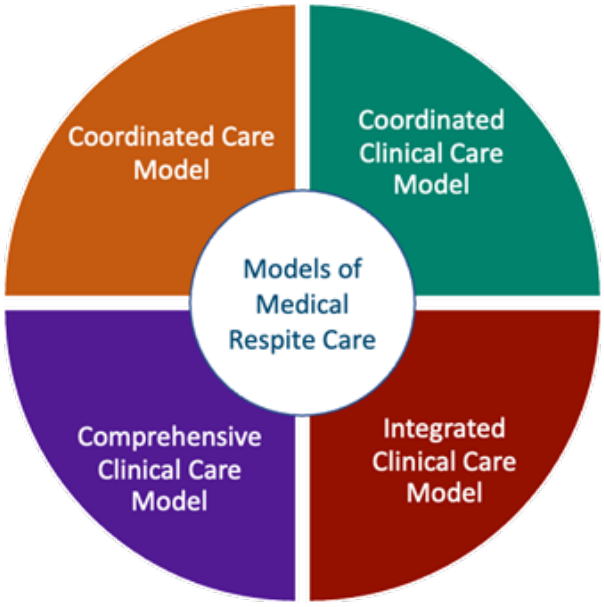
GUIDE

Potential Skills and Staffing of Medical Respite Care

2023

Introduction:

Medical respite care (MRC), also known as recuperative care, is defined as acute and post-acute care for people experiencing homelessness (PEH) 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 and the Standards for Medical Respite Care Programs (the Standards) and share the same fundamental elements: short-term residential care that allows PEH the opportunity to rest, recover, and heal in a safe environment while accessing medical care and other supportive services.



In addition to the Standards for Medical Respite Care Programs, 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 policy makers to have clearer guidance on what constitutes medical respite care. The models may be used to determine the types and intensity of clinical, case management, and care coordination services that can be expected within each MRC setting. The models are structured to describe what services the client[1] has access to while in the medical respite program, which may be provided through collaborations and partnerships through two or more organizations.

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

Intention of this Document:

This document provides an overview of the skills that are needed to implement each of the Models of Medical Respite Care. Additionally included are suggested staff roles, which primarily reflect the staff needed to provide care coordination and clinical services; these suggestions do not reflect the staff needed for program operations. There are many types of staff and providers that have the skills listed for each Model, therefore this list is not prescriptive and should be based on program needs and services provided, which may result in some variability.

Programs will also need to ensure that the scope of practice and licensure of staff meets local guidelines and is appropriately assigned to these roles. It is important 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 scope of practice for licensed and certified roles.

The staffing for each program will also be determined by the facility design, existing partnerships for care, the number of clients served, and the types and acuity of conditions and co-morbidities addressed by the program; thus, the number of staff per each model is not included as a recommendation. However, the number of staff and clinical providers should ensure high quality care that meets the Standards for Medical Respite Care and implements best practices. The skills and staffing within this document may be provided through partnerships, or staff may be directly employed by the MRC program.

This document can be also used as a supplemental guide to identify which Model is most applicable to a specific program, the staff needed to support the services offered within the program and serve as a guide for expansion when programs are seeking to increase services offered.

The skills needed to provide the level of care for each model are identified, along with a list of staff that ***could*** implement these skills. As long as the staff and providers supplying the medical respite services are working within their professional scope and licensure, ***who*** ultimately provides the services will be determined by each program. For example, the Coordinated Care Model may employ a case manager OR a community health worker for care coordination duties, or programs may opt to have both staff roles. For more information on the clinical staff providing services at existing medical respite programs and programs that utilize partner agencies, please see the State of Medical Respite Care.

Essential Skills for All Models of Care:

To achieve the primary goal of medical respite care to provide a safe place to heal, recover, and connect to health care services, every program, at minimum, should provide the skills listed below. The location, intensity, and delivery of services is variable by each model, and informs the acuity and types of conditions that can safely be served within the medical respite program.

- Knowledge and training to implement trauma informed care principles
- De-escalation training and crisis prevention strategies
- Person-centered care
- Cultural Humility
- Knowledge of, and adherence to, health information privacy and HIPAA regulations
- Establish goals focused on maximizing functioning within the community and decreasing the need for emergent care

Note - See Standard 7 of the Standards for Medical Respite Care for more information

Coordinated Care Model

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

Skills and Expertise

Although a provider's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are supported by the overall staffing model and on-site resources to safely provide care within the Coordinated Care model, as well as the facility in which services are provided.

ADMISSIONS SCREENING AND INTAKE

- Extensive knowledge of, and adherence to, admissions criteria.
- Comprehensively screen referrals, including supplemental health information, assess client acuity, program requirements and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within respite program.

CARE PLANNING

- Establish goals with client.
- Conduct individual needs assessment.
- Develop care plan based on the goals of client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections to appropriate providers (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with client.
- Store and/or provide client a place to personally store medications. Storage is secure and client has access to all needed medications.
- Support self-administration of medications and client progress towards self-management of medications.
- Provide space for the client to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy).
- Train staff and implement trauma-informed care, de-escalation strategies, and mental health first aid.
- Orient client to the respite facility and program, including admission agreements, to optimize retention in respite services.

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 client in identifying, discussing, and resolving immediate and long-term needs related to Social Determinants of Health, such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits, etc.
- Provide client education that is tailored to the individual learning style, education and/or reading level, and is sensitive to the culture of the individual.
- Support clients when behavioral concerns arise to maximize client retention in respite services.

HEALTH NAVIGATION

- Assist with prescription management to fill/refill medications or connect to resources that can provide support.
- Connect client to primary care and community health care providers based on individual needs.
- Assist clients with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport to scheduled appointments or assist with scheduling outside transportation services.
- Assist clients in planning for, and navigating, post-respite transportation needs.
- Assist client in developing awareness of the need for treatment services and address concerns or motivation impacting attendance to appointments or engagement in health services.
- Address external barriers to receiving and engaging in services; request needed referrals and navigate intake processes.
- Help 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 to treatment services.
- Facilitate client access to obtain durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed).

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Coordinate with home health agencies to ensure providers arrive as scheduled and clients are at the program when providers arrive.
- Address and/or support client in responding to delays, needed paperwork, or other barriers to attending appointments or receiving home health services.

Coordinated Care Model Potential Staffing

- Case Manager
- Community Health Worker

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 provider's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are supported by the overall staffing model and on-site resources to safely provide care within the Coordinated Clinical Care model, as well as the facility in which services are provided.

ADMISSIONS SCREENING AND INTAKE

- Extensive knowledge of, and adherence to, admissions criteria.
- Comprehensively screen referrals, including supplemental health information, assess client acuity, program requirements and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within respite program.

CARE PLANNING

- Establish goals with client.
- Conduct individual needs assessment.
- Develop care plan based on the goals of client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections to appropriate provider (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with client.
- Store and/or provide client a place to personally store medications. Storage is secure and client has access to all needed medications.
- Support self-administration of medications and client progress towards self-management of medications.
- Provide space for the client to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy).
- Train staff and implement trauma-informed care, de-escalation strategies, and mental health first aid.
- Orient client to the respite facility and program, including admission agreements, to optimize retention in respite services.

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 client in identifying, discussing, and resolving immediate and long-term needs related to Social Determinants of Health, such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits etc.
- Provide client education that is tailored to the individual learning style, education and/or reading level, and is sensitive to the culture of the individual.
- Support clients when behavioral concerns arise to maximize client retention in respite services.

HEALTH NAVIGATION

- Assist with prescription management to fill/refill medications or connect to resources that can provide support.
- Connect client to primary care and community health care providers based on individual needs.
- Facilitate communication with prescribing providers and support client in discussions regarding client tolerance of medications and adherence to medication regimen.
- Advocate for medication regimen simplification, as needed.
- Assist clients with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport to scheduled appointments or assist with scheduling outside transportation services.
- Assist clients in planning for, and navigating, post-respite transportation needs.
- Assist client in developing awareness of the need for treatment services and address concerns or motivation impacting attendance to appointments or engagement in health services.
- Address external barriers to receiving and engaging in services; request needed referrals and navigate intake processes.
- Help 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 to treatment services.

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Coordinate with home health agencies to ensure providers arrive as scheduled and clients are at the program when providers arrive.
- Address and/or support client in responding to delays, needed paperwork, or other barriers to attending appointments or receiving home health services.
- Screen and support the navigation process of accessing services for additional health needs, such as behavioral health or substance use treatment.

CLINICAL STAFFING SKILLS

MEDICAL CARE

- Provide medication management within scope of license, and in accordance with medication guidelines or state regulations, which can include storing, dispensing, administering, reconciling, and monitoring, as indicated by the care plan.
- Educate client on medication administration and management, overall health management and condition monitoring.
- Log vital signs daily and monitor closely for changes in health status as indicated by the care plan.
- Administer pre- and post-procedural or operative care, including wound care, adhere to discharge instructions, monitor for changes in health, and attend follow-up services as needed.
- Facilitate client access to obtain durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed).
- Document all clinical care provided during medical respite stay.

Coordinated Clinical Care Potential Staffing

- Nurse (LVN, RN)
- Case Manager
- Community Health Worker

Integrated Clinical Care Model

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

Skills and Expertise

Although a provider's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are supported by the overall staffing model and on-site resources to safely provide care within the Integrated Clinical Care model, as well as the facility in which services are provided.

ADMISSIONS SCREENING AND INTAKE

- Extensive knowledge of, and adherence to, admissions criteria.
- Comprehensively screen referrals, including supplemental health information, assess client acuity, program. requirements and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within respite program.

CARE PLANNING

- Establish goals with client.
- Conduct individual needs assessment, including clinical evaluation.
- Develop care plan based on the goals of client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections to appropriate provider (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with client.
- Store and/or provide client a place to personally store medications. Storage is secure and client has access to all needed medications.
- Support self-administration of medications and client progress towards self-management of medications.
- Provide space for the client to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy).
- Train staff and implement trauma-informed care, de-escalation strategies, and mental health first aid.
- Orient client to the respite facility and program, including admission agreements, to optimize retention in respite services.

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 client in identifying, discussing, and resolving immediate and long-term needs related to Social Determinants of Health, such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits etc.
- Provide client education that is tailored to the individual learning style, education and/or reading level, and is sensitive to the culture of the individual.
- Support clients when behavioral concerns arise to maximize client retention in respite services.
- Utilize knowledge of systems to complete community case management tasks (e.g., initiating or completing coordinated entry assessments, SSI or SOAR application).
- Offer hope through one's own life experience (peer support) by using personal stories in a conscious, deliberate, and professional way in the service of helping another.

HEALTH NAVIGATION

- Assist with prescription management to fill/refill medications or connect to resources that can provide support.
- Connect client to primary care and community health care providers based on individual needs.
- Facilitate communication with prescribing providers and support client in discussions regarding client tolerance of medications and adherence to medication regimen.
- Advocate for medication regimen simplification, as needed.
- Assist clients with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport to scheduled appointments or assist with scheduling outside transportation services.
- Assist clients in planning for, and navigating, post-respite transportation needs.
- Assist client in developing awareness of the need for treatment services and address concerns or motivation impacting attendance to appointments or engagement in health services.
- Address external barriers to receiving and engaging in services; request needed referrals and navigate intake processes.
- Help 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 to treatment services.
- Complete ongoing assessments of client to identify and address additional health needs.
- Facilitate client access to obtain durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed).

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Coordinate with home health agencies to ensure providers arrive as scheduled and clients are at the program when providers arrive.
- Address and/or support client in responding to delays, needed paperwork, or other barriers to attending appointments or receiving home health services.
- Screen and support the navigation process of accessing services for additional health needs, such as behavioral health or substance use treatment.

CLINICAL STAFFING SKILLS

MEDICAL CARE

- Provide clinical care within scope and license of staff, as indicated by care plans, and within limits of appropriate case load size.
- Educate client on medication administration and management, overall health management and condition monitoring.
- Log vital signs daily and monitor closely for changes in health status.
- Administer pre- and post-procedural or operative care, including wound care, adhere to discharge instructions, monitor for changes in health, and attend follow-up services as needed.
- Provide medication management within scope of license, and in accordance with medication guidelines or state regulations, which can include storing, dispensing, administering, prescribing, reconciling and monitoring, as indicated by the care plan.
- Gather information for a clinical care plan including: a complete physical and psychological history and assessment; list of current medications, dosages, and allergies; vital signs; other pertinent information, such as laboratory or other test results.
- Communicate and develop plan of care with PCP (as applicable).
- Complete daily or frequent nursing assessment and/or medical exam as indicated by care plan.
- Provide comprehensive nursing care, which may include (but is not limited to) 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.
- Assess the need for specialty care and/or home-based health services and make referral when applicable.
- Identify and implement strategies to support independence in health management.
- Monitor clients receiving outpatient treatment (e.g., IV based medical interventions, dialysis, chemotherapy).
- Document all clinical care provided during medical respite stay.

- Share pertinent health information with additional providers (as indicated), with the client and their community-based provider at program discharge, including medication list, PCP and specialty provider contacts, and case management and community resources.

BEHAVIORAL HEALTH CARE

- Address stigmatizing practices by reviewing admission criteria to determine if clients with behavioral health conditions are being excluded based on diagnosis alone.
- Assess and evaluate for mental health conditions or substance use needs, including identifying which symptoms are problematic for the client and strategies they have found to be successful.
- Provide immediate interventions for acute life stressors or psychosocial factors that are impacting the client's medical condition.
- Provide behavioral health therapy and/or support as needed and create a plan for transition to community-based behavioral health providers.
- Prescribe psychiatric medication or complete a direct referral to a prescribing provider; if prescribing, adjust dosage as needed to reduce side effects while still managing symptoms.
- Provide crisis intervention as needed, and in collaboration with, clinical staff and community partners.
- Provide psychoeducation (individual and group sessions).
- Refer client to community recovery and/or harm reduction programs and facilitate transition planning.
- 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.
- Develop treatment plans and provide mental health and substance use disorder therapy services to address the psychosocial needs of clients.
- 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).
- Facilitate group education focused on health and self-management (clinician led or peer support).
- Plan and implement groups focused on optimal mental health including supporting topics centered on well-being, distress tolerance, coping skills, etc.
- Provide individual and group peer counseling and support to validate client experiences.
- 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.

SUBSTANCE USE CARE

- Screen and assess for substance use conditions.
- Assess the need for medication assisted treatment (MAT) when appropriate and refer to community resources as needed.
- Facilitate ongoing recovery-oriented individual and group sessions onsite or connect to an outside agency for services.
- Complete referral and assist with transition planning to community recovery programs.
- Provide harm reduction education, equipment, and services.
- Guide and encourage clients to take responsibility and actively participate in their own recovery.

STAFFING SUPPORT

- Provide 24-hour access to clinical staff and/or on-call medical support (internally or through partnerships).
- Educate clients on how to utilize medical call line to address immediate medical needs.
- Provide guidelines on when to contact on-site provider vs. emergency department care.

Integrated Clinical Care Potential Staffing

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

Comprehensive Clinical Care Model

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

Skills and Expertise

Although a provider's licensed scope of care may be broader than what is listed in this section, the skills listed here are those that are supported by the overall staffing model and on-site resources to safely provide care within the Comprehensive Clinical Care model, as well as the facility in which services are provided.

ADMISSIONS SCREENING AND INTAKE

- Extensive knowledge of, and adherence to, admissions criteria.
- Comprehensively screen referrals, including supplemental health information, assess client acuity, program requirements and bed availability to determine admission eligibility.
- Identify potential clinical and supportive service needs while within respite program.

CARE PLANNING

- Establish goals with client.
- Conduct individual needs assessment, including clinical evaluation.
- Develop care plan based on the goals of client and the reason for referral/admission to the MRC program.
- Coordinate care and facilitate connections to appropriate provider (e.g., PCP, home health, pharmacies, specialty care).
- Identify discharge indicators and develop a discharge plan with client.
- Store and/or provide client a place to personally store medications. Storage is secure and client has access to all needed medications.
- Support self-administration of medications and client progress towards self-management of medications.
- Provide space for the client to engage with home-based clinical services (e.g., home health, home nursing care, physical therapy, speech, occupational therapy).
- Train staff and implement trauma-informed care, de-escalation strategies, and mental health first aid.
- Orient client to the respite facility and program, including admission agreements, to optimize retention in respite services.

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 client in identifying, discussing, and resolving immediate and long-term needs related to Social Determinants of Health, such as access to quality medical and mental health care, housing stability, financial resources, insurance benefits etc.
- Provide client education that is tailored to the individual learning style, education and/or reading level, and is sensitive to the culture of the individual.
- Support clients when behavioral concerns arise to maximize client retention in respite services.
- Utilize knowledge of systems to complete case management tasks (e.g., coordinated entry, SSI, or SOAR application).
- Offer hope through one's own life experience (peer support) by using personal stories in a conscious, deliberate, and professional way in the service of helping another.

HEALTH NAVIGATION

- Assist with prescription management to fill/refill medications or connect to resources that can provide support.
- Connect client to primary care and community health care providers based on individual needs.
- Facilitate communication with prescribing providers and support client in discussions regarding client tolerance of medications and adherence to medication regimen.
- Advocate for medication regimen simplification, as needed.
- Assist clients with setting up and scheduling appointments with established and new providers, ensuring health information is transferred to providers.
- Transport to scheduled appointments or assist with scheduling outside transportation services.
- Assist clients in planning for, and navigating, post-respite transportation needs.
- Assist client in developing awareness of the need for treatment services and address concerns or motivation impacting attendance to appointments or engagement in health services.
- Address external barriers to receiving and engaging in services; request needed referrals and navigate intake processes.
- Help 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 to treatment services.
- Educate client on medication administration and management, overall health management and condition monitoring.
- Complete ongoing assessments of client to identify and address additional health needs.

- Facilitate client access to obtain durable medical equipment (DME), wound care, oxygen, and incontinence supplies (as needed).

REFERRAL NAVIGATION

- Facilitate scheduling of new appointments for specialty services.
- Coordinate with home health agencies to ensure providers arrive as scheduled and clients are at the program when providers arrive.
- Address and/or support client in responding to delays, needed paperwork, or other barriers to attending appointments or receiving home health services.
- Screen and support the navigation process of accessing services for additional health needs, such as behavioral health or SUBSTANCE USE treatment.

CLINICAL STAFFING SKILLS

MEDICAL CARE

- Provide clinical care within scope and license of staff, as indicated by care plans, and within limits of appropriate case load size.
- Log vital signs daily and monitor closely for changes in health status.
- Administer pre- and post-procedural or operative care, including wound care, adhere to discharge instructions, monitor for changes in health, and attend follow-up services as needed.
- Provide medication management within scope of license, and in accordance with medication guidelines or state regulations, which can include storing, dispensing, administering, prescribing, reconciling, and monitoring, as indicated by the care plan.
- Gather information for a comprehensive clinical care plan including: a complete physical and psychological history and assessment; list of current medications, dosages, and allergies; vital signs; other pertinent information, such as laboratory or other test results.
- Communicate and develop plan of care with PCP (as applicable).
- Complete daily or frequent nursing assessment and/or medical exam.
- Provide comprehensive nursing 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.
- Assess the need for specialty care and/or home-based health services and make referral when applicable.
- Identify and implement strategies to support independence in health management.
- Monitor clients receiving outpatient treatment (e.g., IV based medical interventions, dialysis, or chemotherapy).
- Document all clinical care provided during medical respite stay.

- Share pertinent health information with additional providers (as indicated), with the client and their community-based provider at program discharge, including medication list, PCP and specialty provider contacts, and case management and community resources.
- Provide complex medical care as recommended by the care plan (e.g., hospice/palliative care).

BEHAVIORAL HEALTH CARE

- Address stigmatizing practices by reviewing admission criteria to determine if clients with behavioral health conditions are being excluded based on diagnosis alone.
- Assess and evaluate for mental health conditions or substance use needs, including identifying which symptoms are problematic for the client and strategies they have found to be successful.
- Provide immediate interventions for acute life stressors or psychosocial factors that are impacting the clients' medical condition.
- Provide behavioral health therapy and/or support as needed and create a plan for transition to community-based behavioral health providers.
- Prescribe psychiatric medication as needed; adjust dosage to reduce side effects while still managing symptoms.
- Provide crisis intervention as needed, and in collaboration with clinical staff and community partners.
- Provide psychoeducation (individual and group sessions).
- Refer client to community recovery and/or harm reduction programs and facilitate transition planning.
- 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.
- Develop treatment plans and provide mental health and substance use therapy services to address the psychosocial needs of clients.
- 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).

- Facilitate group education focused on health and self-management (clinician led or peer support).
- Plan and implement groups focused on optimal mental health including supporting topics centered on well-being, distress tolerance, coping skills, etc.
- Provide individual and group peer counseling and support to validate client experiences.
- 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.

SUBSTANCE USE CARE

- Screen and assess for substance use conditions.
- Assess the need for medication assisted treatment (MAT) when appropriate.
- Facilitate onsite individual and group sessions that are recovery oriented.
- Complete referral and assist with transition planning to community recovery programs.
- Provide harm reduction education, equipment, and services.
- Guide and encourage clients to take responsibility and actively participate in their own recovery.

GROUP EDUCATION

- Plan and implement groups onsite, which can include:
  - Physical health and wellness management;
  - Interpersonal self-management and self-care practices;
  - Substance use and/or recovery (utilizing a harm-reduction approach);
  - Emotional wellness.
- Provide group peer counseling and support to validate clients' experiences and provide guidance and encouragement to clients.

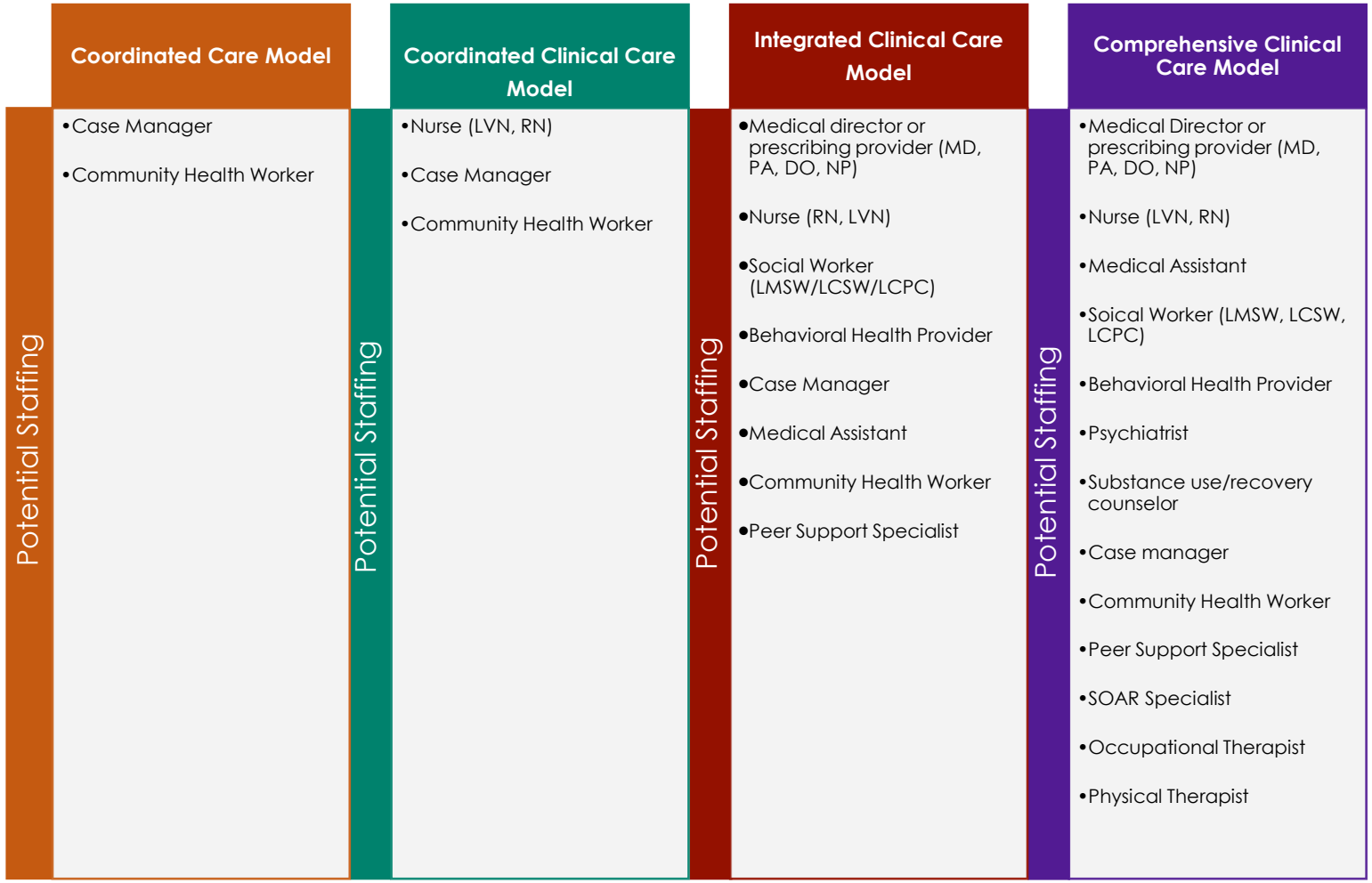
STAFFING SUPPORT

- Provide 24-hour access to clinical staff and/or on-call medical support (internally or through partnerships.
- Educate clients on how to utilize medical call line to address immediate medical needs.
- Provide guidelines on when to contact on-site provider vs. emergency department care.
- Train staff on addressing and monitoring those with high level medical needs (such as hospice care) OR provide 24-hour clinical staff onsite (see above sections on skills for clinical staff).

Comprehensive Clinical Care
Potential Staffing

- Medical director or prescribing provider (MD, PA, DO, NP)
- Nurse (RN or LVN)
- Medical Assistant
- Social Worker (LMSW/LCSW/LCPC)
- Behavioral Health Provider
- Psychiatrist
- Substance use/recovery counselor
- Case manager
- Community Health Worker
- Peer Support Specialist
- SOAR Specialist
- Occupational Therapist
- Physical Therapist

Visual Model of Potential Staffing for each Model of Care:



Recommended Resources

- Demonstrating Quality in Medical Respite Care: The Importance of Data
- Medical Respite Care: Addressing Behavioral Health and the Role of the Behavioral Health Consultant
- Medical Respite Care: The Role of Case Managers, Community Health Workers, and Peers
- Trauma-Informed Care in Medical Respite
- Promising Practices: Providing Behavioral Health Care in a Medical Respite Setting
- Medication Support and Medical Respite Care
- Elements of a Care Plan in Medical Respite Settings
- Skills, Tools, and Strategies for Case Managers, Community Health Workers and Peers

NIMRC has also published several clinical guidelines for medical respite care. To learn more about the Guidelines, please read Intro to Clinical Guidelines. Additional guidelines can be accessed on the NIMRC website in the Medical Respite Tool kit.

CHCF

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