CLINICAL PEARLS FOR SUCCESS IN MEDICAL RESPITE

2018 MEDICAL RESPITE TRAINING SYMPOSIUM
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PRESENTERS:
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LEARNING OBJECTIVES

• Understand the variety of staffing models used in medical respite
• Review admission criteria for medical respite programs
• Discuss specific clinical scenarios and review best practices for successful and safe care
TYPES OF MEDICAL RESPITE

- Apartment/Motel rooms
- Homeless Shelter
- Transitional Housing
- Assisted Living/Nursing Home
- Substance Abuse treatment
- Stand-alone facility
STAFFING MODEL EXAMPLES

• Substance abuse clinic
  → On site clinic
• Nursing home/assisted living
  → Contracted services
  → Potential to utilize existing staff
• Shelter based and transitional housing
  → Contracted services
  • Home care
  • Providers
STAND-ALONE RESPITE STAFFING MODEL

• Providers 7 days a week
  → Two providers per day for 50 patients
  → MD on call nights and weekends

• Nurses 24/7
  → Three nurses (2 LPN’s and 1 RN) daily
  → One LPN at night

• Behavioral Health
  → Psychiatry: both contracted and employed
  → Substance abuse mental health counseling
STAND-ALONE RESPITE STAFFING MODEL

- Security
- Health unit coordinators
- Case management → Two for 50 patients
- Physical therapy
- Driver
- Respite assistants → Two on day and one on nights
STAND-ALONE RESPITE STAFFING MODEL

• Volunteers, Volunteers, Volunteers!!
In memory.....Barney
MEDICAL RESPITE: ADMISSION CRITERIA

I KNOW IT WHEN I SEE IT
MEDICAL RESPITE: ADMISSION CRITERIA

- Clinical Considerations
- Behavioral Considerations
- Staffing/facility considerations
- Partnership considerations
ADMISSION CRITERIA: CLINICAL CONSIDERATIONS

• Case: 55F with T2DM, CKD, opioid use disorder (OUD) referred to medical respite from hospital after right below knee amputation. Relevant issues in referral:
  → Newly on insulin and prescribed QID finger sticks/injections
  → On short acting pain medication but would like to start treatment for her opioid use disorder
  → Daily wound care dressings at surgical site
  → Discharge summary requests weekly labs
  → Worked with physical therapy in hospital and struggled with transfers. Skilled rehab was recommended but the patient could not be placed.
ADMISSION CRITERIA: CLINICAL CONSIDERATIONS

• Independence with ADLs

• Substance Use Disorders
  → Ability to do detoxification
  → Ability to initiate buprenorphine (x-waiver required)

• Medication independence/safety
ADMISSION CRITERIA: CLINICAL CONSIDERATIONS

• Laboratory monitoring

• Primary psychiatric patients

• Medication independence/safety
Case: 34M with TBI, alcohol use disorder (AUD) and recurrent cellulitis of his toe referred to medical respite by street medicine team:

→ Refuses to go to ER/hospital but seems appropriate medically for respite and he wants to come in
→ There is a potential housing opportunity for him
→ He is prone to outbursts and during his last time in respite (18 months ago) he was verbally abusive to staff resulting in a bar
ADMISSION CRITERIA: BEHAVIORAL CONSIDERATIONS

• Issue #1: Safety
  → How to ensure that staff feel safe.
  → How to ensure that other patients feel safe

• Issue #2: Bars/Readmission Criteria
  → How long of a bar is long enough
  → What is the process for mitigation

• Issue #3: Support
  → Develop behavioral support plans
ADMISSION CRITERIA: FACILITY CONSIDERATIONS

• Quick Case 1: 56M with COPD on 2L O2 is referred from hospital after a COPD exacerbation
  → How will you ensure he has enough oxygen?

• Quick Case 2: 64F with morbid obesity is referred for management of RLE cellulitis
  → Do you have adequate facilities (bed, toilet) to support the patient?

• Quick Case 3: 34M with TBI, PTSD admitted for diabetes management. He has an emotional support dog.
  → Can you accommodate the patient and his animal
ADMISSION CRITERIA: PARTNERSHIPS

• Tailor your services to the needs of your partners
ADMISSION CRITERIA: IMPLEMENTATION

• Standardized referral process

• Dedicated staff

• Eyes on the ground
ADMISSION CRITERIA: EYES ON THE GROUND

• Dedicated Nurse - Liaison
  → Two days a week at major referring hospital
  → Rounds on homeless inpatients
  → Coordinates with inpatient teams, ER
  → Close contact with our admissions office
3 CASES TO DISCUSS AND DEVELOP

• Break into 3 groups

• For your assigned case
  1) Discuss any barriers
  2) Explain any policies or procedures that would need to be developed
  3) Discuss any trainings that staff would need
CLINICAL SCENARIOS AND BEST PRACTICES

- Opioid use disorder
- 52M with AIDS and OUD is referred from hospital for wound care related to an abscess. He has pain related to his dressing change and remains on oxycodone 10mg BID but wants to start MAT during his respite stay.
  → What processes do you need to be able to accept this patient
  → What staff trainings and skills are required
  → Develop a protocol that would allow your program to care for this patient
CLINICAL SCENARIOS AND BEST PRACTICES

• Bed bug infestation
  → Cleaning staff or nursing assistants started the weekly cleaning of the female dorm
  → While changing the sheets, they noticed black dots on the box spring cover.
  → They weren’t quite sure what to do
What does your staff do at this point? Who do they report this to?
What are next steps?
What is your policy and procedure for detecting and preventing bed bugs?
Were all steps followed?
Lessons learned?
• IV antibiotics
• 28F with OUD is referred from hospital to complete a 6 week course of IV vancomycin for septic arthritis.
→ What processes do you need to be able to accept this patient
→ What staff trainings and skills are required to care for her safely
→ How would you manage her OUD?
→ Develop a protocol that would allow your program to care for this patient
BEST PRACTICES – OPIOID USE DISORDER

• Recognize and treat withdrawal
  → COWS assessment built into EMR
  → Detox/induction protocol with buprenorphine

• Increase behavioral health support
  → Daily SUD group, individual counseling as needed

• Support staff!!
  → Trauma informed care trainings
  → Small group sessions to address behaviors/burn-out
BEST PRACTICES - INFESTATION
BEST PRACTICES: IV ANTIBIOTICS

• Admission criteria
  → Require central access (PICC vs midline) before admission
  → Require confirmation
  → Pharmacy

• Clinical guidelines
  → Frequency of dosing
  → Administration of medication

• Teaching and training
INFORMATION NEEDED ON ALL ADMISSIONS on IV ABX

All IV antibiotics must be infused through a PICC line/midline

Patient Name: ___________________ DOB: __/__/______

Height: _______ Weight: _______ Allergies: ________________________________

DIAGNOSIS FOR ANTIBIOTICS: ________________________________________

ANY CONDITIONS?: CHF ☐ DIABETES ☐ KIDNEY DISEASE ☐ HTN ☐

1. TYPE OF CENTRAL LINE: ____________________________________________

2. LENGTH OF LINE (in cms): ___________ SIZE OF LINE: (ie: 4 French) ________

3. WHEN WAS THE LINE PLACED: ____________________________

4. PLACEMENT CONFIRMED BY: ☐ CXR ☐ ULTRASOUND

SEND PICC line placement confirmation: ☐ Completed

5. HOW MANY LUMENS: ____________________________

6. LUMENS PATENT: ☐ YES ☐ NO

8. LUMENS LABELLED: ☐ YES ☐ NO

9. NAME OF ANTIBIOTICS: ____________________________________________

Dose: __________ Frequency and Time: _______ STOP DATE: ___/___/___

10. IV DRESSING LAST CHANGED: DATE: ___/___/___

11. TROUGHS # __________ DATE: ___/___/___ NEXT TROUGHS DUE: ___/___/___

12. BUN: ___________ CREAT: ___________

13. ON DAY OF DISCHARGE: Timing of last dose: _____________________________
Questions/ Discussion