MEDICAL RESPITE STANDARDS: AN OVERVIEW

Henry C. Fader, Esq.
Alice Moughamian, RN,CNS
SPEAKER: HENRY C. FADER

• Corporate and health care attorney in the Philadelphia office, Pepper Hamilton LLP

• Practice includes counseling health care providers of all types and sizes – physicians, hospitals, integrated delivery systems, academic medical centers and medical schools, service providers and long-term care providers

• Focuses on organizational structuring and advises clients on tax-exempt financing, the formation and governance of nonprofit organizations, corporate governance and regulatory issues, as well as reimbursement, antitrust, antifraud and contractual matters.

• Recently, gained national expertise relating to legal issues involving homeless healthcare and medical respite care. Serves on Medical Respite Task Force to develop national standards for medical respite care.

215.981.4640 faderh@pepperlaw.com
SPEAKER: ALICE MOUGHAMIAN, RN, CNS

• Nurse Manager, San Francisco Medical Respite and Sobering Center – oversees daily clinical operations, compliance, regulation of Respite program; monitors and evaluates program outcomes/QA activities
• Current Chair, RCPN Steering Committee
• Serves on Medical Respite Standards Development Task Force
• Prior to Respite, worked inpatient medicine/palliative care and then worked as a medication adherence RN in the SFDPH Direct Access to Housing supportive housing sites in San Francisco
TODAY’S SESSION

• Overview of Need for Medical Respite
• Background of Medical Respite Standards
• Process of the Task Force
• Review of Specific Standards
• Public Feedback on Standards
HOMELESSNESS AND HEALTH CARE

- The majority of homeless people do not have health insurance or the ability to pay for medical treatment.
- They are routinely exposed to the elements, disease, violence, malnutrition, stress, drugs and alcohol.
- They are 3 to 6 times more likely to develop serious illnesses than people with adequate shelter.
- Their illnesses frequently co-occur with physical, psychiatric and social problems, as well as substance abuse.
- Many turn to emergency rooms for care—this is both costly and inadequate treatment for ongoing medical conditions.

Source: National Health Care for the Homeless Council
Recovery from illness is difficult for the homeless due to:
- Lack of rest
- Lack of food
- Lack of refrigeration for medications
- Exposure to the elements
- Unsanitary conditions
- Exposure to addictive substances, stress and disease

As a result, many end up back in the emergency room and/or readmitted to the hospital for the same conditions over and over again.
ALTERNATIVE TO PATIENT DUMPING

• Short term residential care that provides access to medical care and other supportive services in a safe environment
• Reduces public costs associated with frequent hospitalizations
• May be government funded or a collaboration among community organizations and health care entities
MEDICAL RESPITE CARE SUCCESS

• Medical respite programs have been shown to reduce future hospital readmissions by half

• Many medical respite care programs are hospital partnerships and, in exchange, the medical respite programs receive access to:
  → Medications, supplies and equipment
  → Labs/radiology services
  → Patient information
  → Ongoing physician or specialty care
  → Reimbursement or financial support
WHY THE NEED FOR STANDARDS?

• Unlike hospitals or FQHCs, Medical Respite does not have mandated services
• Each Medical Respite care organization is unique
• Each Medical Respite has a completely different legal structure
• Each Medical Respite has completely different funding sources
• There are currently no uniform standards for startups or existing Medical Respite Centers
WHY THE NEED FOR STANDARDS (CONT.)

- More emphasis on quality services
- More demand for Medical Respite services
- Expanded need for reliable and sustainable funding
- Need for additional research
- Allow opportunity for accreditation
In order to advance high quality care and improved health outcomes across a range of programs, the Respite Care Providers’ Network is developing universal standards for medical respite programs. A system of standards will accommodate programs with varying degrees of resources and services while providing tangible criteria that can be used to measure program growth. The RCPN believes that a universally adopted set of standards will not only improve quality and health outcomes, but will improve research and opportunities for more stable funding.
PROCESS TO DATE

• Under Leadership of Medical Respite Providers Network
• Medical Respite Standards Development Task Force
  → Representatives of Nursing, Social Work, Medical, Policy, Legal and Consumer Viewpoints
• Conducted monthly meetings
• Focus on the minimum standards
• Alignment with other standards
• Goal to accommodate a diverse range of providers
STANDARDS AS OF NOW/PRESENT STATE OF STANDARDS

- draft, this audience is the first to see them and provide public comment,
- plan to provide more opportunities for public comment,
- looking at opportunities for accreditation
STANDARD 1: HOSPITALITY/ACCOMMODATIONS
MEDICAL RESPITE PROGRAM PROVIDES SAFE AND QUALITY ACCOMMODATIONS

- Ensures safe, livable accommodations inside the facility that promotes functioning, hygiene and safety.
- 24 hour facility
- Onsite shower, laundering facilities
- ADA accessible
- Storage for personal belongings
- Three meals a day
- Emergency procedures
- Code of conduct
STANDARD 2: FACILITIES
MEDICAL RESPITE PROGRAM PROVIDES QUALITY ENVIRONMENTAL SERVICES

- Ensures a safe, clean facility
- Janitorial services
- Medication storage
- Communicable disease management
- Safe handling of biomedical and pharmaceutical waste
STANDARD 3: TRANSITION FROM HOSPITAL TO RESPITE
MEDICAL RESPITE PROGRAM MANAGES TIMELY AND SAFE CARE TRANSITIONS
TO MEDICAL RESPITE FROM ACUTE CARE, SPECIALTY CARE, AND/OR
COMMUNITY SETTINGS

- Ensures a safe and appropriate transition from the referral source to the Respite program
- Referral and admission process
- Ensures only appropriate referrals are accepted
- Transportation provided to Respite facility
- Hospital provides discharge summary, reconciled med list, discharge instructions/follow up appointments
STANDARD 4: CLINICAL CARE
MEDICAL RESPITE PROGRAM ADMINISTERS HIGH QUALITY POST-ACUTE CLINICAL CARE

- Clinical care provided at the Respite program
- Individualized Respite care plan
- Patient care is delivered in an interdisciplinary and patient centered manner.
  → Care plans are assessed, reassessed and altered accordingly
- Patients have encounters with clinical staff based on medical need
- Implements clinical practice guidelines
STANDARD 5: CARE COORDINATION
MEDICAL RESPITE PROGRAM ASSISTS IN HEALTH AND
HEALTH CARE COORDINATION, AND PROVIDES WRAP AROUND
SUPPORT SERVICES.

- Care coordination within the Respite program and
during the Respite stay
- Medical care coordination
- Case Management/Social Service care coordination
- Coordinate or provide transportation to medical and
social service appointments
STANDARD 6: RESPITE DISCHARGE PLANNING
MEDICAL RESPITE PROGRAM FACILITATES APPROPRIATE CARE TRANSITIONS FROM MEDICAL RESPITE TO THE COMMUNITY

• Care coordination with patient and community providers for successful discharge
• Discharge planning
  → Each patient has a designated staff member or team for discharge planning
• Discharge summary given to patient
• A discharge summary is forwarded to all medical and social service providers who are assuming a patient’s care (HIPPA and privacy rights compliant).
STANDARD 7: STAFF COMPETENCY

- Core competencies for staff
  → Includes volunteers
- Job descriptions
- Medical director required
- Appropriate training
STANDARD 8: QUALITY ASSURANCE
MEDICAL RESPITE PROGRAM TRACKS PERFORMANCE DATA
FOR QUALITY IMPROVEMENT, PROGRAM EVALUATION AND
PROGRAM DEVELOPMENT.

• Ability to collect data for quality improvement purposes.
• Program is able to respond to trends in outcomes, patient experience, and performance measures
• Program specific performance priorities for data collected and frequency
• Incident reporting
• Annual self audit
OPPORTUNITY FOR PUBLIC FEEDBACK

• Feedback in paper today
• Feedback emailed to Sabrina Edgington → sedgington@nhchc.org by Thursday June 12, 2014
• Feedback will create a second draft.
• Second draft will be made available for public comment.
• Final version to HRSA.
CONTACT

Henry Fader, Esq.
215.981.4640
faderh@pepperlaw.com

Alice Moughamian, RN, CNS
415-734-4202
Alice.Moughamian@sfdph.org