September 12, 2014
The webinar will begin promptly at 1pm eastern

PROPOSED STANDARDS FOR MEDICAL RESPITE PROGRAMS

An Overview

This webinar is supported by Grant/Cooperative Agreement Number U30CS09746 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the presenters and do not necessarily represent the official views of HRSA/BPHC.

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

PRESENTERS

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AGENDA

- Rationale for developing minimum standards
- Process for development
- Overview of the 7 proposed standards
- Next steps
- Q & A

MEDICAL RESPITE CARE

Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital.

MEDICAL RESPITE CARE

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

WHY STANDARDS?

- Improve consistency
- Improve quality, health outcomes, and reduce costs
- Improve opportunities for research
- Improve opportunities for sustainable federal funding

A 2014 study conducted by Duke University found an emergence of "patchwork [medical] respite" processes in the absence of formal medical respite programming.

Source:

Biederman, D.J., Gamble, J., Manson, M., Taylor, D. (2014). Assessing the need for a medical respite: perceptions of service providers and homeless persons. *Journal of Community Health Nursing, 31*(3),145-56.

GOALS

1. Reflect the needs of the patients served in this setting
2. Promote improved health and high quality care
3. Align with other industry standards
4. Achievable for a range of programs with varying resources

PROCESS TO DATE

- Under leadership of Medical Respite Providers Network
- Medical Respite Standards Development Task Force
  - → Representatives from nursing, social work, medicine, law, advocates, and consumer viewpoints
- Conducted monthly meetings
  - → Fall 2011 to present
- Focus on the *minimum* standards

TASK FORCE

- Sabrina Edgington, MSSW, National Health Care for the Homeless Council
- Leslie Enzian, MD, Harborview Medical Center
- Henry Fader, JD, Pepper Hamilton LLP
- Jessie M. Gaeta, MD, Boston Health Care for the Homeless Program
- Joanne Guarino, Consumer, Boston Health Care for the Homeless Program
- Nancy Hanson, MSW, Interfaith House
- Tim Johnson, BA, BBA, Harmony House, Inc.
- Brooks Ann McKinney, MSW, Mission Health and Hospitals
- Alice Moughamian, RN, CNS, San Francisco Medical Respite and Sobering Center
- Dawn Petroskas, RN, PhD, Catholic Charities of St. Paul and Minneapolis

PROPOSED STANDARDS

- Standard 1: Accommodations
- Standard 2: Environmental Services
- Standard 3: Care Transitions In
- Standard 4: Clinical Care
- Standard 5: Care Coordination and Support Services
- Standard 6: Care Transitions Out
- Standard 7: Quality Improvement

STANDARD 1: ACCOMMODATIONS
PROVIDES SAFE AND QUALITY ACCOMMODATIONS

- 24 hour bed
- Hygienic
  - → Shower facilities
  - → Laundering facilities
  - → Clean linens
  - → Janitorial services
- Accessible and minimal fall risk
- Secured storage

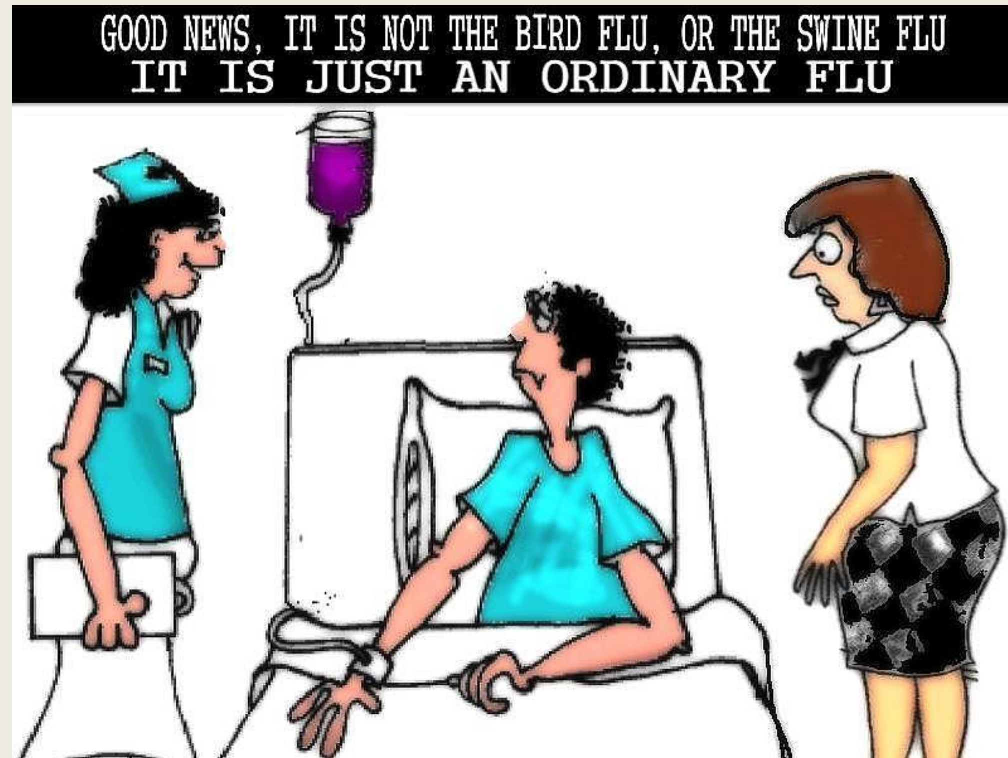
STANDARD 1: ACCOMMODATIONS

- Food (3 meals/day)
- 24 hour staff presence
  - → Trained in first aid and basic life support
  - → 24-hour on call medical support at non-congregate facilities
- Safety plans
  - → Policies and procedures for responding to life-threatening emergencies (i.e., medical emergencies)
  - → Patient understanding of fire and evacuation plans
  - → Code of conduct
  - → Policy for handling alcohol and illegal or non-medical prescription drugs
  - → Policy for weapons and staff response to violence

STANDARD 2: ENVIRONMENTAL SERVICES
PROVIDES QUALITY ENVIRONMENTAL SERVICES

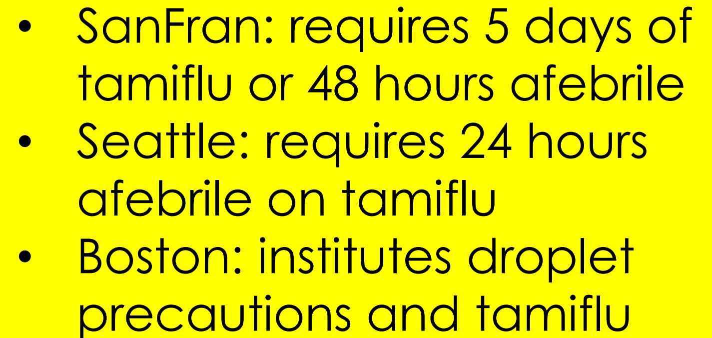
- Safe handling of biomedical and pharmaceutical waste
- Infection control
- Medication storage
- Pest control

STANDARD 2: ENVIRONMENTAL SERVICES
Examples: Infection Control



STANDARD 2: ENVIRONMENTAL SERVICES
Examples: Infection Control

- Influenza
- Tuberculosis
- Clostridium difficile
- Hepatitis A
- Shingles
- MRSA



STANDARD 2: ENVIRONMENTAL SERVICES

Examples: Medication Storage

- Licensing
  - → Administering vs. Dispensing
- Med storage according to manufacturer requirements
- Special considerations
  - → Insulins
  - → Controlled substances
  - → Outpatient chemo regimens

STANDARD 3: CARE TRANSITIONS IN

MANAGES TIMELY AND SAFE CARE TRANSITIONS TO MEDICAL RESPITE FROM ACUTE CARE, SPECIALTY CARE, AND/OR COMMUNITY SETTINGS

CARE TRANSITIONS:

The movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change. This may include the transition from the hospital to a primary care provider, home, or nursing facility.

National Transitions of Care Coalition. (2008). Transitions of care measures. Retrieved from

www.ntocc.org/Portals/0/PDF/Resources/TransitionsOfCare_Measures.pdf

STANDARD 3: CARE TRANSITIONS IN

Improving Care Transitions for People Experiencing Homelessness
http://www.nhchc.org/wp-content/uploads/2012/12/Policy_Brief_Care_Transitions.pdf

STANDARD 3: CARE TRANSITIONS IN

Preadmission

- → Working with hospitals to promote medical respite as a discharge option
- → Trainings to promote appropriate referrals
- → Timely admission decisions by qualified medical personnel
- → Admission decisions based on ability to keep patients safe and provide the care, treatment, and services needed by the patient
- → Communication with referring agencies when beds are not available or a referral is denied

STANDARD 3: CARE TRANSITIONS IN

Admission

- → Designated point of contact for referring entities
- → Transportation responsibilities from referring entity to medical respite is outlined in written agreements
- → Protocols for transferring patient information
- → Medication reconciliation
- → Reinforcement of discharge instructions
- → Patient has and knows his/her accountable provider(s) at all points of care transition

STANDARD 4: CLINICAL CARE

ADMINISTERS HIGH QUALITY POST-ACUTE CLINICAL CARE

- Clinical care provided during medical respite stay
- Ensures adequate level of care to meet patients' needs
- Requires qualified medical personnel and medical record
- Patient-centered
- **Interdisciplinary**

STANDARD 4: CLINICAL CARE

ADMINISTERS HIGH QUALITY POST-ACUTE CLINICAL CARE

- Baseline clinical assessment
- Individualized care plan
  - Treatments, desired outcomes, discharge indicators
- Frequency of clinical encounters based on need
- Interdisciplinary care team
  - Regular case conferences to review patients’ progress
- Clinical practice guidelines
- q24 hour wellness checks

STANDARD 5: CARE COORDINATION/SUPPORT SERVICES
ASSISTS IN HEALTH CARE COORDINATION AND PROVIDES WRAP AROUND SUPPORT SERVICES

- Care coordination
  - → Self-management goal setting
  - → Medication reconciliation
  - → Connection to primary care
  - → Transportation to medical appointments and support services
  - → Facilitating specialty care follow up
  - → Communication with outside clinicians about care plan

STANDARD 5: CARE COORDINATION/SUPPORT SERVICES
ASSISTS IN HEALTH CARE COORDINATION AND PROVIDES WRAP AROUND SUPPORT SERVICES

- Support services via case management
  - → Facilitating access to housing
  - → Assistance with benefits
  - → Referrals to substance use treatment programs
  - → Social support groups
  - → Connection to family, when desired

CASE EXAMPLE

- 54 year old woman recently diagnosed with Non Hodgkin's Lymphoma is referred to medical respite from the hospital to make it possible and safe for her to receive outpatient chemotherapy.
  - → Presentation
    - Noted in shelter to have 50lb weight loss and urinary frequency.
    - Found in ER to have severely elevated Calcium level
    - Work up revealed lytic lesions of spine and splenic mass
    - Bone marrow biopsy confirmed NHL, Stage IV
    - Chemo regimen initiated via permanent portocath

CASE EXAMPLE

- Additional history
  - → Chronically homeless
  - → Disconnected from family
  - → Paranoid behaviors but no prior mental health care
- Referral reviewed by respite RN, who consulted with respite MD about specific chemo regimen and expected side effects
- Clinical assessment conducted by NP on admission to medical respite

CARE PLAN DEVELOPED

- Understand patient's goals of care
- Chemo to be administered in outpatient oncology clinic once every 3 weeks for 5 cycles
- Oncology clinic will follow labs and communicate all information back to medical respite team
- Possible side effects to include alopecia, nausea, fatigue, and leukopenia
  - → Specific plans to manage each made in consult with oncology
  - → Clear guidance on when to transfer patient back to ER
- Arrange for psychiatry consult
- Explore possibility of reconnecting patient with family
- Explore housing opportunities

RESPITE COURSE

- Paranoia improved as high calcium levels normalized
- Reconnected with sister
- Completed 5 cycles of chemo
  - → Re-hospitalized briefly after cycle 4 for leukopenia with fever
- Engaged in cancer support group
- Dramatic decrease in tumor burden
- Disability application submitted
- Discharged to live with sister

STANDARD 6: CARE TRANSITIONS OUT

FACILITATES SAFE AND APPROPRIATE CARE TRANSITIONS FROM MEDICAL RESPITE TO THE COMMUNITY

- Discharge planning
  - → Begins early
  - → Discharge policy & procedure, including who makes discharge decisions
  - → Pt receives at least 24 hours notice prior to discharge from medical respite (exceptions for administrative discharge)
- Discharge summary to the patient and community providers assuming patient care
- Patient provided with options for placement after discharge

Standard 7: Quality Improvement
Care is Driven by Quality Improvement

- Process for collecting and securing data
- Quality improvement plan to respond to trends in outcome measures, including patient satisfaction
  - → Sets priorities for data collection
- Incident reporting and review
- Self-audits of quality of care and documentation

Standard 7: Quality Improvement
Care is Driven by Quality Improvement

- Medical director is physician
- Number and qualifications of clinical staff matches patients' needs and complexity
- Job descriptions and competencies are clear
- Clinical staff are formally credentialed
- Annual performance reviews
- Staff education and training

Standard 7: Quality Improvement
Examples

- Connection to PCP
- Medication reconciliation
- Clinical outcomes
- Medication errors
- Participation in groups
- Connection to housing on discharge
- Successful disability applications

NEXT STEPS

- Public comment period: 9/1/14-9/30/14

http://www.nhchc.org/resources/clinical/medical-respite/

- Revisions based on public comment/Task Force discussion
- Testing at volunteer sites
- Revisions based on testing
- Final standards issued

NEXT STEPS

- Used for training and technical assistance
- Opportunities for accreditation/certification
- Opportunities for research related to health outcomes/quality of care/costs
- Engage in discussions at federal level to promote sustainable funding

Q & A

Public comment period: 9/1/14-9/30/14

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