GUIDE

Elements of a Care Plan in Medical Respite Settings

December 2022

INTRODUCTION & PURPOSE OF THIS RESOURCE

Medical respite care (MRC), also referred to as recuperative care, is acute and post-acute care for people experiencing homelessness (PEH) who are too ill or frail to recover from an illness or injury on the streets or in shelter, but who do not require hospital-level support. MRC programs offer 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.

PEH typically present in MRC settings with complex and interconnected medical, social, and behavioral health needs. Effectively meeting these needs and providing whole-person care that is consistent with the Standards for Medical Respite Care Programs necessitates comprehensive and responsive care planning, from admission through discharge and beyond.

MRC programs' size, structure, personnel, and services vary greatly based on their local needs and available resources. Accordingly, this guide is *not* intended to represent a prescriptive, all-encompassing approach to service delivery in MRC settings. Rather, it aims to:

1. Provide a reference-point to assist MRC programs in developing their own care planning tools that are appropriate to their unique contexts and the needs of PEH in their communities.
2. Help partners and stakeholders interested in learning more about MRC to understand the scope and complexity of the services provided within MRC programs.

Our team at the National Institute for Medical Respite Care (NIMRC) hopes that this resource will be useful in supporting programs and communities as they strive to offer high-quality care for PEH.

CONTENTS

OVERVIEW:

Intake and orientation:
- Discuss the purpose of the program and guidelines/expectations
- Discuss primary reason for referral/admission
- Obtain informed consent
- Discuss discharge timeframe and/or discharge indicators

**Health care may be provided by medical respite program staff or in partnership with another agency, based on the program model.*

Case management assessment and goal planning:
- Build rapport and engagement
- Identify barriers and needs
- Identify strengths and resources
- Collaboratively develop patient-centered goals

Health assessment and goal planning
- Review hospital records to identify current conditions and treatment goals
- Complete history & physical exam
- Complete mental health and substance use screening/assessment
- Collaboratively develop a patient-centered treatment plan

Resource navigation:
- Obtain documentation necessary to access housing, income, and other resources
- Connect and engage with local Continuum of Care (e.g., HMIS and Coordinated Entry)
- Complete various applications (e.g., housing, insurance, employment, SSI/SSDI, etc.)
- Arrange transportation to/from appointments

Health monitoring, management, and navigation:
- Monitor health condition(s) and adjust care plan, as needed
- Medication management and/or reconciliation
- Provide ongoing health literacy and disease management education
- Connect to primary care and specialists
- Connect to mental health and/or substance use treatment, as indicated

Discharge planning and continuity of care:
- Collaboratively determine discharge disposition with patient:
  - E.g., permanent supportive housing; family/friends; shelter; recovery program; etc.
- Warm handoff to ongoing community-based case management/housing navigation
- Document and share goals and progress with key stakeholders, as permitted

Discharge planning and continuity of care:
- Schedule follow-up appointments (e.g., primary care, mental health/substance use)
- Equip patient with knowledge and resources to refill medications
- Provide patient with discharge summary
- Notify partnering providers of patient's discharge and provide relevant information needed to maintain contact with patient

HEALTH ASSESSMENT & GOAL PLANNING

Patient Name: (Preferred name, if different):	Date of Birth:	Today's Date:
Gender & Pronouns: (Sex assigned at birth, if different):	Race & Ethnicity:	

Primary Respite Provider:	
Respite Intake Nurse/Staff:	
Patient's Primary Care Provider (PCP) & PCP Contact Information :	Date last seen:
Pharmacy & Pharmacy Contact Information:	
Home Health Provider (If applicable) & Contact Information:	

History of Present Illness/Hospital Course:

Primary Diagnosis/Reason for Admission: •
Secondary Diagnoses: • • • •

Vital Signs: Blood pressure: Heart rate: SPO2: Respiratory Rate: Temperature: Height: Weight: Pain:
Review of Systems: Cardiac: Respiratory: Neuro: Endocrine: Immune: GI: GU/Repro: Skin/Wounds:
Durable Medical Equipment (DME) Notes: DME Provider & Contact Information:

Medical History:
Surgical History:
Immunizations:

Social History:	Substance Use History: Substance(s) of choice/mode of use: Most recent use: Typical daily volume: Concern for withdrawal: Current/past use of medications for opioid use disorder: Other notes:

Specialists Involved in Patient's Care:	Specialists' Contact Information:

Medications (name, dosage):	Instructions:	Quantity:
Allergies:		

Behavioral Health and/or Mental Status Screening Results (If applicable):

Alert and oriented x:

Behavioral health diagnoses:

Pt reported behavioral health concerns or triggers:

Results from specific screening tools:

Care Preferences and/or Concerns Voiced by Patient:

Clinical Assessment/Summary

Education/Intervention(s) Provided:
Further Education/Reinforcement Needed:

MEDICAL RESPITE TREATMENT GOALS: *(developed in collaboration with patient)*

Diagnosis 1:	Goal 1:
Objective 1a:	
Objective 1b:	
Objective 1c:	

Diagnosis 2:	Goal 2:
Objective 2a:	
Objective 2b:	
Objective 2c:	

Diagnosis 3:	Goal 3:
Objective 3a:	
Objective 3b:	
Objective 3c:	

Diagnosis 4:	Goal 4:
Objective 4a:	
Objective 4b:	
Objective 4c:	

Referrals & Follow-up
Appointment 1 Date: _____ Time: _____ Agency/Provider: _____ Reason: _____ Location: _____ Phone Number: _____ Transportation Notes: _____
Appointment 2 Date: _____ Time: _____ Agency/Provider: _____ Reason: _____ Location: _____ Phone Number: _____ Transportation Notes: _____

HEALTH PROGRESS NOTE

Patient Name: (Preferred name, if different):	Today's Date:

Primary Respite Provider:
Respite Nurse/Staff:

Subjective:	Vital Signs: Blood pressure: Heart rate: SPO2: Respiratory Rate: Temperature: Height: Weight: Pain:
	Objective:
Clinical Assessment/Summary:	

Plan:

Medications Taken Since Last Clinical Encounter			
1. Medication Name/Dosage:	AM [ ] of [ ] times	Mid-day [ ] of [ ] times	PM [ ] of [ ] times
Instructions:	Notes:		
2. Medication Name/Dosage:	AM [ ] of [ ] times	Mid-day [ ] of [ ] times	PM [ ] of [ ] times
Instructions:	Notes:		
3. Medication Name/Dosage:	AM [ ] of [ ] times	Mid-day [ ] of [ ] times	PM [ ] of [ ] times
Instructions:	Notes:		
4. Medication Name/Dosage:	AM [ ] of [ ] times	Mid-day [ ] of [ ] times	PM [ ] of [ ] times
Instructions:	Notes:		
5. Medication Name/Dosage:	AM [ ] of [ ] times	Mid-day [ ] of [ ] times	PM [ ] of [ ] times
Instructions:	Notes:		

Medication Side Effects Reported:	
Updated Medication Orders (If applicable):	Instructions:

Education/Intervention(s) Provided:
Further Education/Reinforcement Needed:

MEDICAL RESPITE TREATMENT GOAL PROGRESS & UPDATES:

Diagnosis 1:	Goal 1:
Progress Toward Goal 1:	
Updated Objectives (If applicable)	
Objective 1a:	
Objective 1b:	
Objective 1c:	

Diagnosis 2:	Goal 2:
Progress Toward Goal 2:	
Updated Objectives (If applicable)	
Objective 2a:	
Objective 2b:	
Objective 2c:	

Diagnosis 3:	Goal 3:
Progress Toward Goal 3:	
Updated Objectives (If applicable)	
Objective 3a:	
Objective 3b:	
Objective 3c:	

Diagnosis 4:	Goal 4:
Progress Toward Goal 4:	
Updated Objectives (If applicable)	
Objective 4a:	
Objective 4b:	
Objective 4c:	

New Referrals & Follow-up
Appointment Date: _____ Time: _____ Agency/Provider: _____ Reason: _____ Location: _____ Phone Number: _____ Transportation Notes: _____
Appointment Date: _____ Time: _____ Agency/Provider: _____ Reason: _____ Location: _____ Phone Number: _____ Transportation Notes: _____

CASE MANAGEMENT ASSESSMENT & GOAL PLANNING

Patient Name: (Preferred Name, if different):	Date of Birth:	Today's Date:
Race & Ethnicity:	Preferred Pronouns:	
Patient's Contact Information:		

Respite Case Manager (CM):	
Community Case Manager (if applicable):	Case Manager Contact Information:

ASSESSMENT:

Important Documents in Patient's Possession:

- ☐ State ID
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Proof of Income (If applicable)
- ☐ Other: _____

Housing & Shelter	
Barriers/Needs:	Assets/Resources:

Income, Benefits, and Budgeting	
Barriers/Needs:	Assets/Resources:

Health & Recovery	
Barriers/Needs:	Assets/Resources:

Other Issues (Support Network, Coping Strategies, Legal Issues, etc.)	
Barriers/Needs:	Assets/Resources:

Additional Notes & Patient Preferences	
Subjective:	Objective:

GOALS: *(developed in collaboration with patient)*

Goal 1:		
Task 1a:	☐ Patient ☐ CM	Target Date:
Task 1b:	☐ Patient ☐ CM	Target Date:
Task 1c:	☐ Patient ☐ CM	Target Date:

Goal 2:		
Task 2a:	☐ Patient ☐ CM	Target Date:
Task 2b:	☐ Patient ☐ CM	Target Date:
Task 2c:	☐ Patient ☐ CM	Target Date:

Goal 3:		
Task 3a:	☐ Patient ☐ CM	Target Date:
Task 3b:	☐ Patient ☐ CM	Target Date:
Task 3c:	☐ Patient ☐ CM	Target Date:

Referrals & Follow-up
Appointment 1 Date: _____ Time: _____ Agency/Provider: _____ Reason: _____ Location: _____ Phone Number: _____ Transportation Notes: _____
Appointment 2 Date: _____ Time: _____ Agency/Provider: _____ Reason: _____ Location: _____ Phone Number: _____ Transportation Notes: _____

Other Resources and/or Education Provided:

CASE MANAGEMENT PROGRESS NOTE

Patient Name: (Preferred Name, if different):	Today's Date:

Respite Case Manager (CM):

NOTES:

Subjective:	Objective:
Assessment:	Plan:

Progress & Accomplishments:
Goal 1:
Goal 2:

Goal 3:
Other:

UPDATED GOALS (If applicable):

Goal 1:		
Task 1a:	☐ Patient ☐ CM	Target Date:
Task 1b:	☐ Patient ☐ CM	Target Date:
Task 1c:	☐ Patient ☐ CM	Target Date:

Goal 2:		
Task 2a:	☐ Patient ☐ CM	Target Date:
Task 2b:	☐ Patient ☐ CM	Target Date:
Task 2c:	☐ Patient ☐ CM	Target Date:

Goal 3:		
Task 3a:	☐ Patient ☐ CM	Target Date:
Task 3b:	☐ Patient ☐ CM	Target Date:
Task 3c:	☐ Patient ☐ CM	Target Date:

New Referrals & Follow-up
Appointment 1 Date: _____ Time: _____ Agency/Provider: _____ Reason: _____ Location: _____ Phone Number: _____ Transportation Notes: _____

Other Resources and/or Education Provided:

APPENDIX A: HEALTH ASSESSMENT EXAMPLE

Patient Name: *Jane Brown* (Preferred name, if different): *n/a*	Date of Birth: *10/5/1969*	Today's Date: *8/17/2022*
Gender & Pronouns: *Female, she/her* (Sex assigned at birth, if different): *n/a*	Race & Ethnicity: *Black/African American*	

Primary Respite Provider: *K. Daniels, FNP*	
Respite Intake Nurse/Staff: *T. Carter, LPN*	
Patient's Primary Care Provider (PCP) & PCP Contact Information : *Nikki Smith, NP at Community Health*	Date last seen: *June, 10th, 2022*
Pharmacy & Pharmacy Contact Information: *Walgreen's [address; phone]*	
Home Health Provider (If applicable) & Contact Information: *n/a*	

History of Present Illness/Hospital Course:

Ms. Brown is a 52-year-old, Black female who presents to respite care following the amputation of her right great toe due to a diabetic foot wound and subsequent osteomyelitis. She was in the care of NP Smith at Community Health and was seen at West Wound Care Clinic prior to her planned admission for amputation. She has a past medical history of type II diabetes, hepatitis C, opioid use disorder, depression, PTSD, and tobacco use. Prior to her hospital admission she was going between friends' houses and staying outside in an encampment downtown.

Per discharge paperwork her R great toe amputation was somewhat complicated by pain in the setting of starting buprenorphine/naloxone 8/2mg BID two weeks prior to the planned surgery, prescribed and managed by PCP. During her hospital course she received dilauded via a PCA which was titrated down. She is now taking buprenorphine/suboxone 8/2mg TID and ibuprofen 600mg Q8H PRN and pain is controlled.

Prior to admission she was struggling to manage her diabetes due to unstable housing and available diet.

She has struggled with opioid use disorder since age 17 and reports a 2-year period of sobriety/use of buprenorphine/naloxone two years ago.

No current discharge plans; needs support with housing.

Primary Diagnosis/Reason for Admission:

- *Wound care s/p amputation of R great toe*
- *Diabetes*

Secondary Diagnoses:

- *Hepatitis C*
- *Opioid Use Disorder*
- *Depression*
- *PTSD*

Vital Signs:

Blood pressure: *132/82*

Heart rate: *84*

SPO2: *97% on room air*

Respiratory Rate: *16*

Temperature: *97.8*

Height: *5'3"*

Weight: *145lbs*

Pain: *3/10*

Review of Systems:

Cardiac: *Denies history of cardiac disease, denies chest pain, trace edema of right foot*

Respiratory: *Reports smoking 1 PPD, started use of patch immediately prior to surgery but does not want to continue after discharge, willing to consider continuation of patch while at respite. Denies history of respiratory disease, had COVID in 2021, denies shortness of breath, comfortable appearing during assessment.*

Neuro: *Denies neurological history, denies seizures, denies past head injuries.*

Endocrine: *Diabetes, diagnosed 10 years ago, poorly controlled per pt. report and hospital discharge, last HgbA1c 9.2.*

Immune: *Denies immune history, reports her PCP tests her for HIV annually, does not know date of last test.*
GI: *Reports occasional diarrhea and constipation related to diet and opioid use.*

GU/Repro: *Denies GU concerns, denies difficulty voiding, denies pain, uses condoms occasionally.*

Skin/Wounds: *R great toe amputation site with stitches in place, well approximated, no erythema noted, trace edema of r foot. Wound care instructions are in discharge paperwork.*
History of injection related abscesses, multiple large scars on bilateral arms, shoulders.

Durable Medical Equipment (DME) Notes:

Walking boot for R foot; Folding walker d/t toe amputation. Need for walker to be reassessed by PT

DME Provider & Contact Information: *Referring hospital supplied*

Medical History:

Diabetes type II, hepatitis C (untreated), opioid use disorder, depression, PTSD, tobacco use disorder.

Surgical History:

Amputation of R great toe 8/10/2022

Immunizations:

COVID-19 Pfizer two-doses (June 2021)

Social History:

Has two children from whom she is currently estranged, support community is friends in encampment. Long history of opioid use disorder, recently restarted suboxone and wants to continue. Goal to rebuild relationship with her children.

Substance Use History:

Substance(s) of choice/mode of use: *Heroin/fentanyl*

Most recent use: *Last use was 8/9/2022 prior to hospital admission, uses intravenously or skin pops.*

Typical daily volume: *12 bags daily prior to starting suboxone.*

	Concern for withdrawal: *Monitor* Current/past use of medications for opioid use disorder: *Current Buprenorphine/naloxone 8/2mg (tablets) – PCP is suboxone prescriber.*

Specialists Involved in Patient's Care:	Specialists' Contact Information:
Rosa Smith, Psych NP, Behavioral Health	
West Wound Care Center, Wound Care	
R. Koonz, MD, Surgeon	

Medications (name, dosage):	Instructions:	Quantity:
Glipizide 10 mg	*One tablet PO daily*	*29 of 30*
Metformin 1000mg	*One tablet BID*	*29 of 30*
Zoloft 50mg	*One tablet daily*	*29 of 30*
Buprenorphine/naloxone 8/2mg (tabs)	*One tablet sublingual TID*	*20 of 21*
Prazosin 1mg	*One tablet daily at bedtime*	*30 of 30*
Ibuprofen 600mg	*One tablet Q8H PRN pain*	*Need filled*
Allergies: *Sulfa drugs*		

Behavioral Health and/or Mental Status Screening Results (If applicable):

Alert and oriented x: *4*

Behavioral health diagnoses: *Depression, PTSD. (Sees a Psych NP at Community Health Center, Rosa Smith).*

Pt. reported behavioral health concerns or triggers: *Reports ongoing stress related to not having a relationship with her children*

Results from specific screening tools: *n/a*

Clinical Assessment/Summary:

Ms. Brown needs respite support for wound care, support with diabetes management, including medication management and dietary support. She needs follow up with PT/OT related to ambulation s/p R great toe amputation. Need for support with tobacco and substance use goals. She was connected with PCP and wound care prior to hospital admission, needs to be reconnected to care. She needs support with housing options.

Care Preferences and/or Concerns Voiced by Patient:

She is considering continuing the patch for nicotine replacement but has also reported that smoking is a coping mechanism for her.
She reports she is scared to return to the street, does not want to develop another foot wound.
She is nervous about having nightmares while at the respite, wants to make sure she gets her Prazosin at night.

Education/Intervention(s) Provided:

- *Wound care – reviewed instructions and practiced*
- *Diabetic foot care*
- *Medication management*
- *Diabetic diet*
- *Smoking cessation: reviewed impact of smoking on wound healing*

Further Education/Reinforcement Needed:

- *Wound care: Reviewed instructions 8/17, needs reinforcement and physical practice with wound care.*
- *Smoking cessation: Discussed 8/17, reviewed impact of smoking on wound healing*

MEDICAL RESPITE TREATMENT GOALS: *(developed in collaboration with patient)*

Diagnosis 1: *R toe amputation*	Goal 1: *Progress with wound healing*
Objective 1a: *Perform wound care BID*	

Objective 1b: *Understand signs and symptoms of infection and when to seek medical care*
Objective 1c: *Understand diabetic foot care and how to prevent future foot wounds*

Diagnosis 2: *Diabetes type II*	Goal 2: *Manage blood sugars while in respite care, goal of fasting BG <150, post prandial <300*
Objective 2a: *Check fasting blood glucose before breakfast, check post prandial blood glucose 1 hour after lunch or dinner.*	
Objective 2b: *Take medications daily as directed*	
Objective 2c: *Gain understanding in how dietary changes can impact diabetes*	
Objective 2d: *Learn about food resources in the community*	

Referrals & Follow-up
Appointment 1 Date: *8/24/2022* Time: *2:00pm* Agency/Provider: *N. Smith, NP (PCP)* Reason: *PCP follow up, suboxone refill* Location: *Community Health Center [address]* Phone Number: *xxx-xxx-xxxx* Transportation Notes: *Van transport set up for 1:30pm (Confirmation #)*
Appointment 2 Date: *8/25/2022* Time: *9:00am* Agency/Provider: *R. Koonz (surgeon)* Reason: *Surgical follow up* Location: *General Hospital Outpatient Building [address]* Phone Number: *xxx-xxx-xxxx* Transportation Notes: *Van transport set up for 8:30am (Confirmation #)*

APPENDIX B: CASE MANAGEMENT ASSESSMENT EXAMPLE

Patient Name: *T. Johnson* (Preferred Name, if different): *n/a*	Date of Birth: *1/1/1970*	Today's Date: *7/22/2022*
Race & Ethnicity: *White (Non-Hispanic)*	Pronouns: *He/him/his*	
Patient's Contact Information: *Phone: xxx-xxx-xxxx email: none*		

Respite Case Manager (CM): *L. Williams*	
Community Case Manager (if applicable): *n/a*	Case Manager Contact Information: *n/a*

ASSESSMENT:

Important Documents in Patient's Possession:

- ☐ State ID
- ☑ Birth Certificate
- ☑ Social Security Card
- ☐ Proof of Income (If applicable)
- ☐ Other: _____

Housing & Shelter	
Barriers/Needs: • *Needs replacement State ID* • *Prior eviction: 2+ years ago from local housing authority-operated property* • *Pt has been staying outdoors in a camp for over 1-year.*	Assets/Resources: • *Has a birth certificate & Social Security Card* • *Is a veteran – discharge status: "other than honorable"; Pt is not currently connected with the VA.*

Income, Benefits, & Budgeting	
Barriers/Needs: • *No source of income* • *SNAP benefits discontinued* • *Has applied for SSI/SSDI in the past and been denied*	Assets/Resources: • *Past employment experience as an electrician assistant* • *Medicaid beneficiary*

Health & Recovery	
Barriers/Needs: • *Reports history of bi-polar disorder: discontinued medications several months ago* • *Hospitalized several times in past 6-months for exacerbation of chronic medical condition*	Assets/Resources: • *Previously connected with mental health provider at local health center* • *Has met with MRC provider/nursing staff and is motivated to manage health and attend scheduled appointments*

Other Issues (Support Network, Coping Strategies, Legal Issues, etc.)	
Barriers/Needs: • *2 recent misdemeanor convictions; Pt believes that he may owe court fees.*	Assets/Resources: • *Has sister in Oregon who is supportive: [phone number]* • *Finds meaning and satisfaction in reading novels*

Additional Notes	
Subjective: • *Pt reports that he does not feel safe in crowded shelter environments and plans to return to his camp upon discharge (in lieu of independent housing).* • *Pt is agreeable to re-establishing mental health care at local health center (release of information obtained).* • *Pt reports minimal, non-problematic substance use and declines further screening.*	Objective: • *Per nursing notes, pt is taking medications provided by hospital, and appointment has been scheduled to re-establish primary care at local health center.* • *Pt's speech seems pressured. Per provider notes, mental health screening was performed, and further evaluation is indicated.*

GOALS: *(developed in collaboration with patient)*

Goal 1: *Make progress toward permanent housing*		
Task 1a: *Update pt's status/location in HMIS and Coordinated Entry*	☐ Patient ☑ CM	Target Date: *7/22/2022*
Task 1b: *Obtain State ID; CM to secure fee and arrange transportation to DMV*	☑ Patient ☑ CM	Target Date: *7/29/2022*
Task 1c: *Contact local housing authority to determine amount of back-rent owed and/or any alternative payment arrangements; CM to assist with call*	☑ Patient ☑ CM	Target Date: *7/29/2022*
Task 1d: *Connect with Homeless Services at area VA hospital to explore eligibility for humanitarian/housing assistance; CM to arrange transportation*	☑ Patient ☑ CM	Target Date: *8/5/2022*

Goal 2: *Increase income*		
Task 2a: *Recertify SNAP benefits through online portal. CM to assist*	☑ Patient ☑ CM	Target Date: *8/5/2022*
Task 2b: *CM to request diagnostic/treatment records from health center and assess eligibility for SOAR application (expedited SSI/SSDI process)*	☐ Patient ☑ CM	Target Date: *7/29/2022*

Goal 3: *Re-establish primary care and mental health care at local health center (per provider/nursing notes)*		
Task 3a: *Set up transportation to appointment through Medicaid-supported program; CM to assist*	☑ Patient ☑ CM	Target Date: *8/2/2022*

Referrals & Follow-up
Appointment 1 Date: *8/2/2022* Time: *11am*
Agency/Provider: *Local Health Center* Reason: *Primary care and mental health services*
Location: *[Address]* Phone Number: *xxx-xxx-xxxx*
Transportation Notes: *Transportation arranged; Arrives at 10am [Confirmation #]*

Appointment 2 Date: *8/5/2022* Time: *1pm*

Agency/Provider: *VA Homeless Services Center* Reason: *Register and explore eligibility*

Location: *[Address]* Phone Number: *xxx-xxx-xxxx*

Transportation Notes: *Bus pass and instructions provided; Pt expressed understanding*

Other Resources and/or Education Provided:

- *Provided contact information for local Legal Aid Society to discuss possibility of expungement and/or waiver of court fees*
- *Explained telephone access procedures and encouraged pt to contact his sister and update her on his status/location*
- *Volunteer will assist pt in creating online library account to access e-books this afternoon*