Westbay Community Action
Rhode Island Medical Respite Pilot Program

How to Make a Referral:

- **Weekdays (Monday – Friday, 8:30 a.m. – 4:30 p.m.)**: Email referral form to RIDOH staff at RIDOH.InfectiousDisease@health.ri.gov. Confirmation of receipt will be sent within the same business day. Please send referrals ENCRYPTED. If you need an encrypted email, please send an email to the above address (RIDOH.InfectiousDisease@health.ri.gov) to request support.
- **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 (kshappy@westbaycap.org) or call 401-262-9009 ***Only accepts voicemails***

** Please send referrals ENCRYPTED. If you need an encrypted email, please let RIDOH know in advance of reporting personally identifiable information.

Some helpful information to share with potential clients 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 30 beds operating on three floors. Elevator access is available.
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 client'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 client will have access to their 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 client are provided to Westbay Community Action. 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 client room, communal microwaves are available to all clients of the program. Clients 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. Clients 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. The 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 7am - 5pm as needed.

13. Westbay will ensure all clients of the Program are assigned to an on-site case manager who will work with providers and the nursing staff to oversee client's care coordination, assessment, evaluation, and social service needs.
14. Security officer(s) will be onsite to ensure safety of the facility 24 hours per day.
15. If clients choose to leave the premises, reentry is not permitted after 11:00pm curfew time each day. Clients are not allowed to leave the premises while they are in isolation from an infectious illness. If clients choose to leave the premises prior to completion of the recommended isolation period, reentry to the facility is not permitted.
16. Intake referrals will be accepted and assessed between 10am- 3pm, 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 10:00 AM- 3:00PM unless otherwise discussed with Westbay staff.

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

17. Clients are encouraged to wear a face mask outside of their rooms. If the client is in isolation for an infectious illness, masking is required, and they will be provided onsite.
18. Visitors are permitted, except when a client is in isolation from an infectious illness. Please refer to the visitor policy.
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
7. Client does not have active Medicaid coverage for time period of stay

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 clients for eligibility with wounds cardiac EF, referring partners should focus on client stability; and if that criterion is met, they 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 clients that are on other precautions other than other standard precautions.
5. Client requires ambulatory equipment: referral form should indicate if client requires ambulatory assistance/what devices are required/recommended, and if the client has their own devices (must be provided prior to admission)
6. Client has dependents/children.

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)

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.

REFERRAL INFORMATION:

- **Date of Referral:**
- **Referred by (Name)&(Agency):**
- **Provider/Referral Tel #:**
- **Assigned (Nurse) Case Manager/ CHW, or Social Worker:**
- **NCM/CHW/SW Contact Information:**

DEMOGRAPHICS:

- **Client Name:** **DOB:**
    - **Client Phone/Contact Info:**
- **Next of Kin/Emergency Contact(s):**
    - **Phone Number:** **Relationship:**
- **Preferred Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them ☐Other ☐ Chose not to disclose
- **Gender:** ☐ Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other ☐Unknown ☐Chose not to disclose
- **Sexual Orientation:** ☐Lesbian or Gay ☐Heterosexual ☐ Bisexual ☐ Other ☐Don't Know ☐Chose not to disclose
- **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
- **Patient's current shelter type:** ☐Shelter ☐Outside ☐Hospital ☐Vehicle ☐Other
- **County where client is currently residing:** ☐Kent ☐Newport ☐Washington ☐Providence ☐Bristol ☐Other:
- **Primary Language Spoken:**

PROVIDER INFORMATION:

- **Does the client have an established Primary Care Provider (PCP)?** ☐Yes ☐No
- **PCP Name:**
- **Practice Name:**
- **Health Insurance:**
- **Medicaid ID:**
- **Primary Medical Diagnosis/Reason for Respite Care:**

☐ IV Antibiotics	☐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): Click or tap here to enter text.

- **Medications (Please attach an up-to-date med list and indicate how client will receive refills if needed):**
  - ☐Med List is attached
- **Acute Need/s:**.
- **Anticipated Patient Needs:** ☐VNA ☐Medication Education ☐Wound Care ☐Physical Therapy ☐ Occ/ Speech Therapy ☐ Behavioral health care ☐ Oxygen in use
- **Appointments (Please include information on upcoming appointments within the next week):**

☐ Appointment List Attached

Physician Name:	Physician Name:
Date/Time:	Date/Time:
Address:	Address:
Reason:	Reason:
☐Transport scheduled	☐Transport scheduled
☐Transport needed	☐Transport needed

- **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

- **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

OTHER INFORMATION:

Please check all that apply: **Checking any of the following will not make a client ineligible for the program.**

☐Client is a smoker Check:

☐ Daily ☐ Social

☐Smoking cessation offered and accepted by client

☐Smoking cessation offered and declined by client

☐Client does not require IV therapy or oxygen therapy

☐Client does not have active TB or C-Diff

☐Client is actively using substances

☐Harm reduction enrollment/Harm reduction supplies needed:

☐Client 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:

☐Client is not in active detox

☐Client has a legal form of picture identification (license, state ID, passport, etc.)

- **Are you assisting the 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:
- **Does client have a service animal or emotional support animal[1]?** ☐Yes ☐No
    - If yes, please attach documentation/proof of current rabies vaccine and ensure appropriate supplies are provided.
- **COVID-19 Vaccinated:** ☐Yes ☐No

  ☐Pfizer ☐Moderna ☐J&J ☐ Primary Series ☐ Booster
- **COVID-19 Symptoms:** 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 is needed for other infectious disease, please specify:**

      ☐Client is symptomatic
        - Date of Symptom Onset:
        - Symptoms:

      ☐Client is asymptomatic
- **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?**

[1] If the client has an emotional support animal, they will need to provide a written doctor's note citing the necessity for this animal to remain with the client along with up-to-date vet documentation.