing, administering, reconciling, and monitoring, as indicated by the care plan.
- Advocate for medication regimen simplification, as needed.
- Provide education to each client to support following discharge instructions, monitoring changes in health, and relevant health management skills.
- Use case conferencing information to develop the clinical care plan and goals or discharge indicators.
- Log vital signs and monitor each client closely for changes in health status, as indicated by the care plan.
- Administer pre- and post-procedural or operative care.
- Document all clinical care provided to each client during their medical respite stay and include relevant information about care provided onsite within the discharge summary.

BEHAVIORAL HEALTH

- Use mental health first aid and trauma-informed de-escalation strategies to address or prevent client escalation or distress.
- Help each client identify, understand, and combat stigma and discrimination associated with mental illness, substance use, and/or homelessness, and develop strategies to reduce self-stigma.
- Screen for behavioral health needs and facilitate connection or reconnection to community behavioral health services.
- Connect each client with needed resources (e.g., harm reduction supplies, recovery support groups) and coordinate with community organizations to increase access to those services.
- Facilitate scheduling of new appointments and/or accessing community behavioral health services.
- Refer each client to community behavioral health, recovery, and/or harm reduction programs and facilitate transition planning, as needed.
- Provide health education for psychiatric medications prescribed by outside providers when needed.
- Address stigmatizing practices by reviewing admission criteria to determine if clients with behavioral health conditions are being excluded based on diagnosis alone.

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 medical respite care clients. Additional services are offered through community connections and partnerships, especially in preparation for transition and discharge.

Skills and Expertise

Although a staff member's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are needed to safely provide services within the Integrated Clinical Care model.

ADMISSIONS SCREENING and INTAKE

- Extensive knowledge of, and adherence to, program admissions criteria.
- Communicate and hold clear boundaries.
- Comprehensively screen referrals, including review of supplemental health information, and assess each client's acuity, program requirements/criteria, and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within the medical respite program.
- Orient each client to the medical respite facility and program, including admission agreements, to optimize retention in the program.
- Maintain positive and collaborative relationships with hospitals, referring entities, and other partners/community providers.
- Communicate to and ensure referral sources/external agencies are aware of the referral process.

Integrated Clinical Care Potential Staffing

- Medical director or prescribing provider (MD/PA/DO/NP)
- Nurse (RN/LVN/LPN)
- Social Worker (LMSW/LCSW/LCPC)
- Behavioral Health Provider
- Case Manager
- Medical Assistant
- Community Health Worker
- Peer Support Specialist
- Medical Respite Assistant/Technician
- Behavioral Health Technician

CARE PLANNING and COORDINATION

- Establish goals with each client.
- Conduct an individual needs assessment, including clinical evaluation, that identifies medical, behavioral health, case management, and care coordination needs.
- Develop a care plan based on the goals of each client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections with appropriate providers (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with each client.

CASE MANAGEMENT

- Identify case management and supportive service needs, including eligibility for community resources and supports needed for housing transition.
- Provide resources for local and community-based organizations and complete referral processes for services, including community case management, Coordinated Entry, etc.
- Coordinate with pre-existing case management and facilitate ongoing case management supports as needed.
- Support each client in identifying, discussing, and pursuing immediate and long-term needs related to Social Determinants of Health (SDOH), such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits, etc.
- Support each client in identifying and removing barriers to immediate and long-term needs related to SDOH.
- Provide each client with an education tailored to the individual's learning style, education, and/or reading level, and that is sensitive to the culture of the individual.
- Support each client in obtaining vital documents such as identification, social security cards, etc.
- Support each client if/when behavioral concerns arise to maximize client retention in the program.
- Develop rapport with each client and offer hope through one's own life experience by using personal stories in a conscious, deliberate, and professional way in the service of helping another, when appropriate.

HEALTH NAVIGATION and HEALTH SELF-MANAGEMENT

- Assist each client with prescription management to fill/refill medications or connect them to resources that can support access to needed medications.
- Connect each client to primary care and community health care providers based on individual needs.
- Assist each client with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport each client to scheduled appointments or assist with scheduling outside transportation services.
- Assist each client in planning for and navigating post-respite transportation needs.
- Assist each client in developing awareness of the need for treatment services and use motivational interviewing and a client-centered approach to address any concerns or motivations impacting engagement in health services, such as attending appointments or completing discharge recommendations.
- Support each client in improving health literacy.
- Identify and address external barriers to receiving and engaging in services; provide advocacy when clients are receiving substandard care, request needed referrals, and navigate intake processes.
- Facilitate each client's access to durable medical equipment (DME) and medical supplies, such as wound care, oxygen, and incontinence supplies, as needed.
- Assist each client with obtaining insurance and/or understanding benefits and provide education on how to navigate their plan.
- Ensure each client can safely store their medications, including ensuring storage is secure, and the client has access to all needed medications.

- Support self-administration of medications and ongoing client progress towards self-management of medications.
- Coordinate with and ensure each client has space in the program to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy), ensure providers arrive as scheduled, and that the client is at the program when providers arrive.
- Facilitate communication with prescribing providers and support each client in discussions regarding their tolerance of medications and adherence to the medication regimen.
- Educate each client on medication administration and management, overall health management, and condition monitoring.

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Address and/or support each client in responding to delays, paperwork needed, or other barriers to attending appointments or receiving home health services.
- Screen for additional health needs, communicate with the prescribing provider any need for referrals or generate referrals, and support the navigation process of accessing those services.

CLINICAL CARE

- Case conference and communicate with program staff and medical providers.
- Provide 24-hour access to clinical staff and/or on-call medical support (internally or through partnerships).
- Educate each client on how to utilize the medical call line to address immediate medical needs.
- Provide each client with guidelines on when to contact the on-site provider vs. emergency department care.
- Provide clinical care within the scope and license of staff, as indicated by care plans, and within limits of appropriate case load size.
- Educate each client on medication administration and management, overall health management, and condition monitoring.
- Provide medication management within the scope of license, and per medication guidelines or state regulations, which can include storing, dispensing, administering, prescribing, reconciling, and monitoring, as indicated by the care plan.
- Simplify medication regimen, as needed.
- Provide education to each client to support following discharge instructions, monitoring changes in health, and relevant health management skills.
- Use case conferencing information to develop the clinical care plan and goals or discharge indicators.
- Log vital signs and monitor each client closely for changes in health status, as indicated by the care plan.
- Administer pre- and post-procedural or operative care.
- Document all clinical care provided during the medical respite stay, including a discharge summary.
- Gather information for a clinical care plan, including completing a physical and psychological history and assessment; reviewing the list of current medications, dosages, and allergies; vital signs; and other pertinent information or medical history, such as laboratory or other test results.

- Communicate and develop a plan of care, coordinating with the PCP or outside specialty providers as needed.
- Complete routine clinical assessments and/or medical exams, as indicated by the care plan.
- Provide comprehensive medical care, which may include wound care, assistance with medication management, pain control, assessment of external body conditions, monitoring of vitals and recovery progress, and other health support, as indicated by the care plan and referring entity.
- Complete ongoing assessments of each client to identify and address additional health needs.
- Assess the need for specialty care and/or home-based health services and make a referral when applicable.
- Assess health management skills and implement strategies to support independence in health management.
- Monitor clients receiving outpatient treatment (e.g., IV-based medical interventions, dialysis, or chemotherapy).
- Generate a discharge summary for the client and send it to community-based providers when possible.
- Plan and implement health education groups onsite, which can include topics of physical health and wellness management, symptom management, food and nutrition, etc.
- Share pertinent health information with additional providers (as needed), with each client and with their community-based provider at program discharge, including medication list, PCP and specialty provider contacts, and case management and community resources.
- Clinical monitoring for those with complex or high-level medical needs, as indicated by the care plan.

BEHAVIORAL HEALTH CARE

- Use mental health first aid and trauma-informed de-escalation strategies to address or prevent client escalation or distress.
- Help each client identify, understand, and combat stigma and discrimination associated with mental illness, substance use, and/or homelessness, and develop strategies to reduce self-stigma.
- Assess and evaluate each client for behavioral health conditions or substance use needs, including identifying which symptoms are problematic for the client and strategies they have found to be successful.
- Conduct screenings and psychological assessments (including diagnostic evaluations); Screening examples may include screenings for depression, anxiety, drug and alcohol use, suicide, cognitive impairments, and/or functional impairments.
- Provide immediate interventions for acute life stressors or psychosocial factors that are impacting the client's medical condition.
- Develop treatment plans and provide behavioral health and substance use disorder therapy services to address the psychosocial needs of clients that are appropriate to the client's length of stay in the program.
- Create a plan for transition to community-based behavioral health providers post medical respite stay.
- Complete a direct referral to a prescribing provider if psychiatric medications are needed.
- Assess the need for medication-assisted treatment (MAT) and refer to community resources, as needed.
- Provide crisis intervention, as needed, in collaboration with clinical staff and community partners.

- Use a wide range of treatment modalities to address the unique needs of clients experiencing and/or at risk of homelessness (e.g., Motivational interviewing, Stepped care, Solution-focused therapy).
- Provide psychoeducation (individual and group sessions).
- Facilitate group education focused on behavioral health, psychoeducation, and self-management (clinician or peer-support-led).
- Provide group peer counseling and support to validate clients' experiences and provide guidance and encouragement to clients.
- Address stigma associated with receiving behavioral health care by:
 - Advocating for and supporting clients in getting needed medications and medical care;
 - Becoming educated on best practices for people with mental health symptoms;
 - Providing medical care that is responsive to the impact of mental health symptoms.
- Facilitate onsite individual and group sessions that are recovery-oriented or connect clients to an outside agency for supportive services.
- Complete referral and assist with transition planning to community recovery programs and/or behavioral health providers.
- Provide harm reduction education, equipment, and services.
- Connect clients to ongoing community resources (such as access to harm reduction supplies) before discharge.
- Guide and encourage clients to take responsibility and actively participate in their recovery.
- Provide education to program staff on best practices for supporting people with behavioral health conditions.
- Address stigmatizing practices by reviewing admission criteria to determine if clients with behavioral health conditions are being excluded based on diagnosis alone.

Comprehensive Clinical Care Model

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

Skills and Expertise

Although a staff member's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are needed to safely provide services within the Comprehensive Clinical Care model.

ADMISSIONS SCREENING and INTAKE

- Extensive knowledge of, and adherence to, program admissions criteria.
- Communicate and hold clear boundaries.
- Comprehensively screen referrals, including review of supplemental health information, and assess each client's acuity, program requirements/criteria, and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within the medical respite program.
- Orient each client to the medical respite facility and program, including admission agreements, to optimize retention in the program.
- Maintain positive and collaborative relationships with hospitals, referring entities, and other partners/community providers.
- Communicate to and ensure referral sources/external agencies are aware of the referral process.

Comprehensive Clinical Care Potential Staffing

- Medical director or prescribing provider (MD/PA/DO/NP)
- Nurse (RN/LVN/LPN)
- Medical Assistant
- Social Worker (LMSW/LCSW/LCPC)
- Behavioral Health Provider
- Psychiatrist
- Substance use/recovery counselor
- Case manager
- Medical Respite Assistant/Technician
- Behavioral Health Technician

CARE PLANNING and COORDINATION

- Establish goals with each client.
- Conduct an individual needs assessment, including clinical evaluation, that identifies medical, behavioral health, case management, and care coordination needs.
- Develop a care plan based on the goals of each client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections with appropriate providers (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with each client.

CASE MANAGEMENT

- Identify case management and supportive service needs, including eligibility for community resources and supports needed for housing transition.
- Provide resources for local and community-based organizations and complete referral processes for services, including community case management, Coordinated Entry, etc.
- Coordinate with pre-existing case management and facilitate ongoing case management supports as needed.
- Support each client in identifying, discussing, and pursuing immediate and long-term needs related to Social Determinants of Health (SDOH), such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits, etc.
- Support each client in identifying and removing barriers to immediate and long-term needs related to SDOH.
- Provide each client with an education tailored to the individual's learning style, education, and/or reading level, and that is sensitive to the culture of the individual.
- Support each client in obtaining vital documents such as identification, social security cards, etc.
- Support each client if/when behavioral concerns arise to maximize client retention in the program.
- Develop rapport with each client and offer hope through one's own life experience by using personal stories in a conscious, deliberate, and professional way in the service of helping another, when appropriate.

HEALTH NAVIGATION and HEALTH SELF-MANAGEMENT

- Assist each client with prescription management to fill/refill medications or connect them to resources that can support access to needed medications.
- Connect each client to primary care and community health care providers based on individual needs.
- Assist each client with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport each client to scheduled appointments or assist with scheduling outside transportation services.
- Assist each client in planning for and navigating post-respite transportation needs.
- Assist each client in developing awareness of the need for treatment services and use motivational interviewing and a client-centered approach to address any concerns or motivations impacting engagement in health services, such as attending appointments or completing discharge recommendations.
- Support each client in improving health literacy.
- Identify and address external barriers to receiving and engaging in services; provide advocacy when clients are receiving substandard care, request needed referrals, and navigate intake processes.
- Facilitate each client's access to obtaining durable medical equipment (DME) and medical supplies, such as wound care, oxygen, and incontinence supplies, as needed.
- Assist each client with obtaining insurance and/or understanding benefits and provide education on how to navigate their plan.
- Ensure each client can safely store their medications, including ensuring storage is secure, and the client has access to all needed medications.

- Support self-administration of medications and ongoing client progress towards self-management of medications.
- Coordinate with and ensure each client has space in the program to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy), ensure providers arrive as scheduled, and that the client is at the program when providers arrive.
- Facilitate communication with prescribing providers and support each client in discussions regarding their tolerance of medications and adherence to the medication regimen.
- Educate each client on medication administration and management, overall health management, and condition monitoring.

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Address and/or support each client in responding to delays, paperwork needed, or other barriers to attending appointments or receiving home health services.
- Screen for additional health needs, communicate with the prescribing provider need for referrals or generate referrals, and support the navigation process of accessing those services.

CLINICAL CARE

- Case conference and communicate with program staff and medical providers.
- Provide 24-hour access to clinical staff and/or on-call medical support (internally or through partnerships).
- Educate each client on how to utilize the medical call line to address immediate medical needs.
- Provide each client with guidelines on when to contact the on-site provider vs. emergency department care.
- Provide clinical care within the scope and license of staff, as indicated by care plans, and within limits of appropriate case load size.
- Educate each client on medication administration and management, overall health management, and condition monitoring.
- Provide medication management within the scope of license, and per medication guidelines or state regulations, which can include storing, dispensing, administering, prescribing, reconciling, and monitoring, as indicated by the care plan.
- Simplify medication regimen, as needed.
- Provide education to each client to support following discharge instructions, monitoring changes in health, and relevant health management skills.
- Use case conferencing information to develop the clinical care plan and goals or discharge indicators.
- Log vital signs daily and monitor each client closely for changes in health status, as indicated by the care plan.
- Administer pre- and post-procedural or operative care.
- Document all clinical care provided during the medical respite stay, including a discharge summary.
- Gather information for a comprehensive clinical care plan, including completing a physical and psychological history and assessment; reviewing the list of current medications, dosages, and allergies; vital signs; and other pertinent information or medical history, such as laboratory or other test results.

- Communicate and develop a plan of care, coordinating with the PCP or outside specialty providers as needed.
- Complete routine clinical assessment and/or medical exam, as indicated by the care plan.
- Provide comprehensive medical care, which may include wound care, assistance with medication management, pain control, assessment of external body conditions, monitoring of vitals and recovery progress, and other health support, as indicated by the care plan and referring entity.
- Complete ongoing assessments of each client to identify and address additional health needs.
- Assess the need for and provide specialty care or refer for specialty and/or home-based health services when applicable.
- Assess health management skills and implement strategies to support independence in health management.
- Monitor clients receiving outpatient treatment (e.g., IV-based medical interventions, dialysis, or chemotherapy).
- Generate a discharge summary for the client and send it to community-based providers when possible.
- Plan and implement health education groups onsite, which can include topics of physical health and wellness management, symptom management, food and nutrition, etc.
- Share pertinent health information with additional providers (as needed), with each client and with their community-based provider at program discharge, including medication list, PCP and specialty provider contacts, and case management and community resources.
- Medical oversight and medication prescribing to address complex medical conditions in coordination with specialty care providers.
- Physical therapy evaluation and treatment to address mobility and musculoskeletal function as indicated by the care plan and impact of conditions.
- Occupational therapy evaluation and treatment to address functional limitations and needs as indicated by the care plan and impact of conditions.

BEHAVIORAL HEALTH CARE

- Use mental health first aid and trauma-informed de-escalation strategies to address or prevent client escalation or distress.
- Help each client identify, understand, and combat stigma and discrimination associated with mental illness, substance use, and/or homelessness, and develop strategies to reduce self-stigma.
- Assess and evaluate each client for behavioral health conditions or substance use needs, including identifying which symptoms are problematic for the client and strategies they have found to be successful.
- Conduct screenings and psychological assessments (including diagnostic evaluations); Screening examples may include screenings for depression, anxiety, drug and alcohol use, suicide, cognitive impairments, and/or functional impairments.
- Provide immediate interventions for acute life stressors or psychosocial factors that are impacting the client's medical condition.
- Develop treatment plans and provide behavioral health and substance use disorder therapy services to address the psychosocial needs of clients that are appropriate to the client's length of stay in the program.

- Create a plan for transition to community-based behavioral health providers post medical respite stay.
- Prescribe psychiatric medication and adjust dosage as needed to reduce side effects while still managing symptoms.
- Assess the need for medication-assisted treatment (MAT), provide bridge dosing, and refer to community resources, as needed.
- Provide crisis intervention, as needed, in collaboration with clinical staff and community partners.
- Use a wide range of treatment modalities to address the unique needs of clients experiencing and/or at risk of homelessness (e.g., Motivational interviewing, Stepped care, Solution-focused therapy).
- Provide individual psychoeducation.
- Facilitate group education focused on behavioral health, psychoeducation, and self-management (clinician or peer-support-led).
- Provide group peer counseling and support to validate clients' experiences and provide guidance and encouragement to clients.
- Address stigma associated with receiving behavioral health care by:
 - Advocating for and supporting clients in getting needed medications and medical care;
 - Becoming educated on best practices for people with mental health symptoms;
 - Providing medical care that is responsive to the impact of mental health symptoms.
- Facilitate onsite individual and group sessions that are recovery-oriented, or connect clients to community recovery services when preferred
- Refer clients to community behavioral health, recovery, and/or harm reduction programs and facilitate transition planning (as needed).
- Provide harm reduction education, equipment, and services.
- Connect each client to ongoing community resources (such as access to harm reduction supplies) before discharge.
- Guide and encourage clients to take responsibility and actively participate in their own recovery.
- Provide education to program staff on best practices for supporting people with behavioral health conditions.
- Address stigmatizing practices by reviewing admission criteria to determine if clients with behavioral health conditions are being excluded based on diagnosis alone.

Visual Model of Potential Staffing for Each Model of Care

Coordinated Care Model	Coordinated Clinical Care Model	Integrated Clinical Care Model	Comprehensive Clinical Care Model
• Case Manager • Community Health Worker • Peer Support Specialist • Social Worker (LMSW/LCSW/LCPC)	• Case Manager • Community Health Worker • Peer Support Specialist • Social Worker (LMSW/LCSW/LCPC) • Nurse (RN/LVN/LPN)	• Case Manager • Community Health Worker • Peer Support Specialist • Social Worker (LMSW/LCSW/LCPC) • Medical director or prescribing provider (MD/PA/DO/NP) • Nurse (RN/LVN/LPN) • Medical Assistant • Behavioral Health Provider • Medical Respite Assistant/Technician • Behavioral Health Technician	• Case Manager • Community Health Worker • Peer Support Specialist • Social Worker (LMSW/LCSW/LCPC) • Medical director or prescribing provider (MD/PA/DO/NP) • Nurse (RN/LVN/LPN) • Medical Assistant • Behavioral Health Provider • Psychiatrist • Substance use/recovery counselor • Medical Respite Assistant/Technician • Behavioral Health Technician • Occupational Therapist • Physical Therapist

Appendix A

Defining the Medical Respite Program Services

Case Management and Care Coordination

Case management and care coordination are **essential services** of all programs and play a vital role in ensuring that clients receive comprehensive, integrated, and continuous care, as outlined by **the Standards for Medical Respite Care Programs** (2021). These components are designed to address the complex needs of clients by bridging the gaps between various services and support systems.

Case Management is a collaborative process that involves assessing, planning, implementing, coordinating, monitoring, and evaluating the options and services needed to meet a client's health and human service needs. This process involves advocacy, communication, and resource management to promote quality and cost-effective interventions and outcomes.

Care Coordination involves purposely organizing patient care activities and sharing information among the client's medical and behavioral health care providers to achieve safer and more effective care. The goal is to ensure that the needs of the client regarding health services and information sharing across the care team sites are met over time.

Medical and Clinical Care

Medical and Clinical Care in medical respite includes assessment of baseline patient health, ongoing reassessments to determine whether clinical interventions are effective, and determining readiness for program discharge. Medical and clinical care should be delivered by qualified personnel. High-quality clinical care identifies and responds to the patient's needs and goals and promotes interdisciplinary teamwork.

Medication Management and Support³

Medication Support is the support that enables a person to manage their medications and activities related to individual medication management.

Medication Management by Health Care Providers is the practice of prescribing, administering, and/or dispensing medication by qualified personnel and monitoring for efficacy and toxicity.

Behavioral Health

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

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

Appendix B

Partnerships with Organizations to Provide Medical Respite Care Services

The key components and program services of MRC may be delivered through collaborations and partnerships involving two or more organizations. Partnerships are crucial for all Models, as they often enable clients to more easily access existing community programs and reduce service duplication. Engaging and connecting with partners can facilitate smoother transitions from MRC to the community and aid in the development of community-based and natural support systems.

The operating organization of a medical respite program may use two different levels of partnership to connect clients to or to provide services.

1. Collaboration with Community Providers

A **collaborative relationship** is one where the medical respite program uses a community organization or program through its typical structures and pathways for accessing services. In these relationships, the medical respite program staff will support the clients in accessing the community organization's services through referrals or appointments, and facilitate the connection by ensuring transportation, helping the client prepare for the appointment, and scheduling. There may be various levels of collaboration, such as having direct contacts to make referrals or cross-training among staff to better understand each program's roles and services offered.

Example of a Collaboration with a Community Partner

A medical respite program refers a client to the community behavioral health clinic. The medical respite case manager completes the referral with the consent of the client through the behavioral health clinic's online platform. The case manager follows up with the client to ensure the behavioral health clinic has contacted the client to schedule an intake assessment. Once the intake is scheduled, the case manager helps remind the client of the appointment, prints the client's medical records and medication list for them to take to the appointment, and arranges a cab ride to and from the appointment. The case manager then receives consent from the client to coordinate with the behavioral provider to include upcoming appointments and goals into the client's ongoing care plan.

2. Formal Partnerships

A **formal partnership** is when a medical respite program has a formalized relationship with a community organization or service, and these services are meaningfully integrated within the medical respite program to increase access to care or services. In a formal partnership, the program will have a contract, MOU, or other formalized documentation of the services the partner organization will be providing, and where and how the services will be provided. There may be varying levels of formal partnerships, such as having direct access to held appointment slots at the primary care clinic to expedite the person's first medical appointment or having the mobile medical unit come onsite 3 days a week to provide the medical services.

Example of a Formal Partnership

A medical respite program has a contract with a community behavioral health provider to provide behavioral health services. As part of this contract, a behavioral health therapist comes to the program twice a week to meet with clients of the program, to provide both individual and group sessions. The therapist sees the clients who are suggested by the medical respite team and identifies additional clients during groups and informal interactions. A psychiatrist also comes on site once every two weeks to provide psychiatric medication management for clients of the program needing this service. In preparation for discharge, clients transition to attending their sessions at the behavioral health program, and the therapist facilitates a warm hand-off if the person will be transitioning to a new therapist.