GUIDE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Supporting IV Antibiotics in Medical Respite Care Programs

2026

Introduction

Outpatient Parenteral Antimicrobial Therapy (OPAT), or the administration of intravenous antibiotics (IV antibiotics) and other antimicrobials, is a medical intervention used to treat serious infections by delivering medication through the bloodstream. Here, we focus on bacterial infections treated by IV antibiotics. IV antibiotics are recommended when there are no oral alternatives available that are strong enough to treat the infection or when the IV version is better able to reach and treat the infection. People experiencing homelessness are at a higher risk of developing conditions requiring treatment with IV antibiotics, such as endocarditis or osteomyelitis. These risk factors are due to the high prevalence of contributing conditions, such as intravenous substance use, pre-existing heart conditions, diabetes, decreased access to dental care, and wounds.[1,2] Historically, many people who use drugs and/or are experiencing homelessness are not offered outpatient IV antibiotic treatment as an option for serious infections.[3,4] Instead, many are required to complete the treatment during a lengthy inpatient hospitalization (6-8 weeks), which can be challenging for multiple reasons, including the requirement to remain in a restricted environment, loss of case management support, functional status declines, and increased risk of hospital-acquired infections or significant decompensation for those who stay for the duration of care. Due to these challenges, many individuals are unable to complete full treatment in a hospital setting. Other models include discharging the person to a skilled nursing facility to complete treatment, which includes similar barriers as hospitalization (e.g., restrictions on being able to leave the facility) as well as stigma towards those with substance use or mental health histories, policies that do not support the use of methadone or buprenorphine and overall lack of substance use treatment and support, and also involves access challenges due to costs and insurance.[5]

Despite initial perceptions, research has found that people who have a history of substance use can successfully complete outpatient IV antibiotic treatment when thoughtful and client-centered treatment and follow-up plans are put into place as part of the hospital discharge plan.[6,7,8,9]

Medical respite care (MRC) is a promising and effective approach to support people experiencing homelessness who are receiving IV antibiotic treatment.[1] Supporting people prescribed IV antibiotics can be achieved across the Models of Medical Respite Care (Models of Care) and across the spectrum of low-barrier to abstinence-based programs. In fact, medical respite care programs can be a more appropriate location for individuals to receive this type of treatment than higher levels of care, such as hospitals or skilled nursing facilities. This is due both to the expertise of programs in supporting the complex medical and behavioral health care needs of those who are unhoused and also their focus on care coordination and community connection to address multiple needs, not just the completion of the IV antibiotic treatment course. Additionally, programs that implement a trauma-informed approach and allow clients to engage in community activities may have more success in retaining individuals until their course of treatment is completed and prevent unplanned and early discharge.

Understanding the Evidence:

- Several studies have demonstrated that **OPAT can be successful in a supervised medical respite setting**, including for people with remote or current substance use.[9]
- A 2021 study demonstrated that **people with histories of homelessness and substance use had higher odds of clinical cure and retention in substance use treatment at 30 days post hospital discharge if they received four interventions:** 1) an inpatient infectious disease consult, 2) an inpatient addiction medicine consult, 3) a referral for post-discharge case management in the community, and 4) discharge with ongoing buprenorphine or methadone treatment for those with opioid use disorder.[1]
- The **cost savings** of treating someone in medical respite versus an inpatient hospital setting **were $25,000 per treatment course.** **Error! Bookmark not defined.**

This guide is intended to describe the central practices medical respite programs should have in place to support people with IV Antibiotic treatment needs in their program. Programs can use this document to evaluate their current capacity to support this client population or identify the next steps needed to expand services.

How to use this guide:

- These recommendations are based on existing evidence and promising practices implemented within the field of medical respite care.
- See Appendix A for key terms and definitions related to IV antibiotic treatment and conditions.
- Additionally, programs may want to use the supplemental resource, Clinical Guidelines for Medical Respite Care Programs: IV Antibiotics, for staff education and training, and for education and advocacy with potential partner organizations.
- Appendix B: Program Readiness Assessment can be used after reviewing this resource to identify a program's readiness and any action items needed to support people with IV antibiotics within medical respite.

Essential Partnerships

Partnerships are critical when supporting clients with IV antibiotic treatment needs across all Models of Care, although the level of partnership may vary based on the availability of onsite clinical staff. It is crucial that all functions of these partnerships are in place, and the following partnerships will be beneficial for programs:

Hospital Discharge Planning Team

Programs should work in close partnership with the discharge planning team to determine eligibility and ensure that all supports or referrals needed for the client are in place before leaving their hospital stay. Discharge planners should have a strong understanding of the medical respite program, the level of self-management required (e.g., administering their own antibiotics versus being present for nursing staff to administer), and what other partner referrals need to be made prior to discharge (for example, home care infusion services to be delivered in the medical respite). Many medical respite programs will require that the discharge planning team has made the home health or infusion service referral and ordered the IV antibiotics at the preferred pharmacy. The program and hospital will also need to confirm the delivery date and the storage requirements for the medications once they are at the program.

Home Health Care

Home health care teams have clinical staff that can provide administration of IV antibiotics and management of the insertion site and lines. Programs without in-house clinical support will need to establish working partnerships with home health services to provide medication administration, dressing changes, injection site monitoring, lab draws, and/or client education.

Infusion Services

Infusion services can provide IV antibiotic administration via infusion teams that visit the client or through outpatient infusion centers. Infusion services can also provide all supplies for completing the treatment, and through partnership, can also provide education for staff. In situations where a person will be administering their own antibiotics, infusion center teams can provide initial and ongoing education to support the self-administration. Programs without clinical oversight should establish partnerships with in-home or clinic-based infusion services to manage antibiotic administration. Based on the frequency or dosing of the IV antibiotics, in-

home services may be preferred. When establishing partnerships, programs can communicate this preference or their capacity to support transportation to infusion clinics for dosing.

Medication-Assisted Treatment (MAT) & Outpatient Substance Use Treatment Services

Like other clients admitted to the medical respite care program with a history of substance use, clients should be offered connection to MAT and other available substance use services. If initiated in the hospital, these services should be continued without interruption at the transition into medical respite care.

Skilled Nursing Facilities and Other Higher Levels of Care

In some cases, the hospital may be unwilling to discharge the person with IV antibiotics to the medical respite program due to concerns about the person's ability to manage the treatment requirements or refrain from using the line for substance use if in the community. In other cases, the MRC program itself may have determined they are not able to support IV antibiotics onsite but can provide a safe step-down and discharge location for clients who can complete this treatment course in a skilled nursing facility (SNF). MRC programs can create intentional partnerships with SNFs for a coordinated transition in which the care is coordinated and connected from the time of hospital referral. MRC programs may also offer to provide care coordination for clients while they are in the SNF, to provide an extra level of support and relationship building with the client. This partnership and referral pathway may increase the likelihood that the SNF is willing to take the patient, as the medical respite care transition ensures a safe discharge plan.

Advocacy Opportunities

The partnerships noted here are highly dependent on strong working relationships. Setting clear expectations and having a communicative point of contact for partners can improve the function of partnerships and client outcomes. When possible, programs can offer tours to partners, standing meetings, or offer to come to staff trainings to give an overview of their program. These strategies can help improve essential partnerships, especially for partners who have less experience working with people experiencing homelessness.

Advocating for clients with a history of substance use:

Partners may have different assumptions or understandings of the risk involved in IV antibiotic administration for clients with a history of substance use. While caution is warranted, programs have an opportunity and onus to advocate for their clients and to challenge denied referrals based on stigma. See: Safety and Integration of Harm Reduction Practices for more information about supporting clients with a history of substance use, as well as the companion resource Clinical Guidelines for Medical Respite Care: IV Antibiotics.

Program Operations

Role of Staff Across Models of Care

As noted in the introduction, all Models of Medical Respite Care can support and provide care to people receiving IV antibiotic treatment. There are differences across Models regarding the role of staff, the client's role in their own care, and the integration of partnership organizations. As a central role for medical respite care, all programs will provide care coordination for the clients to ensure engagement with their prescribed antibiotic treatment and the providers overseeing that care, and to address the additional medical and social needs the person may have. For those receiving IV antibiotics, there may be increased transportation and appointment management needs based on the administration and infusion schedule.

All programs will also benefit from relationship building with their clients, and by providing a supportive environment for clients to continue treatment and engage in care, which can be challenging due to its duration and intensity.

The following sections will describe the roles of staff within the different Models of Medical Respite Care to support those receiving IV antibiotics. For more information on the potential staff to provide services within each Model of Care, please see Potential Skills and Staffing of Medical Respite Care.

Coordinated Care:

In the Coordinated Care Model, there are no onsite clinical staff. In this Model, clients will either be administered their medication by an outside or partner clinical provider (such as a home health team or infusion team/clinic) or may be responsible for self-administering their medications. To help support client success within the Coordinated Care Model, staff will need to:

- Ensure the client has received education from the hospital, prescribing providers, or the home care/infusion team on how to administer medications when they are self-administering. Staff should confirm that the client has demonstrated the ability to do medication administration to their providers; this process will occur in the hospital before discharge to medical respite care.
- Ensure the client has adequate storage for refrigerated medications either within their personal area or within the program's medication storage.
    - Medical respite program staff may need to ask or advocate for being prescribed and receiving medications that fit storage space. For example, if a client is using a personal minifridge, they may not be able to receive and store more than 3-4 days of medications at a time.
    - If the program stores medications on behalf of the client, they need to ensure they are following state guidelines for medication storage and that the client will be able to access medications at all dosing times.
- Ensure the client is available for home health or infusion team visits when they will occur onsite.
- Ensure the client has transportation to off-site infusion treatment or appointments as needed.
- Provide check-ins and monitoring of clients. Although one wellness check per 24 hours is the minimum requirement of programs, staff may opt to check in with the client more regularly to support safety and address any client concerns.
    - The clients should be made aware of the frequency of check-ins and expectations around their engagement with staff.
- Work with partners to educate medical respite program staff on how to support the client (e.g., looking for changes around the insertion site, who to contact with concerns, especially overnight).
- Screen for the need for and facilitate connection to outpatient behavioral health treatment, including medication-assisted treatment.
- Provide harm reduction education and access to harm reduction services, as needed.
- Engage with the client to identify ongoing concerns and support self-advocacy to address ongoing health needs with providers (e.g., pain management needs, how to access on-call or after-hours providers).

Coordinated Clinical Care:

In the Coordinated Clinical Care Model, many of the same staffing roles and considerations will be in place as with the Coordinated Care Model listed above. However, within this Model, onsite staff include nursing staff, who can provide certain onsite clinical services. These staff members may play a greater role in day-to-day oral medication administration, monitoring, and client education. Although the IV antibiotic medications will most likely be administered by an outside provider (home health team, infusion services) or by the client themselves, staff within the Coordinated Clinical Care Model can additionally provide support to:

- Review prescribed medications, complete medication reconciliation, and ensure the client has all medications as prescribed; and contact prescribing providers with concerns.
- Monitor for changes at the insertion site and report concerns to the prescribing provider, home health care team or infusion team.
- Complete basic vital signs (e.g., temperature, blood pressure) to monitor for changes or signs of infection.
- Assess the client's ability to self-administer medications and report concerns to prescribing provider.
- Review and remind clients of the dosing schedule.
- Screen for the need for and facilitate connection to outpatient behavioral health treatment, including medication-assisted treatment.
- Provide harm reduction education and access to harm reduction services, as needed.
- Engage with prescribing providers to express concerns around administration, status of insertion site, lab results, or other client-expressed concerns and priorities.

Integrated Clinical Care:

In the Integrated Clinical Care Model, the capacity to provide on-site medical and clinical support increases due to the integration and regular availability of medical/clinical providers (including prescribing providers and nursing staff). The clinical staff may provide increased education and management, while coordinating with the prescribing provider (e.g., Infectious Disease), home health, and infusion services. In addition to the care coordination and support activities included in the previous models, the staff within the Integrated Clinical Care Model may also need to be equipped and receive training to:

- Complete a history and physical and integrate the IV antibiotic treatment within the clinical care plan.
- Provide regular clinical assessment as indicated by the care plan, and communicate changes and progress to prescribing providers.
- Coordinate directly with Infectious Disease and other care team members regarding antibiotic treatment course, IV-line management, lab results, and other medical needs.
- Provide education regarding the IV antibiotic dosing schedule, administration, and management of the insertion site.
- Oversee or conduct medication administration of IV antibiotics, and/or assess clients' ability to self-administer medications.
- Monitor insertion site and conduct dressing changes as ordered.
- Prescribe and provide support for co-occurring health conditions, including for behavioral health needs.

- Advocate with IV antibiotics prescribing providers to adjust or address barriers to care as needed, for example, exploring an oral regimen if there are issues with the preferred IV medication.
- Provide harm reduction education as it relates to the infection being treated, PICC line, or insertion site.

Additionally, on-site behavioral health providers can provide on-site services to:

- Screen for and ensure connection to community-based behavioral health care.
- Provide initial and time-limited behavioral health interventions to bridge the client while they are accessing community-based care, such as therapy to address pain management or develop regulation skills to tolerate long-term treatment.
- Provide harm reduction education and access to harm reduction services, as needed.

Comprehensive Clinical Care:

The Comprehensive Clinical Care Model includes robust onsite clinical and behavioral health providers. Although the IV antibiotic course is prescribed by an outside provider (e.g., Infectious Disease), more on-site providers can play an important role in management and follow-through on the antibiotic treatment course. Staff within the Comprehensive Clinical Care Model should be trained and able to:

- Communicate with referring partners for case discussion and advocacy to refer clients with IV antibiotic needs to the program.
- Complete a clinical assessment regularly, as indicated by the care plan, and communicate changes and progress to other prescribing providers.
- Complete a history and physical and integrate the IV antibiotic treatment within the clinical care plan.
- Provide education regarding the IV antibiotic dosing schedule, administration, lab and follow-up requirements, and management of the insertion site.
- Oversee or conduct medication administration of IV antibiotics, and/or assess clients' ability to self-administer medications.
- Monitor insertion site and conduct dressing changes as ordered.
- Provide harm reduction education as it relates to the infection being treated, PICC line, or insertion site.
- Prescribe and provide support for co-occurring health conditions.
- Prescribe MAT treatment, even as an initial bridge while waiting to connect to outpatient treatment programs.
- Advocate with IV antibiotics prescribing providers to adjust or address barriers to care as needed, for example, exploring an oral regimen if there are issues with the preferred IV medication.

Additionally, behavioral health providers can provide on-site services to:

- Screen for and ensure connection to community-based behavioral health care.
- Provide initial and time-limited behavioral health interventions to bridge the client while they are accessing community-based care, such as therapy to address pain management or develop regulation skills to tolerate long-term treatment.
- Provide substance use-based counseling or short-term interventions, to serve as a bridge to community-based care.

Considerations for Abstinence-Based and Low-Barrier Services

All medical respite care programs have policies around substance use that generally fall on a spectrum between requiring total abstinence while in the program and a lower-barrier approach that does not allow substance use on-site but does allow clients to come back into the space intoxicated. Due to local policies, programs generally do not allow open substance use on-site.

Closed Facility

Clients of the program are not allowed to leave the program or facility unless for an appointment and/or if accompanied by program staff. Closed facilities allow for more monitoring of the client and can reduce the risk of the person using substances off-site, missing scheduled antibiotic doses, or using the PICC line inappropriately. However, having limited access to the community can be challenging for many clients, and programs will need to have ample opportunity to engage in preferred leisure and social activities, and provide products or supplies clients would desire to purchase off-site (such as tobacco products, beverages, and snacks). Note, harm reduction and overdose monitoring protocols are still needed in closed facilities.

Open Facility

In an open facility, clients can leave the program within the parameters and guidelines of the program (e.g., during certain hours or returning by curfew, doing activities outside of appointments). In an open facility, clients have more autonomy and choice about how they spend their time and can stay connected with their community. However, open facilities can increase the risk of the person accessing substances or returning to substance use and increase the risk that the person may not return to the program. Open programs also increase the risk that clients will not be available or at the facility when they have home health or infusion visits, or at their prescribed dosing time. In open programs, staff should ensure they have overdose monitoring and communicate a desired schedule for check-ins with the client. There may be additional individual contracts and plans made with the client to ensure they are at the program for home health/infusion services and/or that they are self-administering medications as expected.

It is important to note that for the general population, outpatient IV antibiotics do not require the person to stay at home 24/7, and that these patients often go out into the community.

They manage the same considerations for follow-up treatment (e.g., being available for home health visits).

Abstinence-Based Programs

These programs do not allow clients to use substances in their programs and may have strict criteria or guidelines in response to a person using non-prescribed substances. Abstinence-based programs may choose to have a closed model to decrease access and reduce the risk of clients being exposed to or using substances. Programs that do not allow substance use and operate a closed campus should be aware that these are barriers to service for some clients and exclude some eligible clients from their services, as well as those who may be apprehensive about being in such a program. Additionally, clients who experience a relapse may lose the medical care needed as a result. A positive to this model is that the program has more control over the client's experience and can ensure against improper use of PICC lines during their antibiotic treatment. Using an abstinence-based model may be more acceptable to hospitals and infectious disease providers and can provide an initial opportunity to build partnership and trust among entities.

Low Barrier Programs

Programs that do not allow substance use on-site but allow people to come into the space intoxicated or after using, can provide services to clients who may not be able to successfully stay or qualify for an abstinence-based program. This can be invaluable for the client and hospital, but each client should be carefully assessed before

program admission for the ability to abstain from using their intravenous access for substances and engage in the prescribed care and administration plan. Lower barrier programs often have an open model, and while there is an increased need to be able to offer support, a higher level of client self-management is required. Low barrier programs have an increased risk for PICC line misuse, as the client may be off-site without staff supervision, and the staff should assess each prospective client carefully. It should be noted that in programs using this model, incidents of PICC line misuse are very rare.

Mixed Approach Programs

Some programs may be overall lower-barrier (such as not requiring abstinence) but have stricter policies for those with PICC lines or receiving IV antibiotics. This might include not allowing clients to leave without staff supervision or increased monitoring of clients while on-site.

Overdose Response and Monitoring

Regardless of substance use policy, all onsite staff should be trained to assess, monitor, and respond to suspected overdose, and naloxone should be readily and easily accessible to staff and clients.

Policy and Procedure Modifications or Considerations

The key differences in program design raise different considerations and a need for an explicitly written program policy. Programs should be sure to cover the following subjects in their policies and procedures:

Non-Prescribed use of PICC line:

- Programs should have a policy for when (or if) a client is suspected of using a PICC line to inject things outside of their prescribed antibiotic regimen.
- This policy should include how to monitor for suspected misuse (e.g., placing a clear film dressing over the port when not in use and having staff initial the dressing), which (internal or partner) clinical staff are responsible for determining misuse, and the next course of action and treatment modification, such as removal of the PICC line.
- In cases where the PICC line will be removed, programs can advocate for continued antibiotic treatment through an oral regimen when/if possible. This oral treatment can be provided while the person is in the medical respite care program. By continuing at the medical respite, the person will likely benefit from the increased support and care coordination services to support follow-through on the oral regimen, in addition to other services.
- In other cases, it may be determined that the person will need to continue their IV antibiotic treatment in a higher level of care. In these cases, the medical respite program can facilitate the transition into these facilities (such as a SNF) and offer medical respite care as a discharge location to the client once treatment is completed, if appropriate.

Protocol for when a client is not able to self-administer or manage their PICC line:

- Programs should have a policy for how to respond when a client is not able to meet the level of self-management needed with the existing supports.
- Referral pathways should include options for increased support from home health or infusion services, referral to Skilled Nursing Facilities, re-admission to the hospital, or a transition to an oral medication regimen when possible.

Safety and Integration of Harm Reduction Practices

Many people with substance use histories have challenges in accessing IV antibiotics as care, especially in the community, due to concerns of safety. Integrating harm reduction practices can help to reduce potential harm, increase client safety, and support people's ability to access and complete their recommended course of treatment. Integrating safety practices can benefit all clients receiving IV antibiotics, even if there are no immediate concerns for substance use or overdose. These strategies should be implemented across programs, including abstinence-based, low-barrier, open, and closed programs.

Staff and client training in the use of naloxone:

- Provide regular training to staff and clients on the administration of Naloxone and overdose response (e.g., oxygen) and ensure it is available throughout the medical respite program for easy access.

Overdose monitoring:

- Develop a process for routine check-ins for clients to monitor for overdose.
- Programs may opt to complete the same number/frequency of check-ins for all clients, or develop a risk decision tree that would indicate a person needs more frequent check-ins.
- Communicate the schedule of check-ins and expectations of clients to participate in check-ins at admission and again throughout the client's stay to ensure the client is aware of the expectations.
- Develop relationships with clients so that they feel comfortable communicating concerns of use or overdose for themselves or for other clients in the program to staff.

Client Education:

- Clients should receive direct education on the risks associated with using the PICC line for anything other than medication administration, and on the importance of caring for and cleaning the insertion site as directed.
- Provide education and referrals to resources that can provide harm reduction education, such as alternative methods for substance use, as needed.

Develop a protocol to communicate concerns to prescribing providers:

- Staff should be educated on warning signs of infection, including redness, drainage, or swelling at the insertion site or fever and feeling unwell, and have a process for communicating concerns to the home health team and prescribing provider.
- Staff should also be educated on when/how to report concerns of the client using substances or accessing their insertion site for substance use. Of note, this may include the need to advocate for the client to receive alternative treatment (versus discharge from the program or services).

Connection to MAT or pain management:

- Inadequately treated pain, unmanaged withdrawal, and cravings can all prompt a person to begin using substances. Identifying these concerns with the client early in care and making sure they know how to communicate needs and concerns can support overall wellbeing and recovery goals.
- Non-clinical staff can also help advocate with prescribing providers regarding pain management needs.

For more information on integrating supportive strategies for people who use substances and harm reduction strategies, please visit these resources:

- Harm Reduction Approaches to Supporting Clients with Past or Current Substance Use in Medical Respite Settings
- Organizational Self-Assessment for Programs Serving Clients with Past or Current Substance Use
- Harm Reduction in Medical Respite Care Online Course
- Substance Use Guideline Series

Client Support

Client support may come directly from the program or from a collaboration between the program and other partners. The client should be empowered and educated throughout the process to take the lead where they can in their health journey, including self-management and administration when necessary.

Education:

- Program staff, home health, or infusion service staff should educate the client about the following:
    - basics of IV antibiotics
    - insertion site monitoring and care (e.g., protecting the dressing in the shower)
    - how to administer medications and problem-solve if issues arise
    - signs of complications or infection
- Clients should be educated through in-person demonstrations, verbal instructions, and be given written instructions on who to contact with any questions or how to alert staff in case of emergency. Clients should be given opportunities to ask questions and review the information throughout their treatment.

Encouragement:

- Program staff should encourage and support the client in their medical respite journey to self-determination and support them in developing the self-management skills needed for when they leave the program.
- Clients will also benefit from acknowledgment that IV antibiotic treatment courses can be challenging and will benefit from positive feedback regarding their engagement in care or changes they have made related to their health.

Connection to Supportive Services:

- Programs should offer connections to behavioral health services to address both conditions contributing to the need for antibiotic treatment, but also to address any additional concerns, changes in mood, or anxiety related to the condition or treatment.
- Peer support services can provide a different but necessary support for those undergoing treatment or considering changes in their substance use by offering their expertise gained from lived experience.
- Engagement in social and leisure activities provides meaningful ways for clients to spend their time and shift their focus primarily from their health and into activities they enjoy or have not been able to enjoy for a long time.

Conclusion

Medical respite care programs choosing to support people prescribed IV antibiotics can increase access to essential and life-saving care for those in their community. Although the procedures around supporting these clients can be more complex, medical respite care programs are well-positioned to provide the client-centered support and care coordination required for successful outcomes. By advocating for clients and developing community partnerships, programs can reduce barriers to care and have a positive impact on their local health systems and the quality of life for their clients.

Appendix A - Key Terms and Definitions

Antimicrobial Treatments refer to medications used to prevent and treat infectious diseases in humans. Antimicrobials include **antibiotics** – used to treat bacterial infections, **antifungals** – used to treat fungal infections, **antivirals** – used to treat viral infections, and **antiparasitics** – used to treat parasitic infections. In medical respite care, most people receiving long-term treatment for an infection will be treated with antibiotics.

Endocarditis refers to inflammation of the lining of the heart's valves and chambers; it is most often caused by a bacterial infection.

Harm Reduction is a philosophical approach to medical care that extends beyond substance use and, in general, establishes individual agency and self-determination as central to any health intervention or efforts towards well-being. Harm reduction approaches call for the non-judgmental, non-coercive provision of services and resources to people experiencing homelessness to assist people in reducing harm related to chronic health conditions or health behaviors. Harm reduction-based care is collaborative, provides education on available interventions, and centers the goals of the individual in care planning.

Intravenous Antibiotics (IV antibiotics) are antibiotics delivered directly into the bloodstream via intravenous access. Intravenous antibiotics are used in critically ill people and for infections that require intravenous administration.

Medication-Assisted Treatment is the use of prescribed medications, often alongside behavioral health intervention or other supports, to treat substance use disorders. Medications used include buprenorphine, methadone, and naltrexone for the treatment of opioid use.

Osteomyelitis refers to an infection of the bone. Treatment includes long-term antimicrobial treatments and may include surgical removal of infected bone and related hardware, if in place (for example, prosthetic joints).

Parenteral is a term used to describe medications, food, or fluids that are administered to people in a manner that does not involve the gastrointestinal tract, so not by mouth or via the stomach. Parenteral can be used to refer to intravenous administration of medications, food, or fluids.

Peripherally Inserted Central Catheters (PICCs or PICC lines) are flexible intravenous catheters (tubes) that are inserted into a vein in the upper arm and go into a larger vein in the chest, ending just before the heart. PICC lines are often used long-term for intravenous medication infusion, typically remaining in place from several weeks to several months.

Peripheral Intravenous Access refers to intravenous catheters that are inserted into a small vein, usually in the hand or arm, and that are intended only for short-term use (usually up to three days).

Trauma Informed Care (TIC) is a patient-centered approach to care that recognizes the impacts of trauma and actively works to prevent re-traumatization and promote recovery. The principles of TIC are grounded in establishing a trusting relationship and a safe physical and psychological space in which to address needs.

Appendix B – Program Readiness Assessment to Provide Support for Clients Receiving IV Antibiotics

This checklist can be used by programs to determine if they are ready or have the capacity to support clients receiving IV antibiotics.

Partnerships and Referrals:

Does our hospital initiate outpatient IV antibiotic treatment for people experiencing homelessness and/or who have a history of substance use?

- ☐ Yes
- ☐ No

Are there infectious disease providers willing to prescribe IV antibiotics to people within medical respite programs?

- ☐ Yes
- ☐ No

Are there outpatient infusion centers or home health care organizations willing to come onsite to provide IV antibiotics administration and care to clients within our program?

- ☐ Yes
- ☐ No

If you answered "No" to the above questions, what initial next steps could you take?

- ☐ Identify infectious disease providers within our referring hospital systems to collaborate with
- ☐ Advocate for the use of IV antibiotics with hospital-based infectious disease teams with people experiencing homelessness in medical respite care
- ☐ Identify home health and infusion care organizations to develop a strong partnership with for IV antibiotic treatment and care
- ☐ Advocate to the home health and/or infusion care organizations to provide care within your medical respite care program
- ☐ Gather resources and evidence to support the need for the medical respite program to support or receive referrals for people who need IV antibiotic treatment
- ☐ Developing a formalized contract or MOU with IV antibiotics prescribers, home health agencies, and infusion clinics to determine delivery of care, provision of supplies/support, and client education
- ☐ Resources needed: _____

Programmatic & Staff Capacity:

What is our current approach to supporting people who use drugs or have a history of substance use?

- ☐ Low barrier
- ☐ Abstinence-based
- ☐ A combination of both

Do our approach or procedures need to change for clients who receive IV antibiotics? If yes, how so?

Do we have staff capacity to coordinate care with infusion clinics and/or home health care teams for multiple doses of IV antibiotic treatment?

- ☐ Yes
- ☐ No

Do we have transportation support to assist clients in getting to infusion centers frequently for treatment?

- ☐ Yes
- ☐ No

Are our non-clinical staff educated and trained to monitor the status of clients receiving IV antibiotics and navigate prescriptions, appointments, and follow-up care?

- ☐ Yes
- ☐ No

Are our clinical staff trained to provide client education on the management of IV antibiotics?

- ☐ Yes
- ☐ No
- ☐ N/A – we do not have onsite clinical staff

Do we have processes for providing or connecting clients to harm reduction education and services when needed?

- ☐ Yes
- ☐ No

Do we have staff and client training in overdose monitoring and response?

- ☐ Yes
- ☐ No

Do we have processes to identify and refer clients to outpatient substance use treatment, including MAT?

- ☐ Yes
- ☐ No

If you answered "No" to the above questions, what initial next steps could you take?

- ☐ Increasing our care coordination or case management capacity
- ☐ Increasing our ability to provide transportation to off-site infusion centers
- ☐ Increasing our connections to community-based providers to increase access to various types of care. Connections or additional partnerships needed: _____
- ☐ Developing policies and procedures specific to when someone is receiving IV antibiotics care
- ☐ Training for non-clinical staff: Training needs: _____
- ☐ Training for clinical staff: Training needs: _____

Based on this guideline and the Clinical Guidelines for Antibiotics in Medical Respite, do you have additional reflections or needs for your program to be able to expand services to support this client population?

References

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