Westbay Community Action
Rhode Island Medical Respite Pilot Program:
Isolation Support Referral Form

How to Make a Referral:
Weekdays (Monday – Friday, 8:30 a.m. – 4:30 p.m.): Email referral form to RIDOH staff, Morgan Wieck (morgan.wieck.ctr@health.ri.gov) or Amanda Prymak (Amanda.l.prymak.ctr@health.ri.gov). Confirmation of receipt will be sent within the same business day. If you do not receive a response, please call 401-601-6279. Please send referrals ENCRYPTED. If you need an encrypted email, please let Morgan Wieck and Amanda Prymak know in advance of reporting personally identifiable information.
Weekdays after hours and weekends (Monday – Friday, 4:30 p.m. – 6 p.m., and Saturday – Sunday, 10 a.m. – 6 p.m.): Email referral form to Westbay Community Action (medical-respite@westbaycap.org) or call 401-262-9009.

Some helpful information to share with potential guests reviewing the expectations and policies regarding the Medical Respite Pilot Program:

*Please note this is a mixed-use facility meaning some individuals may be referred to isolate onsite from infectious illnesses. Infection preventionists have been engaged in planning and have provided recommendations and advisement on safe operating procedures for this facility.

1. Hallworth House, 66 Benefit Street, Providence RI, has a capacity of 20 beds operating on Floors 2 and 3 with the possibility of expansion in the future. Elevator access is available.
    a. A limited number of beds are reserved for isolation.
2. Participation is limited to people experiencing homelessness or housing insecurity with acute medical and/or behavioral health support needs throughout Rhode Island.
3. Length of stay will be dependent on each person's recovery period as determined by their treating provider, public health authority, or will terminate upon the Pilot's end date. As medical conditions improve, discharge prior to obtaining either permanent or temporary housing is possible.
4. Each patient will have access to his or her own room, bed, refrigerator, TV, and a safe place to store personal things. Access to a shared bathroom, shower facilities, phone, and communal space is available.
5. We are not responsible for the loss of personal items or valuables; there is a locked cabinet for each client to use and store belongings securely. Dimensions are 19in.x27in.x14.5in.
6. Three daily dietary appropriate meals per guest are provided to Westbay Community Action through Amos House. The facility has no control over the types of meals provided. Westbay will do our best to accommodate any dietary restrictions, dislikes, and/or allergies.
7. There is a mini fridge in each guest room, communal microwaves available to all guests of the program. Guests are encouraged to bring food and toiletries with them.
8. Coordination with a Medication Assisted Treatment provider is available to clients of the Medical Respite Program if they are currently receiving treatment or wish to be enrolled in this treatment in the future. Individuals must be able to administer all other prescribed medications independently.
9. Smoking is allowed in the designated outdoor area. Smoking in the building is NOT permitted.
10. Cleaning service performs regular cleaning and disinfection of all spaces in the program.
11. NO drugs or alcohol are permitted on the premises.
12. Alert medical staff will provide on-site clinical care to clients of the program every day between 8am -10pm as needed.

14. Westbay will ensure all clients of the Program are assigned to an on-site case manager who will work with providers and the nursing service to oversee client's care coordination, assessment, evaluation, and social service needs
15. Security officer(s) will be onsite to ensure safety of the facility 24 hours per day
16. Intake referrals will be accepted and assessed between 10am- 6pm, seven days per week. Referrals will be reviewed and responded to in the order that they were received. Clients are expected to present to the facility for intake between 10 a.m.- 6 p.m. unless otherwise discussed with Westbay staff.

The following policies are subject to a client's isolation status at Medical Respite:

16. Guests are encouraged to wear a face mask outside of their rooms. If isolating from an infectious illness, masking is required and will be provided onsite.
17. Visitors are permitted, except when a client is isolating from an infectious illness. Please refer to visitor policy*
18. If guests choose to leave the premises, reentry is not permitted after 9:30pm curfew time each day. Clients are not allowed to leave the premises while isolating from an infectious illness. If guests choose to leave the premises prior to completion of the recommended isolation period, reentry to the facility is not permitted.
19. Laundering of client clothing will be offered 1 time per week. Laundering of personal clothing is not available for clients admitted to Medical Respite strictly for an isolation period of less than one week.
20. Access to communal space is prohibited during an isolation period.

☐Please check to confirm all information above was discussed with potential client

The Medical Respite Pilot Program Exclusion Criteria:

1. Client is unable to complete ADLs, personal care and medication administration
2. Client has active Tuberculosis/C-DIFF
3. Client has recently displayed combative or aggressive behavior towards staff, peers, or others
4. Client is in active detox from substance use (i.e., alcohol, benzos) (acute/ active detox)
5. Client has current/ active homicidal or suicidal ideations
6. Client requires the level of care provided by a Skilled Nursing Facility

Some criteria are intentionally left off the overarching inclusion and exclusion criteria and will be assessed on a case-by-case basis: (Please contact Westbay directly if any of the below apply):

1. Client has stage 3 or higher wounds or ulcers and cardiac EF % < 30%: When assessing patients for eligibility with wounds cardiac EF, referring partners should focus on patient stability; and if that criterion is met could be a candidate for the medical respite program
2. Client has a new tracheotomy: ("new" will be assessed case by case) (consistent settings/ may not need routine care could be considered for the program
3. Client requires IV therapy or oxygen therapy
4. Client is currently infected with communicable diseases: evaluate patients that are on other precautions other than other standard precautions
5. Client requires ambulatory equipment: referral form should indicate if patient requires ambulatory assistance/ what devices are required/ recommended and if the patient has their own devices (must be provided prior to admission)
6. Client has dependents/children
7. Client has been convicted of a sex crime

Westbay's Medical Respite Program is developed from the core Medical Respite Standards[1] published in 2021 by the National Institute for Medical Respite Care (NIMRC) and Respite Care Providers Network (RCPN). These standards may be built upon as new information becomes available in the domain of medical respite and recuperative care. The national standards are as follows:

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

[1] National Standards of Medical Respite Care Standards for Medical Respite Care Programs - National Institute for Medical Respite Care (nimrc.org)

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Medical Respite Pilot Referral Form

Please fill out the following information as completely as possible. Receiving this information helps us to provide the best care for our clients and helps inform program utilization, to ensure we are reaching and serving an equitable and representative population.

Date of Referral:

Referred by (Name)&(Agency):

Provider/ Referral Tel #:

Assigned (Nurse) Case Manager/ CHW:

NCM/CHW Contact Information:

Patient Name: DOB:

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Chose not to disclose

Patient's current shelter type: ☐Shelter ☐Outside ☐Hospital ☐Vehicle

County where client is currently residing: ☐Kent, ☐Newport, ☐Washington, ☐Providence, ☐Bristol

☐Other:

Patient Phone/Contact Info:

Next of Kin/Emergency Contact(s):

Phone Number: Relationship:

COVID-19 Vaccinated: ☐Yes ☐No ☐Pfizer ☐Moderna ☐J&J ☐ Primary Series ☐ Booster

Ethnicity: ☐Hispanic/Latino ☐ Not Hispanic/Latino ☐Chose not to disclose

Race: ☐Asian ☐ Native Hawaiian ☐Hawaiian/Other Pacific Islander ☐Black or African American

☐ American Indian/Alaska Native ☐White ☐More than one race ☐ Chose not to disclose

Primary Language Spoken:

English-Speaking: ☐Yes ☐No

Gender: ☐ Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other ☐Unknown ☐Chose not to disclose

Sexual Orientation: ☐Lesbian or Gay ☐Heterosexual ☐ Bi-Sexual ☐ Other ☐Don't Know ☐Chose not to disclose

Does the patient have an established Primary Care Provider (PCP)? ☐Yes ☐No

PCP Name:

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Practice Name:

Health Insurance:

Medicaid ID:

Please check all that apply:

Checking any of the following will not make a client ineligible for the program.

☐Patient is a smoker Check: ☐Daily ☐Social
☐Smoking cessation offered and accepted by client
☐Smoking cessation offered and declined by client
☐Patient does not require IV therapy or oxygen therapy
☐Patient does not have active TB or C-Diff
☐Patient is actively using substances
☐Harm reduction enrollment/Harm reduction supplies needed:

☐Patient is enrolled in MAT and will continue with current MAT provider during MRC
☐CODAC form submitted/will be receiving delivery
☐Offered MAT willing to enroll. Selected MAT provider:
☐Patient is not in active detox

☐Patient has a legal form of picture identification (license, state ID, passport, etc.)
If no, attach copy to referral if provider has a copy

Are you assisting client with obtaining identification ☐Yes ☐No ☐N/A (Has ID)

What case management services are you working on with this client?

Does client have a housing resource/voucher? ☐Yes ☐No
If yes, please note what type if known:

Primary Medical Diagnosis/Reason for Respite Care:
☐ IV Antibiotics ☐Chronic Disease Management ☐Rehab PT/OT ☐Respiratory Illness ☐Strained/Torn Muscle ☐ Wound Care/Skin Issue ☐Mental Health Concern ☐Substance Use Disorder ☐ Preparing for inpatient/outpatient procedure or recovery ☐ Infectious Disease ☐Chemotherapy/Radiation ☐Burn Care
☐Other (Explain Below):

Secondary/Additional needs:

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If a client is experiencing symptoms of COVID-19 or has tested positive, please answer the following questions and attach a copy of the test results if applicable.

Date of Positive COVID Test:
If isolation needed for other infectious disease, please specify:
☐Client is asymptomatic
☐Client is symptomatic

Date of Symptom Onset:

Symptoms:

Anticipated Patient Needs: ☐VNA ☐Medication Education ☐Wound Care
☐Physical Therapy ☐ Occ/ Speech Therapy ☐ Behavioral health care ☐ Oxygen in use

If client has a scheduled appt with specialist/VNA before first contact with provider, please check the following that apply:
☐Transportation needed ☐ Provider coordinating transportation ☐ Appointment at MRC facility

Does client have a service animal or emotional support animal? ☐Yes ☐No
Please attach documentation/proof of current rabies vaccine and ensure appropriate supplies are provided.

Anticipated Length of Stay:

Assistive device(s) required by patient: ☐Wheelchair ☐Walker ☐Cane ☐Crutches ☐ Knee Scooter
☐Other:

☐No Device required

Please check the following that apply:
☐Client will have device(s) at the time of entry into respite
☐Client can ambulate independently with device (if needed)
☐Client is in the process of obtaining device(s) for assistance

Medications (Please attach a med list and indicate how client will receive refills if needed):

Does client have any food allergies or dietary restrictions? If yes, please describe as we want to start their meals as soon as possible.

If pregnant- how many weeks and are there any pregnancy related medical concerns?