GUIDE

Integrating Behavioral Health Services Into Medical Respite Programs

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A Project of the National Institute for Medical Respite Care,
a Program of the National Health Care for the Homeless Council

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Executive Summary

The United Health Foundation, the philanthropic foundation of UnitedHealth Group, awarded the National Health Care for the Homeless Council a three-year, $2.9 million grant to support the following aims: expand operational capacity in medical respite programs that serve rural and urban homeless populations; provide technical assistance and training; evaluate how greater integration of medical and behavioral health services leads to improved access, better patient outcomes and greater care continuity for patients experiencing homelessness; and share best practices on integrated medical respite care. Four medical respite care (MRC) organizations (Bob Tavani House for Medical Respite, Duluth, MN, Haywood Street Congregation, Asheville, NC, Hennepin County Health Care for the Homeless, Minneapolis, MN, Pathways to Care-Catholic Charities of Central Florida, Orlando, FL) participated in the project.

The project was facilitated through the National Institute for Medical Respite Care (NIMRC), a program within the National Health Care for the Homeless Council. MRCs completed a baseline self-assessment that informed a tailored plan with technical and training assistance developed by NIMRC, focusing on providing high quality behavioral health care. Programs participated in a peer learning community and received resources for data gathering and reporting that were associated with quality improvement processes and fidelity to NIMRC's Standards for Medical Respite Care. MRCs provided quarterly reports on the frequency of patients screened and treated for behavioral health disorders in addition to completing a self-assessment at the completion of the program.

The evaluation focused on understanding how behavioral health services were implemented and identifying factors that supported and barriers that hindered successful implementation. The Consolidated Framework for Implementation Research (CFIR) was adapted as the theoretical framework. Semi-structured interviews were conducted with MRC key informants and focused on the experience with implementation, perceived impact of the intervention, barriers and facilitators encountered, and factors influencing sustainability.

Programs implemented behavioral health services by hiring or expanding staff with experience, promoting staff training and certification in behavioral health competencies, adding on-site services, and facilitating access to community-based services. Barriers to implementation included: workplace culture and organizational legacy traditions and practices; state regulations, complex organizational infrastructure, and compliance requirements; a shortage of qualified candidates for key roles, and; reliable and sustained program funding. The following facilitators to implementation were noted: a local community environment that provided a supportive milieu, resources, and partnerships; an organizational structure, processes, and culture that was non-hierarchical and flexible, and; funding sources that were unencumbered by regulatory requirements.

A high percentage of clients were identified with behavioral health needs on admission across the cohort. There was variability in screening clients and connecting to behavioral services

among medical respite sites. However, the overall impact of implementing behavioral health services in MRCs was described as improving the lives of patients/clients by promoting engagement and enabling therapeutic relationships to meet their comprehensive care needs. In addition, the benefits of behavioral health interventions extended to care providers, program policies, finances, and operations. There were multiple lessons learned highlighted by MRCs. First, developing and adopting standard workflow policies and protocols with staff support are essential. Next, program operations need to account for the fiscal model. Organizational structures also need to be adaptable to support service expansion. Finally, the implementation process is iterative, time intensive, and provides opportunities for learning and adaptation.

Based on the evaluation, the following recommendations can promote the implementation of behavioral health services in medical respite programs.

1. Sustainable fiscal models need to account for flexible reimbursement pathways while maintaining the program mission.
2. Patient engagement and comprehensive assessments are integral program practices.
3. Governance and operating procedures and policies should reflect patient needs, the organization's infrastructure, and regulatory requirements.
4. Behavioral health personnel need to have experience and training that can respond to the needs of patients and staff.

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Introduction

Persons experiencing homelessness (PEH) have high rates of premature death and a greater prevalence of serious mental illness, substance use disorders, and both acute and chronic diseases (Fazel et al., 2014). Serious and persistent mental illness (SMI), such as schizophrenia, bipolar disorder, and major depression, are associated with higher rates of experiencing homelessness (Greenberg & Rosenheck, 2010) and a reduced likelihood of exiting homelessness (Nilsson et al., 2019). Cognitive impairment is also disproportionately experienced in PEH when compared to the general population (Hurstak et al., 2017; Stone et al., 2019). The lifetime risk of traumatic brain injury is approximately five times greater (Hwang et al., 2008). Substance use disorders are prevalent among homeless and vulnerably housed populations, who experience higher rates of adverse childhood experiences, trauma, and toxic stress that contribute to use of substance-related coping strategies in an effort to mitigate symptoms (Brown et al., 2009; Palepu et al., 2013).

PEH are subject to higher rates of trauma and adverse life experiences and, during periods of homelessness, encounter further psychological distress through economic insecurity, unsafe living conditions, diminished access to basic needs, and re-exposure to trauma (Bransford & Cole, 2019). Factors such as environmental exposure, substance use, and barriers to accessing health care, contribute to more advanced stages of disease burden (Baggett et al., 2018; Lee et al., 2005). As a result of barriers to accessing and maintaining health care (Zur et al., 2016b), many PEH seek health care through emergency departments and hospital settings (Hwang et al., 2009), which are reflected in high cost health service utilization rates (Fazel et al., 2014).

Medical respite care refers to recuperative or convalescent services that respond to the health care needs of PEH (National Health Care for the Homeless Council, n.d., 2025; Zerger, 2006). Unlike "respite" that is commonly associated with caregivers, "medical respite" is short-term residential care that allows individuals experiencing homelessness the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services (National Health Care for the Homeless Council, n.d.). Medical respite care can be offered in a variety of settings including freestanding facilities, homeless shelters, motels, and transitional housing (National Health Care for the Homeless Council, n.d.). Medical respite programs (MRPs) provide medical (Zur et al., 2016a) services and nursing care, but vary in the services provided and in the types of facilities in which care is provided (National Health Care for the Homeless Council, n.d.). The National Institute for Medical Respite Care (NIMRC) is a special initiative of the National Health Care for the Homeless Council has outlined standards and provides technical assistance to MRPs (National Health Care for the Homeless Council, n.d., 2025).

Description of Program

In 2022, the United Health Foundation, the philanthropic foundation of UnitedHealth Group, awarded the National Health Care for the Homeless Council a three-year, $2.9 million grant to

advance behavioral health services in medical respite settings in Florida, Minnesota and North Carolina. Programs across the three states were invited to submit Letters of Interest (LOIs) for the grant outlining how they would use funds to expand their behavioral health capacity and reduce barriers to their program for individuals with behavioral health needs. After reviewing the LOIs, NHCHC staff invited a selected number of programs to submit full grant proposals. Four organizations (Bob Tavani House for Medical Respite, Duluth, MN, Haywood Street Congregation, Asheville, NC, Hennepin County Health Care for the Homeless, Minneapolis, MN, Pathways to Care-Catholic Charities of Central Florida, Orlando, FL) were selected as the grant recipients. Each program received approximately $500,000 during the award period. In addition to re-granting dollars intended to directly impact client care, United Health Foundation funded NHCHC to focus on the following aims:

- Expanding operational capacity in medical respite programs that serve rural and urban homeless populations.
- Providing technical assistance and training for each of the selected programs, including the creation of a "United Health Foundation Medical Respite Cohort" peer learning community.
- Assessing and evaluating how greater integration of medical and behavioral health services leads to improved access, better patient outcomes and greater care continuity for patients experiencing homelessness.
- Sharing best practices on integrated medical respite care for reducing health disparities and improving outcomes among individuals experiencing homelessness.

Core Components

Each organization completed a pre-program REDCap survey that included organizational-level information (e.g., number of clients receiving services) and a self-assessment that was guided by the NIMRC Standards of Medical Respite Care. Organizations had the option to select any, or all, of the following standards for the self-assessment:

- Standard 1: Medical respite program provides safe and quality accommodations.
- Standard 2: Medical respite program provides quality environmental services.
- Standard 3: Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings.
- Standard 4: Medical respite program administers high quality post-acute clinical care.
- Standard 5: Medical respite program assists in health care coordination, provides wrap-around services and facilitates access to comprehensive support services.
- Standard 6: Medical respite program facilitates safe and appropriate care transitions out of medical respite care.
- Standard 7: Medical respite care personnel are equipped to address the needs of people experiencing homelessness.
- Standard 8: Medical respite care is driven by quality improvement.

The selected standards were mapped to a series of items with a response key of Not Met/Met and a qualitative descriptive field. Based on the item responses, the REDCap survey provided a percentage summary score for each standard completed. The percentage was calculated by dividing the "Met" responses by the total number of items in each standard and multiplied by 100. The pre-program survey provided the following normative information:

- A total overall percentage of 70% (or 78 Met items) was considered good fidelity to the Standards.
- If a program achieved an overall 70% Met rate, yet there were individual standards that fell below 70%, those standards should be reviewed and targeted for improvement.
- Programs with each standard at 70% or above should review items that were Not Met and determine if these areas should be targeted goal areas to achieve or use clinical reasoning and judgement to determine if these cannot be met due to program limitations.
- Additionally, programs can make efforts to establish structures so that the Standards are implemented even if there is staff turn-over or changes and should re-review and re-assess periodically to ensure things haven't shifted in response to systemic changes, as part of a continuous quality improvement process.
- A program that has an overall percentage below 70% (50 or less Met items) demonstrates a need for program improvement to better align with the Medical Respite Standards.
- Any Standards that are at less than 70% met should be targeted for program development and improvement.
- Programs can review resources in the Medical Respite Toolkit to support improvement efforts.

Based on the results of the self-assessment, NIMRC developed a tailored plan and provided technical and training assistance with a focus on providing high quality behavioral health care. MRCs participated in a peer learning community and were provided resources for data gathering and reporting that were associated with quality improvement processes and fidelity to NIMRC's Standards for Medical Respite Care. As part of the tailored plan, all programs provided quarterly reports that included the frequency of patients: (1) screened for behavioral health disorders on admission; (2) identified with known behavioral health disorders on admission; (3) referred to substance use (SUD) treatment and; (4) engaged in SUD treatment 30 days post admission.

At the completion of the program, each organization completed a REDCap survey that included a self-assessment guided by the NIMRC Standards of Medical Respite Care, a response key of Not Met/Met, a qualitative descriptive field, and an Upload File field for documentation if meeting the standard.

Evaluation

The evaluation focused on understanding how behavioral health (BH) services were implemented and identifying factors that supported and barriers that hindered successful implementation. Given variation in program structure, resources, and local context, the evaluation identified barriers and facilitators encountered by each site, as well as strategies that proved effective or ineffective in integrating BH services into medical respite care. By examining implementation processes across the four programs, the evaluation sought to generate practical, experience-based insights that could inform future efforts. Findings are intended to support other MRC programs in designing, adapting, and implementing BH interventions that are responsive to their unique settings and populations, while building on lessons learned from the pilot sites.

Objectives

The evaluation addressed the following questions:

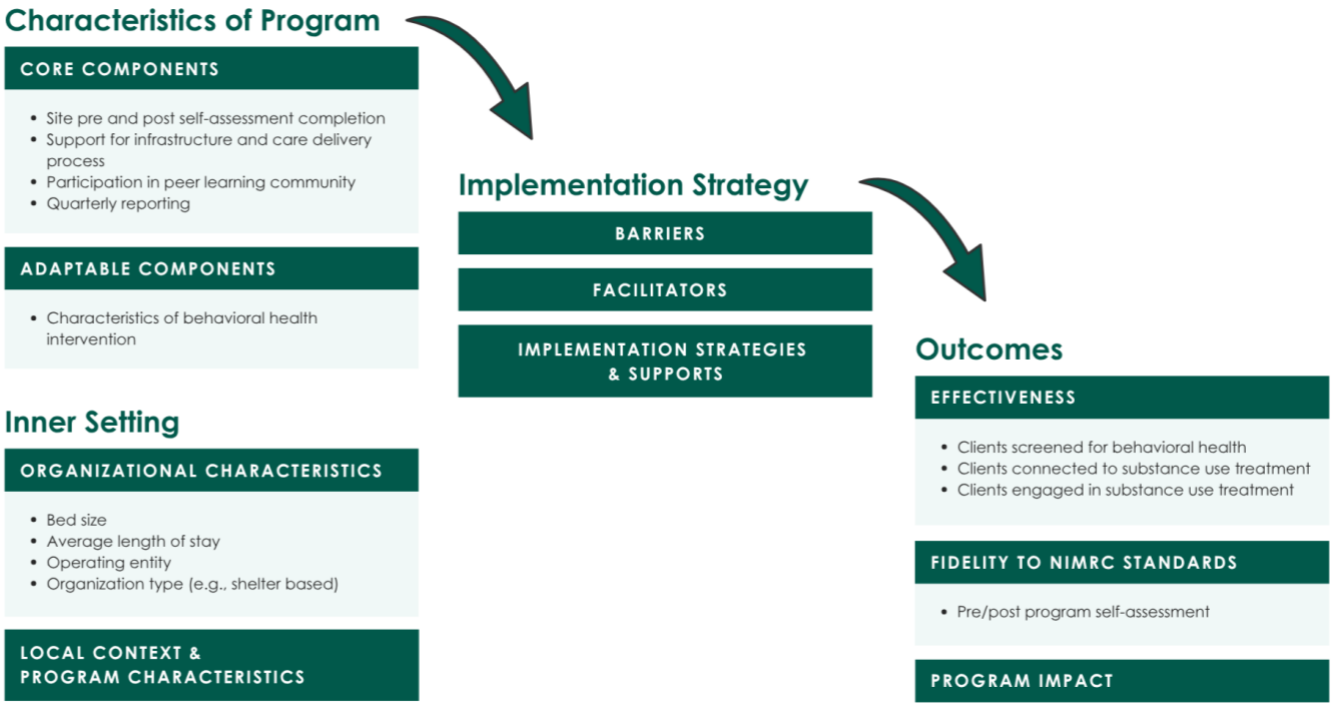
- What **barriers and facilitators** influenced the implementation of BH services across participating MRC programs, including factors related to staffing, workflows, partnerships, and organizational capacity?
- How did **local context and program characteristics** shape implementation processes, adaptations, and the uptake of BH services at each site?
- Which **implementation strategies and supports** (e.g., technical assistance, peer learning, quality improvement processes) were perceived as effective, and which were not effective, in supporting BH integration?
- What **common challenges and successful practices** emerged across sites during implementation that can inform future BH integration efforts in medical respite settings?
- What **lessons learned** from the four pilot sites can inform how other MRC programs design, adapt, and implement BH interventions aligned with nationally recognized standards?

Theoretical Framework

The Consolidated Framework for Implementation Research (CFIR), an implementation science framework that offers a typology to promote implementation theory development and verification about what works where and why across multiple contexts, was adapted for the evaluation. The CFIR is composed of five major domains: intervention characteristics, outer setting, inner setting, characteristics of the individuals involved, and the process of implementation. Eight constructs are identified related to the intervention (e.g., evidence strength and quality), four constructs were identified related to outer setting (e.g., patient needs and resources), 12 constructs are identified related to inner setting (e.g., culture, leadership engagement), five constructs were identified related to individual characteristics, and eight constructs were identified related to process (e.g., plan, evaluate, and reflect). CFIR constructs that are most relevant for program evaluation guided assessments of

implementation context, evaluate implementation progress, and help explain findings (Damschroder et al., 2009). Figure 1 below depicts the CFIR that was adapted to the UHF-NIMRC program and guided evaluation.

Figure 1. Adapted Consolidated Framework for Implementation Research (CFIR)



Methodology

A mixed-methods approach was used to describe and analyze the experiences of participating Medical Respite Care (MRC) programs, drawing on both project-generated data and data collected specifically for the evaluation. Project-generated data included document-based information from progress reports and quantitative data collected quarterly by participating programs between 2023 and 2025 as part of the program activities. In addition, qualitative data were collected specifically for this evaluation through semi-structured interviews with key personnel at each site.

Data Sources

Quarterly Program Reports

Key metrics were reported by participating programs quarterly (Y1Q1 to Y3Q4) and captured key aspects of behavioral health screening, referral, and engagement.

Key metrics included:

- Number of clients screened for behavioral health (BH) needs
- Number of clients admitted with a BH diagnosis
- Number of clients connected to substance use disorder (SUD) treatment
- Number of clients engaged in SUD treatment one month after connection
- Number of clients connected to mental health treatment
- Total number of clients served

Semi-Structured Interviews

For semi-structured interviews, key informants were individuals at each site who self-selected to participate in the interviews, due to their level of involvement in and knowledge of the implementation of the intervention. We interviewed a total of eight participants across the participating respite programs. Participants held a range of roles, including licensed social workers, a behavioral health specialist, an executive director, a social services manager, and a grants manager.

Interviews were guided by interview protocols designed to elicit information about the implementation and sustainability of behavioral health interventions in medical respite care settings.

Key topics covered in the semi-structured interviews included:

- Description of the behavioral health intervention selected by each site and experiences with implementation
- Perceived fit of the intervention with site workflows, staff roles, and organizational values related to behavioral health care
- Barriers and facilitators encountered during implementation, including staffing, training, policies, and partnerships
- Supports and resources that aided implementation, such as technical assistance, clinical champions, and external linkages
- Factors influencing the sustainability and integration of the intervention into routine medical respite care, including perceived benefits and value added

Interviews were conducted via Zoom and lasted approximately 45 minutes. We used Zoom's built-in features, including AI tools, to audio-record the sessions and generate meeting summaries. At the start of each interview, interviewers reviewed the purpose and goals of the conversation to participants and clarified that, because the interviews were intended for quality improvement rather than research, a formal consent form was not required. During each session, interviewers took detailed notes and asked clarifying and follow-up questions as needed.

Analytic Approaches

Analysis

Qualitative Analyses

Interviews with key participants were audio-recorded and summarized using Zoom's built-in AI tools. Summaries were subsequently reviewed for accuracy and were supplemented with interviewers' notes and targeted audio review to ensure completeness and fidelity prior to analysis.

After interview data were reviewed, a codebook was generated based on the questions addressed in the interview guides. The codebook was refined using interview summaries in the following way:

- Included any important themes or topics missing in the original interview guides.
- Assessed whether code descriptions were accurate and clearly defined.
- Determined whether examples and key features were complete and illustrative.
- Added, modified, or clarified codes as needed.
- Created specific sub-codes when content fit within a broader code but described a distinct concept that warrants its own category.

Once investigators agreed on a final version of the codebook, the codebook and summaries were entered into NVivo qualitative software (version 15). Two evaluators (TD, CRS) independently coded the meeting summaries, synthesizing findings across themes through an iterative memo writing process. The memos were later reviewed, together, by the two evaluators until consensus was reached to ensure accuracy of interpretation of data and finalize content. We member checked the data by sharing the themes and codes with participants who provided edits and clarifications.

Quantitative Analysis

Standard descriptive statistics (e.g., totals, proportions, and other summary measures) were generated to characterize the data. Participant data from the pre-program, quarterly, and post-program instruments were used to calculate descriptive statistics for the cohort. Quarterly program submissions informed the development of tables for each individual program as well as the full cohort in aggregate. Investigators used figures to visualize cumulative outcomes (e.g., total clients served, screening reach, and connection to substance use and mental health resources) and quarterly outcomes (e.g., number of screenings, positive screenings, and connection to services over time).

Results from the NHCHC standards self-assessment, administered before and after the program, were aggregated to assess changes in mean scores for total fidelity and fidelity to each individual standard (Standards 1-8). Program evaluators created tables to show percent change across each of these categories.

Results

Results are presented following the CFIR framework categories described above; Adaptable Components, Inner Setting, Implementation Strategy (Facilitators, Barriers, Implementation Strategies and Supports), and Outcomes. A summary of themes, sub themes and supporting codes are presented within each CFIR domain.

Adaptable Components

Table 1. Characteristics of Intervention & Technical Assistance

Site	Intervention	Technical Assistance Provided
Bob Tavani House	-Hire executive director -Support Co-site Directors	-Refine policies and procedures -Best practices for hospital partnerships -Support for data sharing and collaborative expansion with partners
Haywood Street	-Universal assessment completed by trained clinician (LCAS or LCSW) who can offer counseling -Trained peer supporters (2) -Staff training -Facility enhancement	-Staff training for clients with substance use disorders
Hennepin County	-Hire peer support specialist -Increase screening and engagement for mental health and substance use -Provide harm reduction supplies and recovery conversations -Expand activities for respite patients in community room, purchase wellness items for patient and program use.	-Start up and expansion of peer support program
Pathways to Care	-Mental health assessment during admission intake -Behavioral health clinicians provide counseling	-Build community partners -Best practices in hospital partnerships -Staff training -Sustainable funding

Intervention Characteristic Themes

a. **Programs promoted behavioral health services by hiring or expanding staff with experience.**
   - Utilizing supplemental funding to hire medical professionals (director, nurses with mental health backgrounds) (BTH)

- Embedding a Licensed Clinical Social Worker (LCSW), adding peer support specialists (Haywood).
- Hired a peer support specialist and expanded the role of their clinical social worker to provide mental health services (Hennepin).
- Peer support specialists who organized activities like art classes and puzzles (Hennepin).
- Collaboration with part-time psychiatric nurse practitioner (Pathways)
- Hiring nurses with mental health backgrounds to enhance service quality (BTH)
- Implementation of peer support and behavioral health interventions, highlighting the value of lived experience in mental health support (Hennepin)

b. Training and certification in behavioral health associated competencies was a complementary strategy.

- Implementing peer recovery support certification for staff (BTH).
- Providing community health worker training for house managers (BTH).
- Providing comprehensive staff training (Haywood).
- Mental Health First Aid training for all staff members (Pathways)
- Trauma-informed care education and ongoing awareness building (Pathways)
- Self-care training to help staff manage secondary trauma (Pathways)
- Creating certification pathways for staff professional growth (BTH)

c. Organizations implemented on-site services and facilitated access to community-based services.

- Serving as a bridge to community services for behavioral health and substance use support (BTH).
- Implementation of on-site behavioral health services (Pathways)
- Brief solution-focused therapy adapted to short-term setting (Pathways)
- Focus on emotional regulation skills and mindfulness (Pathways)
- Weekly "meditation minute" sessions (20 minutes) teaching coping skills (Pathways)
- Education about mental health symptoms and conditions (Pathways)
- Focus on achievable goals rather than deep trauma work (Pathways)

d. Program implementation strategies focused on relationship building with patients.

- Conducting healthcare assessments over several days to build rapport (BTH).
- Using family-style dinners to create comfortable environments for disclosure (BTH)
- Establishing personal relationships as foundation for effective intervention (BTH)
- Balancing formal assessment with relationship-building (BTH)
- Focusing on achievable goals and providing patients with a basic understanding of their mental health issues (Pathways)
- On-site specialists can intervene immediately with established relationships (Pathways)

e. Organization-level approaches included changes to operating structures, physical space, milieu, and reimbursement models.

- Change from a legacy founder model to a new operational structure (BTH).
- Implementing Medicaid-reimbursable services through community health worker certifications (BTH)
- Establishing policies and procedures for staff and guests, and creating a collaborative work culture (BTH)
- Upgrading the physical space with supplies like TVs and microwaves to improve quality of life during respite stay (Hennepin).
- Implementation of a mental health program in a remodeled building (Hennepin)
- Building a library and video collection (Hennepin).
- Integration of behavioral health services into existing medical respite framework (Pathways)
- Increased awareness among staff about trauma issues among residents and has improved the overall milieu of the program (Pathways)
- Creating standard operating procedures and policies (BTH)
- Implementing whistleblower policies and other baseline documentation (Tavani)
- Developing guest guidelines to ensure compliance with Medicaid requirements (Tavani)
- Establishing official referral processes before admission (BTH)
- Cross-training staff improved organizational flexibility (BTH)
- Addressing staff safety concerns (e.g., website modifications) (BTH)
- Program expanded its scope to accept referrals from diverse sources beyond hospitals, including community outreach workers and mental health providers (Haywood)
- Weekly group supervision sessions with clinical staff proved highly effective for supporting hospitality coordinators and peer support specialists (Haywood).
- Community partnerships, particularly with the Continuum of Care (COC) and local healthcare providers, were crucial to the program's success (Haywood).
- Staggered implementation over time ultimately worked well, allowing for the purchase of necessary supplies and the hiring of staff (Hennepin).

Inner Setting

Table 2. Organizational Characteristics of Medical Respite Programs (Source: NHCHC)

Characteristic	Bob Tavani House	Haywood Street	Hennepin County	Pathways to Care
Operating Agency	Private, non-profit	Private, non-profit	County government	Private, non-profit
Type	Stand-alone	Stand-alone	Stand-alone shelter	Assisted living/skilled nursing facility

Average Length of Stay (Days)	46-60	31-45	61-90	46-60
Funding Source	Private donations, Medicaid, foundations, grants	Medicaid; local and state government; private donations, grants	Federal (HRSA); local and state government	Hospital; local and state government; private donations; grants
Population Served	Men, women, trans/nonbinary, veterans, older	Men, women, trans/nonbinary, veterans, older, undocumented	Men, women, trans/nonbinary, veterans, older undocumented	Men, women, transgender/nonbinary, veterans, older, undocumented
Structure of Physical Space	Single and double resident occupancy units	Dorm or congregate rooms that are gender designated	Single and double occupancy rooms	Single-resident occupancy units; double/multiple resident occupancy units

Local Context and Program Characteristic Themes

a. Programmatic and organizational-level factors such as budget, culture, and the availability of specialized staff can impact feasibility and adaptation.

- [The organization] focused on these affordable interventions while working within their budget constraints, as they did not have full capacity for their medical team (BTH)
- They had a nurse-managed program from 2014 until 2.5 years ago, with hospitality coordinators handling day-to-day operations (Haywood)
- Faith-based approach, which enables them to provide extended care when medically appropriate, despite potential funding challenges. (Pathways)

b. An organization's structure and resources shape its culture, readiness to address challenges, and ability to adapt to change.

- Organization's flat, non-hierarchical structure as beneficial for adaptation and communication (Haywood)
- On-site services help prevent escalation of challenging situations (Pathways)
- Supervision and proper support systems had significantly increased her confidence in providing client care. (Pathways)
- The physical environment, such as the building, can support the implementation of both central and complementary components (Hennepin)
- A remodeled building, which included providing TVs, microwaves, and other amenities to residents (Hennepin)
- The clinic lacks a dedicated space for long-term assessments (Hennepin)

- A culture of increased collaboration and cooperation can make the atmosphere more agreeable (Pathways)
- Ongoing education and training bring new insights into practice (Pathways)
- Organization is working toward becoming fully trauma-informed (Pathways)

c. Linkages and coordination with community organizations and other stakeholders are key factors (Haywood)

- Partnerships with Federally Qualified Health Centers (Haywood)
- The partnership with the county hospital (Hennepin)
- A supportive environment provided by the county is always beneficial (Haywood)

Implementation Strategy

Barrier Themes

a. Workplace culture and organizational legacy traditions and practices can contribute to staff resistance to service expansion and cross-disciplinary collaboration.

- Administrative barriers to expanding services and incorporating behavioral care into medical care (Hennepin, Pathways)
- Managing paperwork across disciplines was described as very challenging (Pathways)
- Staff opinions often differ on when discharge is appropriate (Pathways)
- Process of founders stepping away from direct control (BTH)
- Balancing mission-driven care with financial sustainability (e.g., volunteer model to professional non-profit) (BTH)
- Difficulty managing and defining boundaries for multiple subpopulations with varying needs and goals (medical needs, mental health needs, substance use needs) in one setting (Haywood, Hennepin)
- Challenges in maintaining person-centered care while having different accountability standards for patients with different goals (Haywood)
- Challenging labor-intensive nature of the expanded approach as well as the need for support for staff (e.g., when dealing with active addiction) (Haywood)

b. State regulations, a complex organizational infrastructure, and requirements associated with compliance, documentation, approvals, and billing are administrative impediments to implementation.

- Managing supply inventory (Hennepin)
- Clinic lacking adequate spaces for intervention-component implementation, such as long-term assessment, or prioritizing medical tasks over behavioral health interventions (Hennepin)
- Sometimes residents no longer need medical respite but would benefit from continued mental health support (Pathways)

- Need for a longer runway and a structured transition plan for the board to move from a working board to a governing board. (BTH)
- Navigating the complexities of state regulations for Medicaid billing compliance, creating contracts with managed care organizations, and navigating the creation and implementation of effective billing software.
- Navigating the changing landscape of federal and state government rules and regulations regarding Medicaid.
- Concern about the integrity of their reporting due to difficulty separating mental health, behavioral health, and substance use categories as most patients have substantial overlaps (Haywood)
- Outcome measures evolved over time, making longitudinal comparison difficult (Haywood)

c. Contextual factors that are outside of the program, such as a shortage of qualified candidates for key roles or limited discharge options for patients, can create barriers to implementation and disrupt care continuity.

- Finding candidates with specific respite experience (Hennepin)
- Difficulty finding qualified behavioral health providers in an area with limited qualified candidates (Pathways)
- Connecting residents with programs in their preferred discharge area (Pathways)

d. Reliable and sustained program funding is often a challenge, particularly when sources of support, such as hospitals, may have objectives that are not aligned with the program.

- Challenges of aligning funding with implementation goals (Hennepin)
- Hospital partners primarily concerned with preventing 30-day readmissions (Pathways)

<u>Facilitator Themes</u>

a. The local community environment can provide a supportive milieu, resources, and partnerships to promote and sustain initiatives.

- City/municipality/county government evolving approach to homelessness created a supportive environment (Haywood)
- Value of the Continuum of Care (COC) coordination across community organizations (Haywood)
- County's investment in outreach capacity through EMS and fire department specialized teams (Haywood)
- Partnerships with Federally Qualified Health Centers (FQHCs) (Haywood)
- County's continued support for a staff position which already exists and has been expanded to include a behavioral health component (Hennepin)
- Medical respite programs as recognized solution in state/county (Hennepin)

b. An organizational structure, processes, and culture that is flat, non-hierarchical, and flexible is beneficial for adaptation and innovation.

- Organization's flat, non-hierarchical structure as beneficial for adaptation and communication (Haywood)
- Standing, weekly multidisciplinary case manager review meetings of patients (Pathways)
- Importance of staff support, flexibility, and continued service adaptation to meet the needs of patients (Hennepin).
- Having "heart for the folks" who have experienced trauma (Pathways)
- Strong leadership that supports comprehensive patient care considering funding pressures (Pathways)
- Faith-based mission promotes care beyond medical needs (Pathways)
- Streamlined documentation and discharge planning for transition to mental health services (Pathways)

c. Funding sources that are flexible and unencumbered by regulatory requirements can support the adaptive needs of the program.

- Funding to be flexible (lump sum) and supportive of needs rather than reimbursement-based funding (Hennepin)

<u>Implementation Strategies and Supports Themes</u>

a. Effective training facilitates the implementation process.

- Peer recovery support certification (BTH)
- Community health worker training (BTH)
- Certified Peer Support Specialist (CPSS) training, programs including resilience training, and boundary-setting, motivational interviewing and the stages of change model (Haywood)
- Nonviolent Crisis Intervention Trainer Certification through Crisis Prevention Institute (Pathways)

b. Funding needs, unanticipated support for specialized staff, or expansion of on-site services can stretch funding.

- Supplemental funding to hire medical professionals with mental health backgrounds (BTH)
- Hiring peer support staff, for example, with relevant mental health and substance abuse experience, as well as lived experience of homelessness (Hennepin)

c. Standard operating procedures and protocols that address staff safety and other regulatory requirements can promote an intervention's effectiveness and sustainability.

- Implementing whistleblower policies (BTH)
- Guidelines to ensure compliance with Medicare requirements (BTH)
- Need for streamlined forms and integrated documentation (Pathways)
- Establishing official referral processes before admission, or expanding referral sources, for example, beyond hospitals to include community outreach, paramedics, and mental health providers (BTH, Haywood)
- Regular supervision for behavioral health providers and comprehensive staff training in trauma informed care is essential for overall program effectiveness (Pathways)

d. Balancing mission and financial sustainability is important along the way (BTH)

- Aiming to maintain 30% of beds for unpaid care while ensuring the remaining 70% is supported through paid services. (BTH)

Outcomes

Effectiveness

Cohort Descriptive Statistics

	Number	Proportion of Total Served
Total Number of Clients Served by Cohort Programs	1,157	100%
Clients Screened for Behavioral Health Needs	853	74%
Clients Admitted with Behavioral Health Diagnosis	881	76%
Clients Connected to Substance Use Disorder Services	420	36%
Known Clients* Connected to Behavioral Health Services	387*	47%* (n = 823)

**Data for Behavioral Health Service connections missing for three quarters. Total (n) for this variable was 823.*

Quarterly Cohort Data

Quarterly run charts for the full cohort are provided below.

Chart 1. Behavioral Health Screening Reach (Percentage of Total Served) Over Time

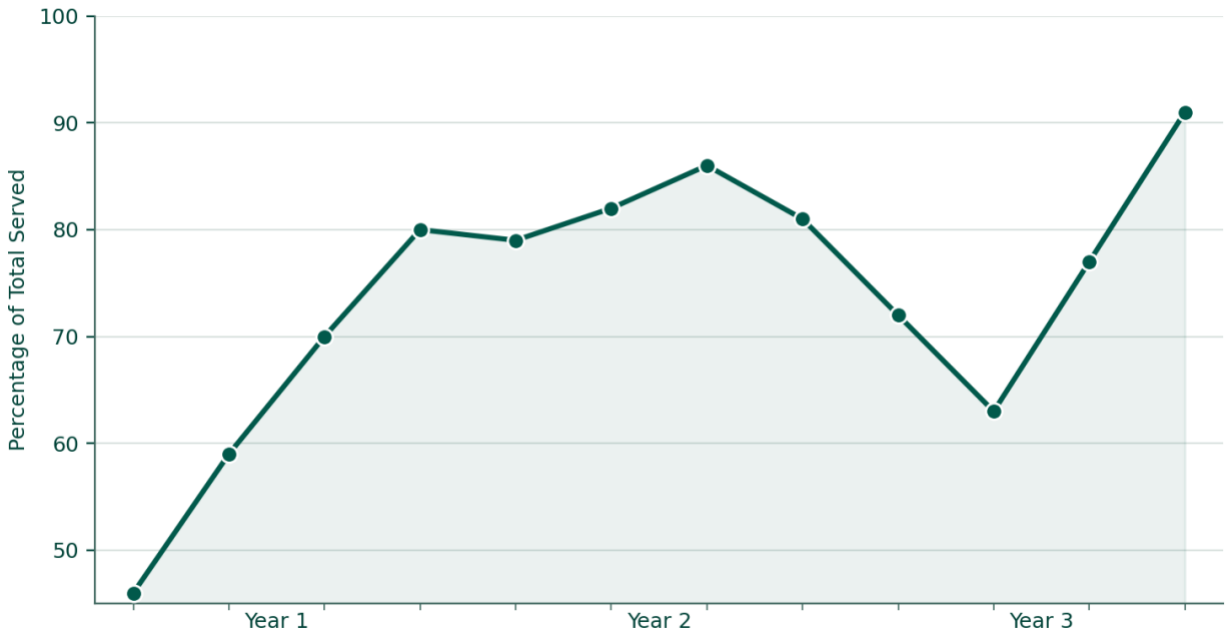


Chart 2. Percentage of Clients Connected to SUD Services Over Time

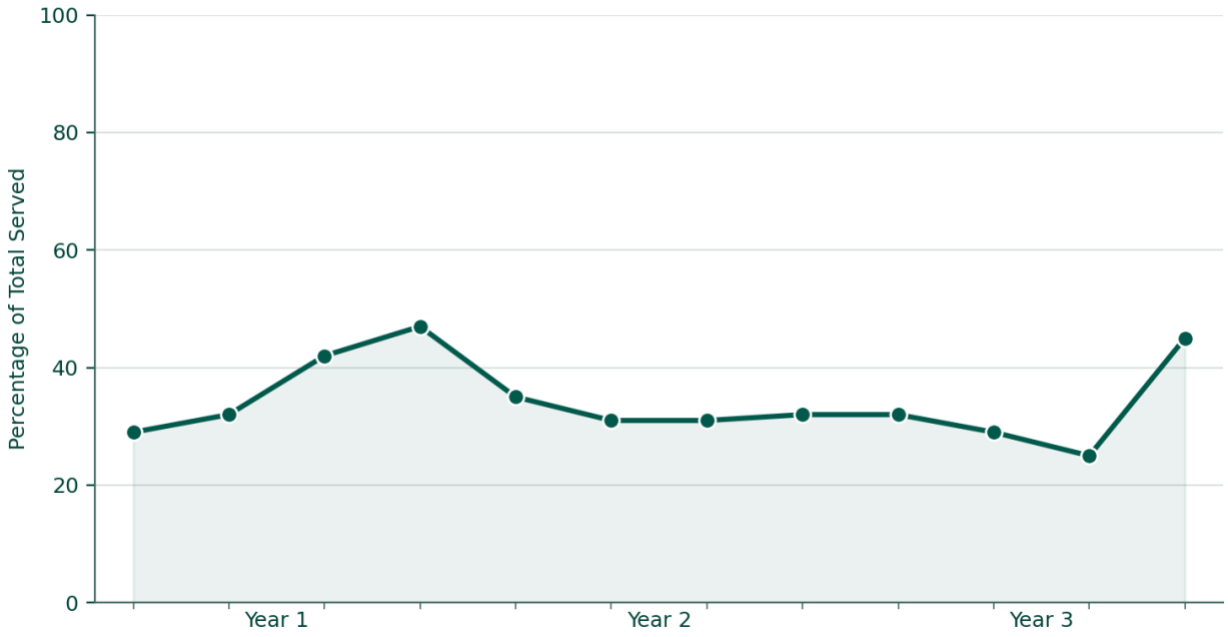
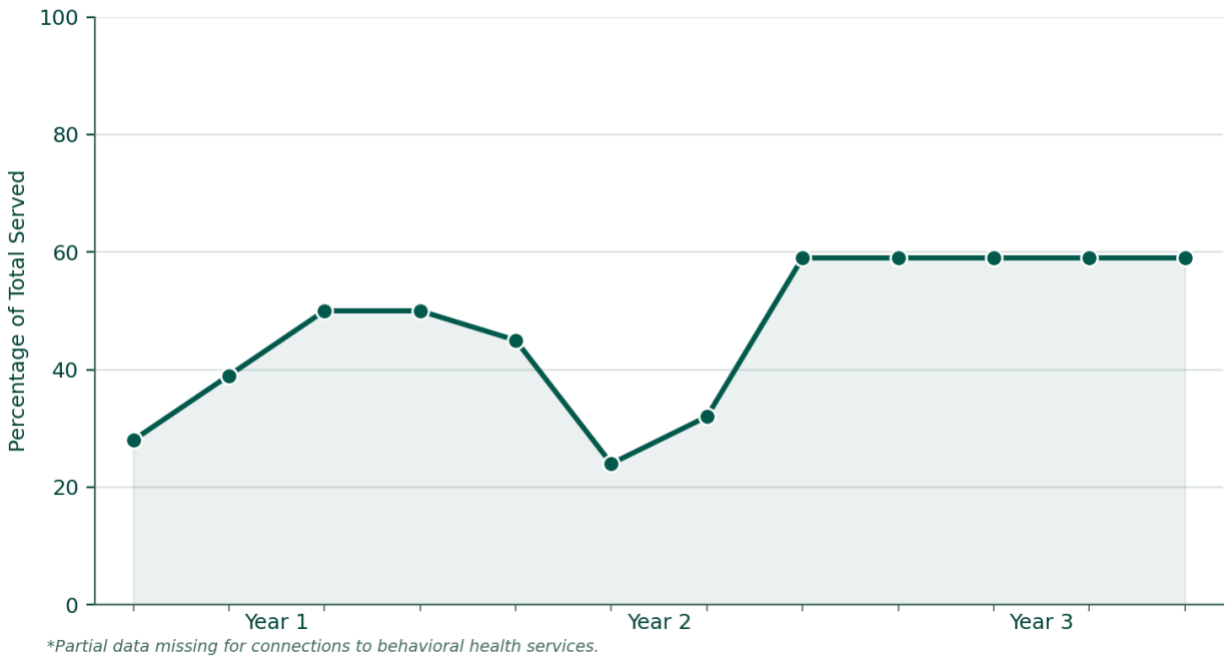


Chart 3. Percentage of Clients Connected to Behavioral Health Services Over Time*



Partial data missing for connections to behavioral health services. Year 1 is omitted from this run chart.

Fidelity to NHCHC Medical Respite Care Standards

Aggregate mean scores show an improvement in Total Fidelity and in every individual Medical Respite Care standard across the cohort. The cohort's aggregated results from the Medical Respite Organizational Self-Assessment are in the table below.

	Pre-Program Mean Score	Post-Program Mean Score	Percent Change in Mean Score
Standard 1	68	89	+30.9%
Standard 2	61	77.75	+27.5%
Standard 3	79.25	91.75	+15.8%
Standard 4	67.5	92.5	+37.0%
Standard 5	92.25	100	+8.4%
Standard 6	68.5	85	+24.1%
Standard 7	66.75	87.5	+31.1%
Standard 8	57.75	94	+62.8%
TOTAL FIDELITY	70.75	90.25	+27.6%

Perceived Impact Theme

a. **On-site services, personnel, and embedded workflows improved the lives of patients/clients by promoting engagement and enabled therapeutic relationships to meet comprehensive care needs.**

- On-site services made a significant difference in the lives of their guests, establishing trust and addressing various health and social issues. (BTH)
- Healthcare assessments, which included mental health screenings and substance use discussions, conducted over several days build rapport with guests (BTH)
- Program evolved to serve patients with more complex behavioral health needs than previously possible (Haywood)
- The peer support specialist helped integrate services and free up the social worker's time for discipline-specific tasks (Hennepin)
- Supplies to improve the quality of life for program participants (Hennepin)
- Improved consistency in resident participation in behavioral health services (Pathways)
- Prevented escalation of challenging situations and improved appointment attendance (Pathways)
- Increased access to services (Pathways)

b. **The benefits of behavioral health interventions extend to care providers in the program.**

- The impact of behavioral health interventions, while initially targeted at clients, staff, and patients, often extend to the medical team (Hennepin)
- The team's efforts to flatten hierarchy, which has led to stronger interdisciplinary collaboration and respect among staff, despite not always agreeing (Hennepin)
- Benefits extended beyond residents to staff members, who gained trauma-informed perspectives and felt more supported (Pathways)
- Increased awareness among staff about trauma issues among residents (Pathways)

c. **Larger program policies, finances, and operations are enhanced by behavioral health interventions.**

- The intervention impacted the organization's operations, particularly regarding the management of art supplies and the community room. (Hennepin)
- There were changes in staff responsibilities, including organizing and distributing supplies, as well as adjusting access policies to address security concerns (Hennepin).
- Funding remained free from federal or state complications, which has positively impacted other funding sources (Hennepin).
- Facility atmosphere and overall milieu described as "more settled" with increased collaboration (Pathways)

Lessons Learned

There were several lessons learned that were described by program participants.

a. **Developing and adopting standard workflow policies and protocols are essential.** Programs highlighted that the capacity to adapt existing clinical practices to best respond to the needs of the patient population, such as brief solution-focused therapy adapted to short-term settings, or developing more robust mental health discharge planning processes is a critical component for implementation.

b. **Staff buy-in and support are required for successful implementation.**

   Programs noted that establishing clear work roles can foster a culture of collaborative decision-making. In addition, regular staff support and supervision for behavioral health providers, multidisciplinary team meetings and perspectives, and implementing comprehensive staff training promote buy-in and support.

c. **Program operations need to account for the fiscal model.**

   Programs emphasized that funding models and strategies need to be aligned with program needs and costs. This may involve navigating Medicaid reimbursement requirements and documentation, leveraging grant funding strategically for key positions, and adopting cost effective interventions within budget constraints.

d. **Organizational structures need to be adaptable to support service expansion.**

   Programs commented on challenges such as increasing board membership to support policy development or remodeling the program website to address staff safety concerns.

e. **The implementation process is iterative, time intensive, and provides opportunities for learning and adaptation.**

   Programs reflected on the need for an adequate implementation timeline, that is inclusive of launch dates, hiring additional staff, and being more realistic about the time required for approvals. The need for intentional planning involved thinking more carefully about the hiring process ahead of time (e.g., onboarding key positions sooner, consider ideal combination of skills during hiring process).

Recommendations

Based on the evaluation, the following recommendations will promote the implementation of behavioral health services in medical respite programs.

1. **Sustainable fiscal models need to account for flexible reimbursement pathways while maintaining the program mission.**

Creating a financially sustainable model while maintaining mission focus (BTH)

Targeting 70% of beds for paid services to support 30% unpaid care (BTH)

Leveraging grant funding for key positions (medical director, nurses) (BTH)

Implementing affordable interventions within budget constraints (BTH)

Balancing the mission of providing care for all with the need for financial sustainability (BTH)

2. **Patient engagement and comprehensive assessments are key program practices.**

Healthcare assessment process conducted over several days to build rapport (BTH)

Family-style dinners to create comfortable environments for disclosure (BTH)

Building trust with guests who have experienced stigma and discrimination (BTH)

Balancing formal assessment requirements with relationship-building (BTH)

Social worker and peer support staff are effective at advocating for patients and helping the team prioritize care (Hennepin)

3. **Governance and operating procedures and policies should reflect patient needs, the organization's infrastructure, and regulatory requirements.**

Navigating Medicaid reimbursement requirements and documentation (BTH)

Challenges with billing systems and state regulations (BTH)

Continue developing standard operating model policies and procedures (BTH)

Ensure all staff sign whistleblower policy and other baseline policies (BTH)

Refine guest guidelines to ensure compliance with Medicaid requirements (BTH)

Implement official referral process before admission (BTH)

Development of board decision-making processes (BTH)

Consider increasing board membership to support policy development (BTH)

Remodel website to address staff safety concerns (BTH)

Continue refining documentation processes for compliance (BTH)

Maintain collaborative decision-making while ensuring clear accountability (BTH)

Group supervision allowed staff to discuss cases, diagnoses, and treatment approaches (Haywood)

Regulatory compliance issues and staff resistance to expanding services (Hennepin)

Importance of regular supervision for behavioral health providers (Pathways)

Focus on emotional regulation skills, mindfulness, and education about mental health conditions (Pathways)

Regular supervision for behavioral health providers was essential for effectiveness (Pathways)

Ensure regular supervision for behavioral health providers (Pathways)

Implement comprehensive staff training in trauma-informed approaches (Pathways)

Create structured multidisciplinary team meetings (Pathways)

Focus on achievable mental health goals in short-term settings (Pathways)

Develop robust mental health discharge planning processes (Pathways)

Need to streamline the candidate search process for similar programs (Pathways).

Teaching emotional regulation skills and mindfulness, collaborating with psychiatry to manage patient care, and educating patients about their symptoms (Pathways)

Need for trauma-informed care and ongoing education (Pathways)

4. **Behavioral health personnel need to have experience and training that can respond to the needs of patients and staff.**

Monthly individual supervision for peer support specialists, later expanded to all staff (Haywood)

Hospitality coordinators had lived experience, creating overlap between staff roles (Haywood)

Staff were hesitant to use individual supervision, possibly confusing it with administrative supervision (Haywood)

Ideal candidate needed a unique combination of skills (Pathways)

- Experience with homeless populations
- Understanding of both clinical social casework and psychotherapy
- "Heart for the folks" - ability to connect with people who have experienced trauma
- Ability to work with clients who may be gruff, tough, and not initially receptive
- Skills in brief solution-focused therapy adapted to short-term settings

Staff training requirements, including non-violent crisis intervention and mental health first aid, as essential components for both licensed providers and all staff members (Pathways)

Appendix

1: Program Self-Assessment

https://nhchc.org/resource/medical-respite-recuperative-care-organizational-self-assessment

2: Semi-Structured Interview Guide

Semi-Structured Interview Guide for Implementing Behavioral Health in Medical Respite Programs

Your medical respite site has participated in a program that was sponsored by the National Institute of Medical Respite Care (NIMRC) and the United Health Fund to promote the implementation of behavioral health services. Overall, we are interested in your opinions about your experience with implementing your behavioral health initiative, and the barriers and facilitators that would contribute to the sustained adoption of your intervention at your site.

PAUSE

INTRODUCTORY QUESTION

1. To begin, please tell me about the intervention that you chose and your experience with implementing it.

Follow-up: Why did you choose this intervention?
What were the challenges with implementing the intervention?
What would you have done differently?

TRANSITION

2. How well did the intervention "fit" with work style at your site and the values about behavioral health care?

   Follow-up: For example, did the intervention slow things down?
   Did the intervention allow staff to get a better sense of what the patient needed?
   Did the intervention allow the staff to better address patient needs?

3. How well did the intervention "fit" with the medical respite site's priorities about behavioral health care?

   Follow-up: For example, the site focuses on efficiency and the intervention slowed things.

Did intervention open "a can of worms"?
Did the intervention improve the patient's satisfaction with their care?

TRANSITION

4. As you think about how you implemented the intervention, what have been some of the barriers (or obstacles) to implementing it?

5. What has been most helpful for facilitating the implementation of the intervention?

Follow-up: Office policies/standard operating procedures/protocols
Staff training
Personnel/IT or clinical champions
Web or other help linkages

TRANSITION

6. As you think about your experiences with implementing the intervention, what would be needed to fully adopt it into routine care and sustain its use over time?

Follow-up: Office policies/standard operating procedures/protocols
Staff training
Personnel/IT or clinical champions
Community service provider linkages
Potential barriers to sustainability
Potential facilitators to sustainability

CLOSURE

7. We have talked about a lot of things regarding implementing your behavioral health intervention today. What would you say are the benefits, if any, of the intervention?
    - If there are benefits, what do you think is the most important "value added" from the intervention?
    - If there are no benefits, how would you design an intervention, or implement it differently?
    - Are there potential benefits from the intervention, or how you implemented it, that the site has not yet realized?

Thank you for spending part of your day with me.

3: Behavioral Health Implementation Evaluation Codebook

Codes	Description	Examples and Key Features
Description of intervention	Explanation of what intervention(s) were implemented and why	unique to site, responsive to program need, responsive to grant initiative
Implementation strategies and support	Supports and resources that aided in the implementation and integration of the interventions	-technical assistance -peer learning -quality improvement processes -clinical champions -external linkages external funding -staff training
Experience with the implementation process	Perceived fit of the intervention with site workflows, staff roles, and organizational values related to behavioral health care	staff development, workflows and standard operating procedures
Barriers	Any factors that made implementing the intervention more difficult or required workarounds.	E.g.: Factors related to: financing/business model, budget, regulatory environment, legacy culture, managing multiple patient subpopulations and staff work expectations -staffing -Workflows -partnerships -organizational capacity
Facilitators	Any factors that made implementing the intervention easier or straightforward	E.g.: Factors related to: expanded not compressed timeline, coordination across other community and government agencies, organizational structure -staffing -Workflows -partnerships -organizational capacity

local context and program characteristics	Contextual or programmatic features that shaped the implementation process and uptake of BH services at each site	E.g.: factors related to: organizational structure change (volunteer to 501c3), institutional culture and legacy
Perceived impact (positive or negative) of BH intervention implementation	Perceptions of how the intervention implementation may have already changed client's or staff attitudes, behaviors.	Examples include perceptions of: -Patients engagement with BH services -Changes in attitudes toward other (non-BH services and activities) -Staff and leadership wellness and workflow dynamics -Facility culture and atmosphere
Challenges	Factors making the sustainability and integration of the intervention into routine medical respite care, more challenging	E.g.: challenge of different patient populations; substance use disorder, medical, (E.g.) diff discharge criteria (is there a more general term for this?), etc.
Successful Practices	Factors influencing the sustainability and integration of the intervention into routine medical respite care, including perceived benefits and value added	E.g.: factors related to: organizational structure, culture, and legacy.
Lessons learned/Recommendations	Overall experience, insights, thoughts that can inform how other MRC programs design, adapt, and implement BH intervention	Organizational level, program level, staff level

4: Individual Medical Respite Site Outcomes

Individual Program Run Charts (Change Over Time)

Chart 4. Behavioral Health Screening Reach (Percentage of Total Served) Over Time – Bob Tavani House

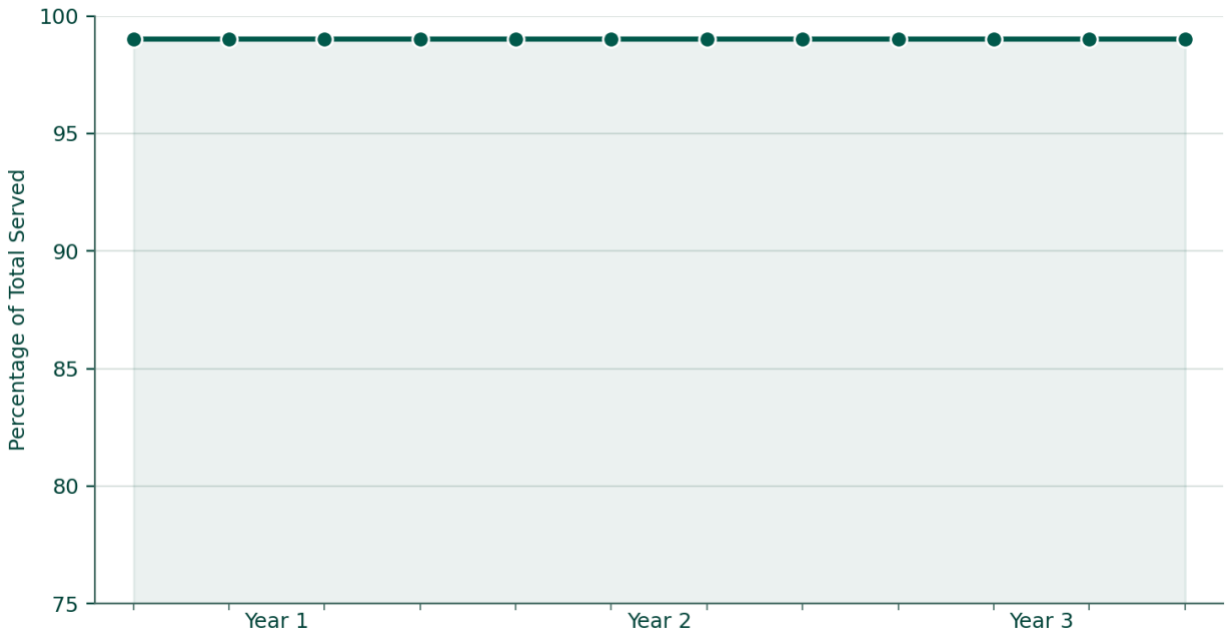


Chart 5. Behavioral Health Screening Reach (Percentage of Total Served) Over Time – Hennepin County

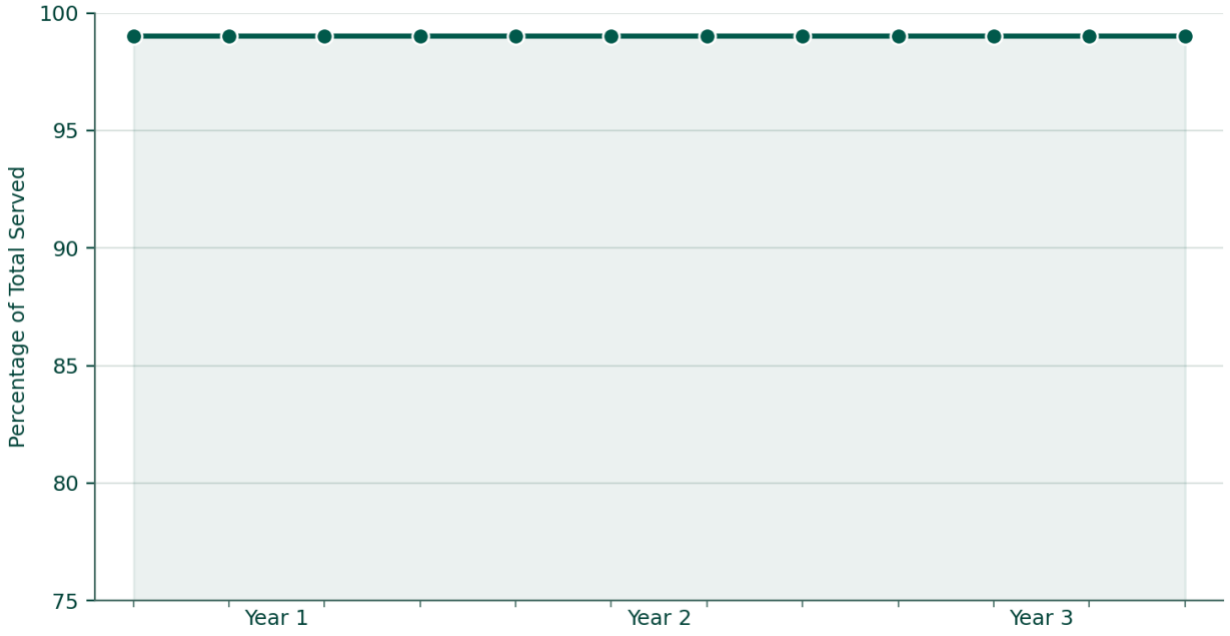


Chart 6. Behavioral Health Screening Reach (Percentage of Total Served) Over Time – Pathways to Care

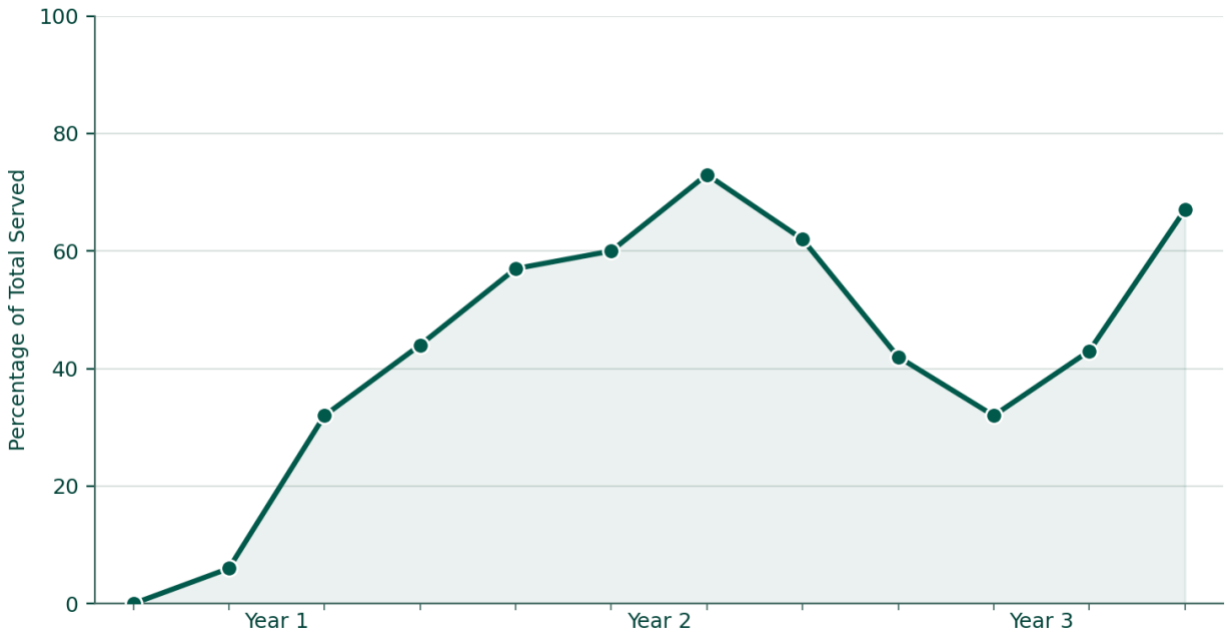


Chart 7. Behavioral Health Screening Reach (Percentage of Total Served) Over Time – Haywood St.

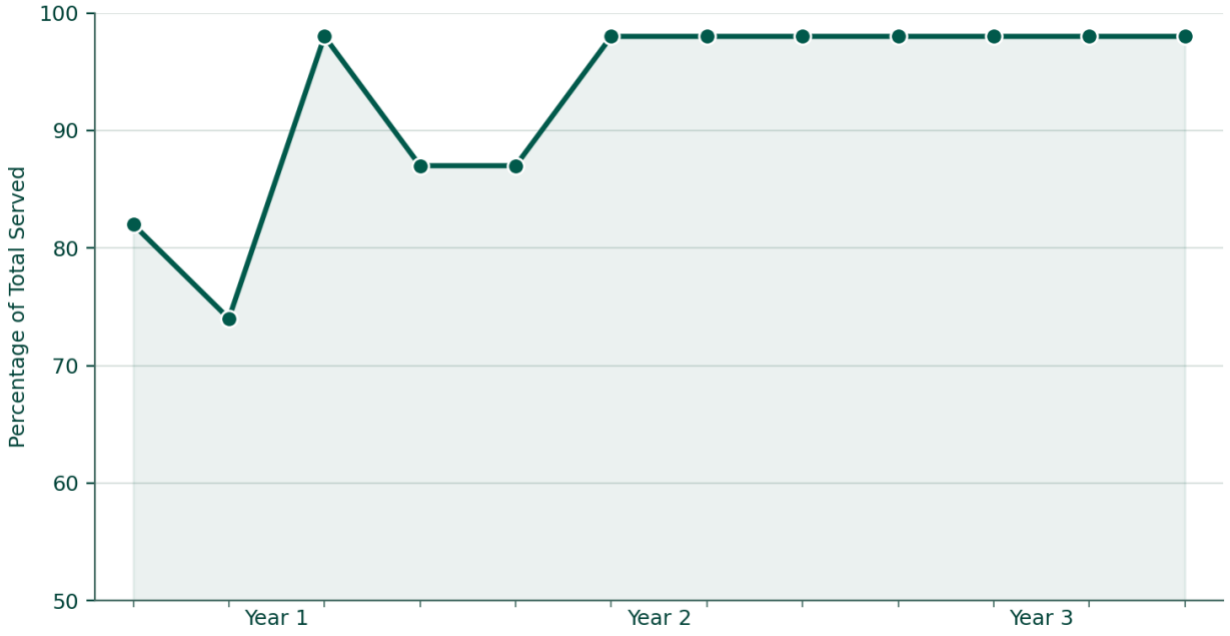


Chart 8. Percentage of Clients Connected to SUD Services Over Time – Bob Tavani House

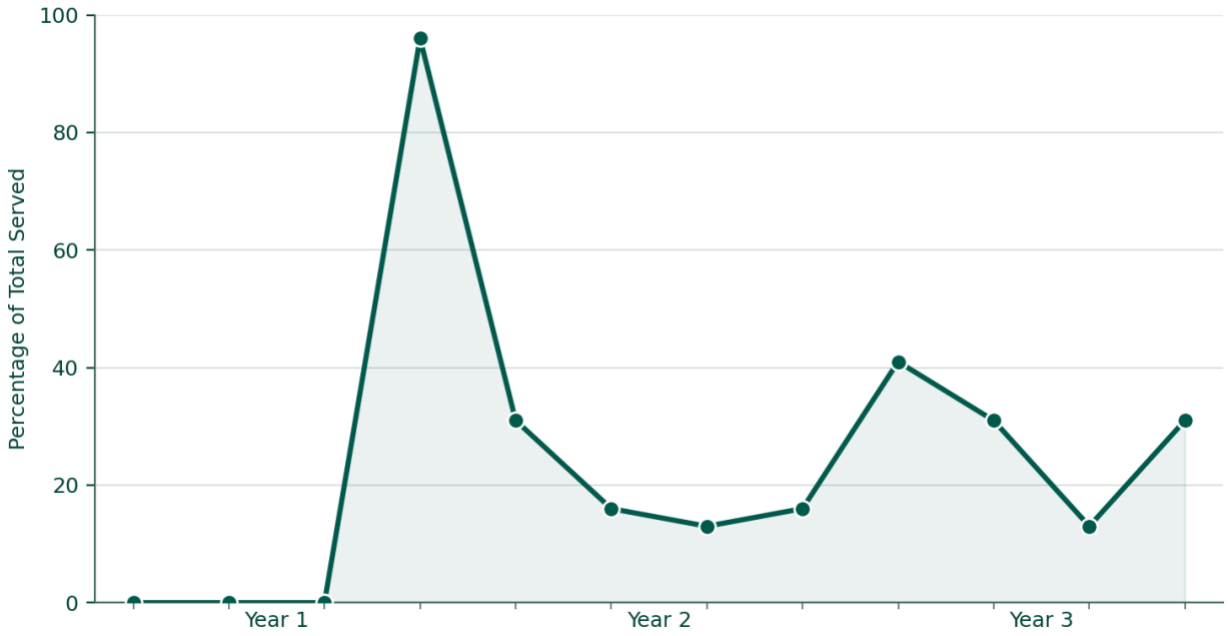


Chart 9. Percentage of Clients Connected to SUD Services Over Time – Hennepin County

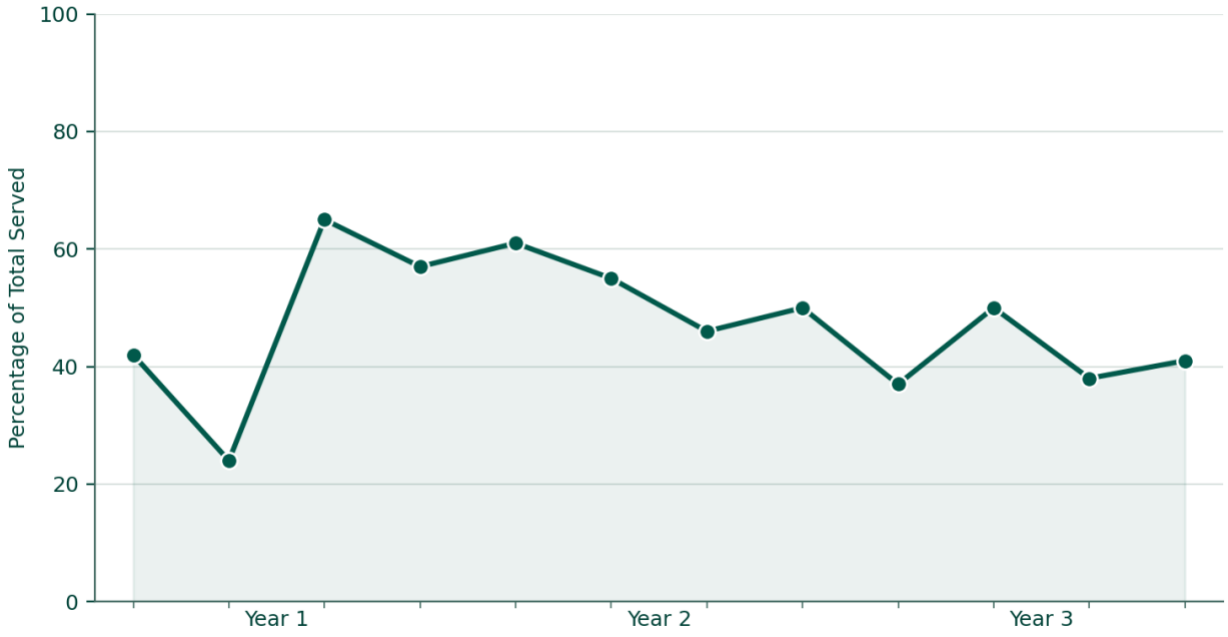


Chart 10. Percentage of Clients Connected to SUD Services Over Time – Pathways to Care

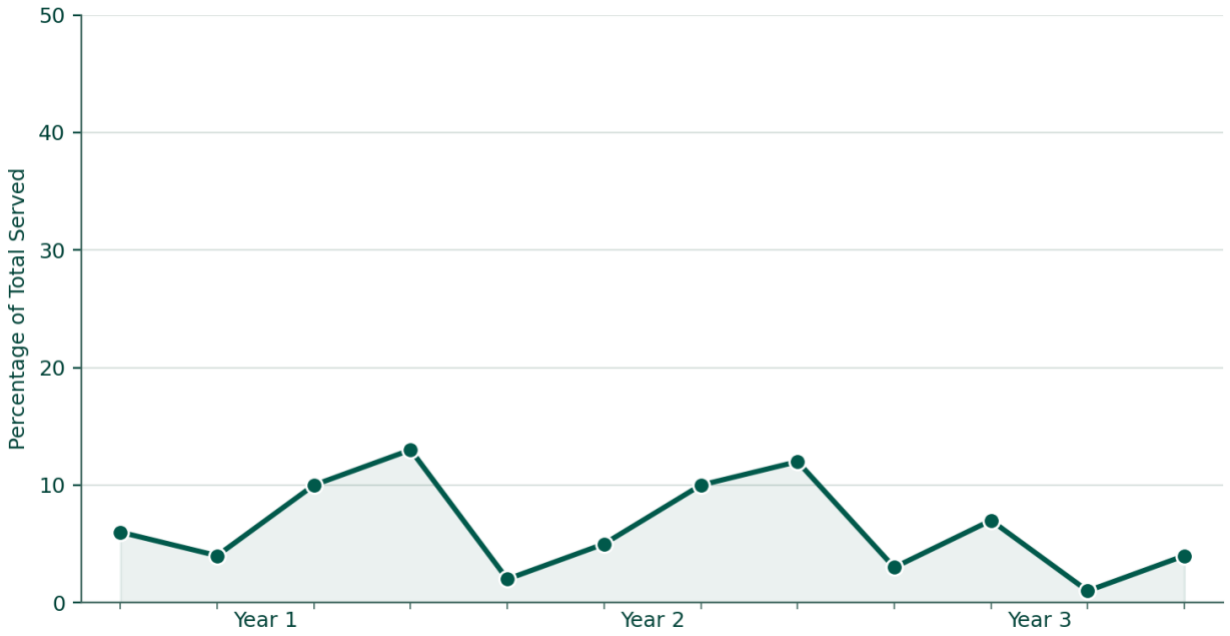


Chart 11. Percentage of Clients Connected to SUD Services Over Time – Haywood St.

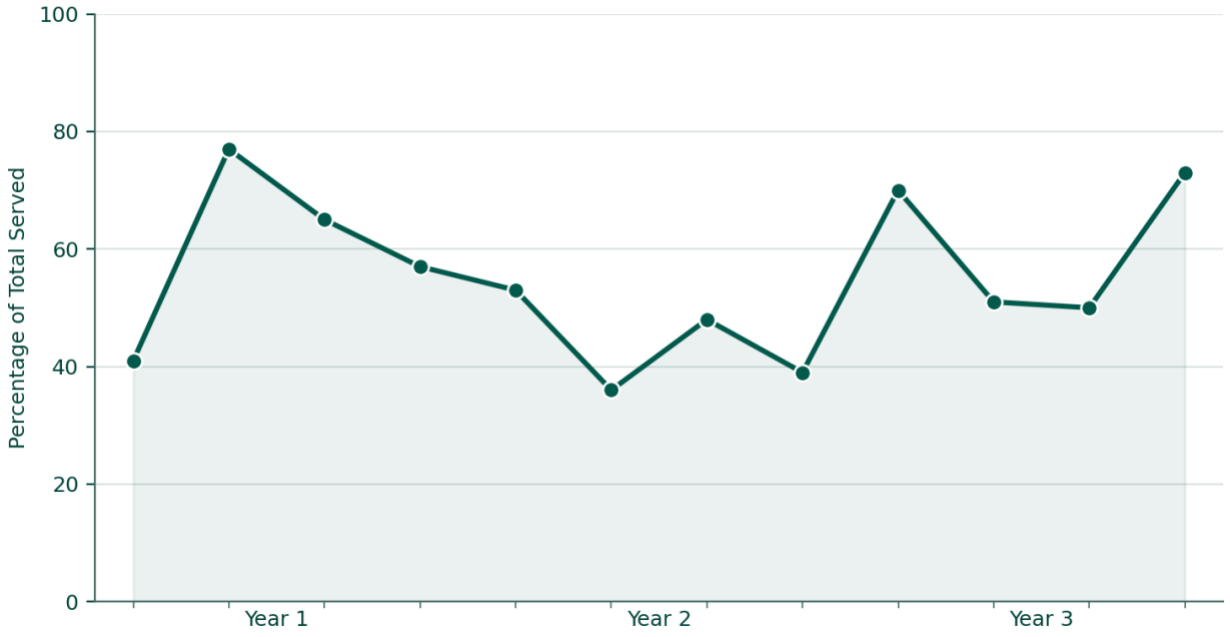
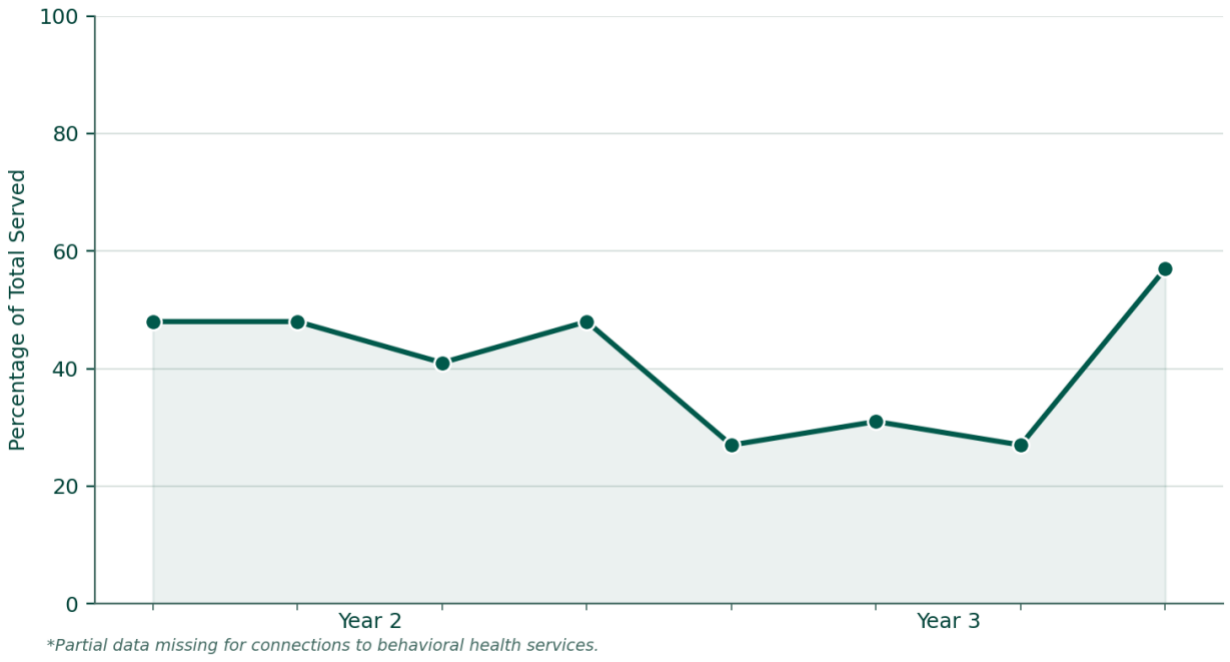
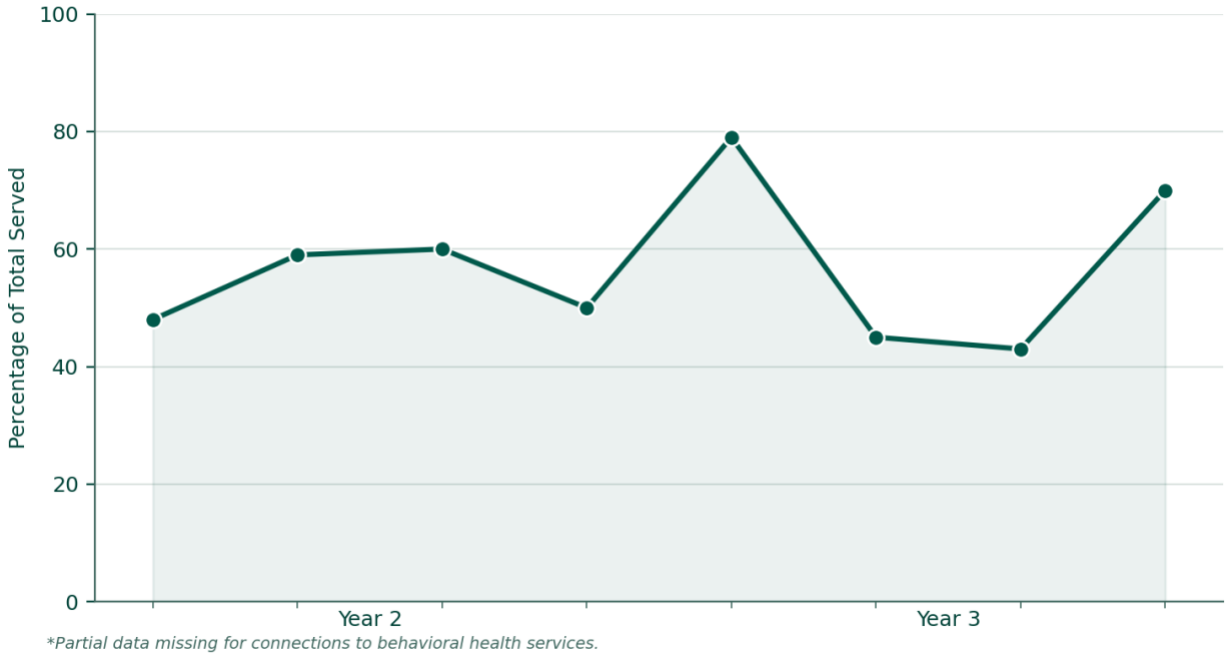


Chart 12. Percentage of Clients Connected to Behavioral Health Services Over Time – Bob Tavani House*



*Partial data missing for connections to behavioral health services.

Chart 13. Percentage of Clients Connected to Behavioral Health Services Over Time – Hennepin County*



*Partial data missing for connections to behavioral health services.

Chart 14. Percentage of Clients Connected to Behavioral Health Services Over Time – Pathways to Care*

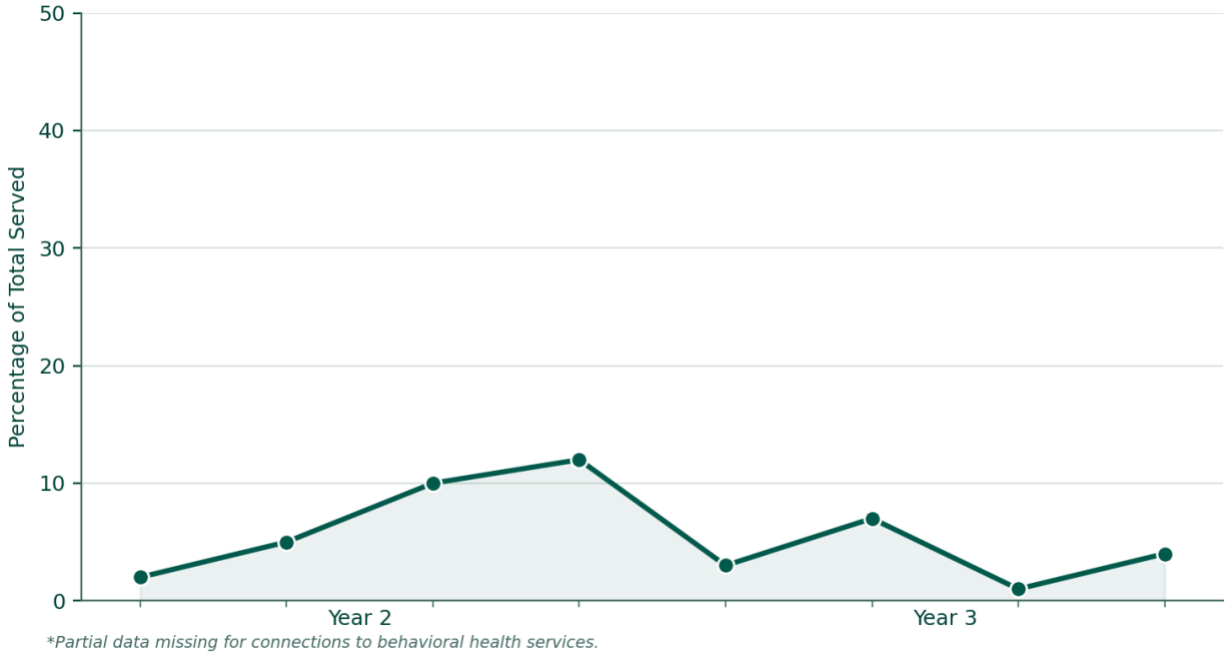
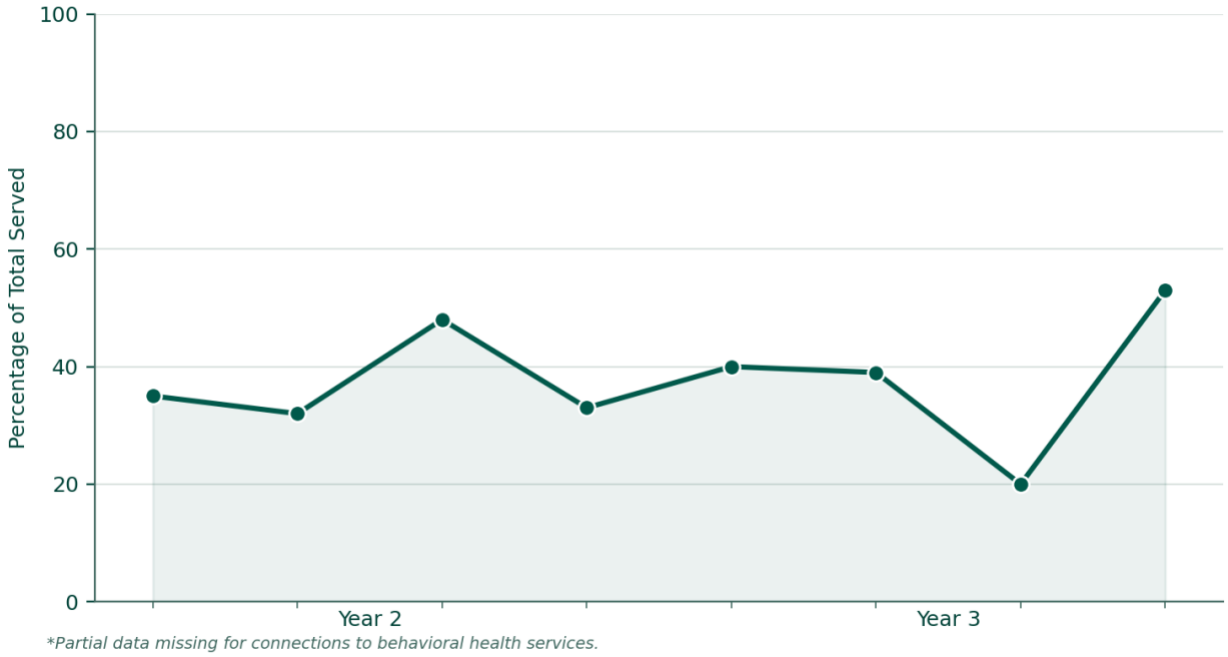


Chart 15. Percentage of Clients Connected to Behavioral Health Services Over Time – Haywood St.*



Partial data missing for connections to behavioral health services. Year 1 is omitted from these run charts.

5: Individual Pre- and Post-Program Scores – NHCHC Medical Respite Care Standards Self-Assessment

Bob Tavani House

	Pre-Program Mean Score	Post-Program Mean Score	Percent Change in Mean Score
Standard 1	33	61	+85%
Standard 2	0	11	n/a
Standard 3	58	83	+43%
Standard 4	30	80	+167%
Standard 5	100	100	-
Standard 6	47	67	+43
Standard 7	11	72	+555%
Standard 8	8	92	+1050%
TOTAL FIDELITY	38	73	+92%

Hennepin County

	Pre-Program Mean Score	Post-Program Mean Score	Percent Change in Mean Score
Standard 1	94	100	+6.4%
Standard 2	100	100	-
Standard 3	92	100	+8.7%
Standard 4	100	100	-
Standard 5	81	100	+23.5%
Standard 6	93	100	+7.5%
Standard 7	100	100	-
Standard 8	92	100	+8.7%
TOTAL FIDELITY	94	100	+6.4%

Pathways to Care

	Pre-Program Mean Score	Post-Program Mean Score	Percent Change in Mean Score
Standard 1	89	100	+12.4%
Standard 2	100	100	-
Standard 3	92	92	-
Standard 4	80	100	+25%
Standard 5	100	100	-
Standard 6	67	80	+19.4%

Standard 7	89	89	-
Standard 8	85	92	+8.2%
TOTAL FIDELITY	87	94	+8%

Haywood St.

	Pre-Program Mean Score	Post-Program Mean Score	Percent Change in Mean Score
Standard 1	56	95	+69.6%
Standard 2	44	100	+127.3%
Standard 3	75	92	+22.7%
Standard 4	60	90	+50%
Standard 5	88	100	+13.6%
Standard 6	67	93	+38.8%
Standard 7	67	89	+32.8%
Standard 8	46	92	+100%
TOTAL FIDELITY	64	94	+46.9%

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