

Albuquerque Health Care for the Homeless, Inc.

# Request for Proposals

January 15, 2024

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Albuquerque Health Care for the Homeless, Inc. (AHCH) is the only integrated primary care, behavioral health and social services organization serving exclusively the homeless population of Central New Mexico.

AHCH is a Federally Qualified Health Center and Health Care for the Homeless 330(h) special population grantee of the US Department of Health & Human Services/Health Resources & Services Administration/Bureau of Primary Health Care Health Centers program. In addition, AHCH manages 40-50 total funding streams in any given year, from additional federal, to state, city, county grants and contracts, philanthropic contributions and Medicaid billing.

As AHCH marks nearly 40 years in operation, it has embarked on several ambitious strategic initiatives and partnerships. Among those are development and implementation of a Medical Respite Program. Descriptions of the National Institute for Medical Respite Care (NIMRC) standards, and of the local impetus and model developed since 2017 are included in Attachments A & B respectively.

A medical respite facility is estimated to be operational in the second half of CY24. Among the systems innovations and resources leveraged to the project to-date are: named inclusion of AHCH as pilot project lead in the state's 1115 waiver currently being negotiated with the Centers for Medicare & Medicaid Services; a contract with the City of Albuquerque for general fund housing vouchers dedicated to exit directly from the Medical Respite Program; and a state legislative appropriation in FY24 for an evaluation design, partner agreement development and training, and preparation to assess program and partnership effectiveness, as well as return on investment. This scope comprises the first of two anticipated phases for the project. The second phase will be evaluation project implementation.

The contract for Phase I of the independent evaluation will be 100% funded through the New Mexico Department of Health, Office of Primary Care and Rural Health, Population and Community Health Bureau, Public Health Division.

## Statement of Work

AHCH seeks an independent evaluator to lead Phase I.

### Timeline:

- Procurement January 2024 - February 16, 2024
- Award selection announced February 26, 2024
- Engagement: March 2024
- Active Project Implementation: March 2024 – June 2024

### Basic Scope

Work with AHCH leadership to:

- Design a rigorous and comprehensive evaluation.

- Conduct primary research with industry informants from the NMIRC and other like communities of practice about essential elements and methods for evaluating medical respite.
- Formulate agreements for participation and data collection/sharing for evaluation across partnership.
- Identify measures and key data for analysis as defined by the evaluation design.
- Formulate and train a partnership working group for evaluation implementation readiness; including any pre-testing feasible per changes to the medical respite operational timeline.
- Use design process as a vehicle for organizational development to build evaluation capacity for participant organizations.
- Prepare AHCH to move to Phase II of medical respite evaluation (i.e., implementation).

AHCH understands that this process will require on-site work with consultants in addition to any portions of the project that can be completed remotely through technology. Travel will be reimbursed with prior approval and in adherence to AHCH's policy and procedures.

## Request for Information/Proposals

Albuquerque Health Care for the Homeless, Inc. seeks brief proposals from consultants/firms nationwide.

Concise 3-5 page proposals should include:

1. **Contact information**
2. **Short explanation of interest in this project**
3. **Description of consultant experience and capacity**, including but not limited to experience working with medical respite programs and partnerships, nonprofit organizations, Health Care for the Homeless federal grantees, other homeless service providers, Federally Qualified Health Centers generally, or other relevant organizations working with vulnerable populations.
4. **Additional information about area(s) of expertise**
5. **Approach to strategic planning/thinking/positioning**
6. **Important principles of your approach**, including but not limited to introduction to AHCH and entry into this type of project, communication and process when/if conflict arises, using process as a vehicle for leadership development or other capacity development.
7. **Budget proposal and/or fee structure**

***Please submit proposals by February 12, 2024 via hard copy or electronically to:***

Miranda Sedillo  
Chief Operations Officer  
**SUBJECT: RFP Submission – Medical Respite Evaluation**  
Albuquerque Health Care for the Homeless, Inc.  
PO Box 25445, Albuquerque, NM 87125-0445  
[mirandasedillo@abqhch.org](mailto:mirandasedillo@abqhch.org)  
(505) 767-1169

AHCH plans to conduct phone interviews based on written proposals and make a selection by February 26, 2024.



## Albuquerque Medical Respite Model

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### 1. Need

People who experience homelessness are likely to be sicker and have a more difficult time recovering from injury or illness. Access to resources and support to follow a treatment plan, or to have a place to rest and eat regular, healthy meals is out of reach without intervention by medical and social services institutions.

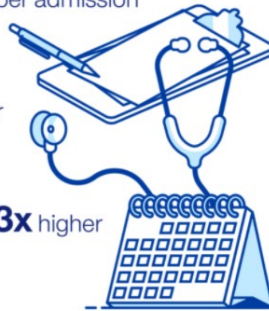
Those experiencing homelessness are more likely to have worse medical care outcomes, including:

Length of hospital stay is **4.1** days longer



Cost of care is about **\$4,000** more per admission

Inpatient readmission rate is **2x** higher



Number of emergency room visits are **3x** higher

30-day emergency room readmission rate is **6x** higher

SOURCE: NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

Recent peer-reviewed research showed evidence indicates “**medical respite programs reduced future hospital admissions and hospital days, reduced 90-day hospital readmissions, and reduced hospital length of stay among homeless patients.**”<sup>i</sup>

**Patients experiencing homelessness stay in the hospital 4.1 days longer per admission than other low-income patients.**<sup>ii</sup>

**+ 4.1 Days**

Currently, the Barrett Foundation and Heading Home’s Albuquerque Opportunity Center provide 37 beds in their shelters for recuperative care in a social respite model. The beds are contracted through hospitals and MCOs. **The social model of recuperative care provides a safe place to recover from injury or illness but does not meet the needs of people that require a higher level of medical care.**

A 2017 Albuquerque Medical Respite Community Needs Assessment concluded that there remains an unmet need in our community for medical respite services. The last point in time count reported a



minimum of 1,524 people experiencing homelessness on January 28, 2019. AHCH and community partners estimate at least 16,000 persons – approximately 2.3% of Bernalillo County residents – will experience homelessness during the year. In Albuquerque, homelessness has been increasing at an average annual rate of 7.7% since 2013<sup>iii</sup>. A Columbia University report projects an increase in homelessness by 40-45% this year over January 2019 due to the COVID-19 pandemic.<sup>iv</sup>

## 2. Objective

To provide patient-centered medical care for people experiencing homelessness to improve clients' health, thereby reducing avoidable emergency department usage, potential hospital readmissions, improving transitions of care from inpatient to outpatient sites, and decreasing lengths of inpatient hospital stays. Medical respite will provide necessary social services and an immediate connection to permanent supportive housing.

This project will be a collaborative effort between hospitals, homeless shelters, Albuquerque Health Care for the Homeless, partner Federally Qualified Health Centers (FQHCs), and the City of Albuquerque.

**What it is:** Acute and post-acute medical care for people who are homeless who are too ill to recover from sickness or injury on the street, but not sick enough to warrant hospital level care. Short-term residential care that allows people who are homeless to rest in a safe environment while accessing medical care and support services.

**What it is not:** skilled nursing facility, nursing home, assisted living, or supportive housing. These are higher levels of care than medical respite. Medical respite can complement these programs.

## 3. Goals

1. To exit medical respite clients directly into permanent housing.
2. To improve the transition of care from inpatient to ambulatory sites for people without homes.
3. To reduce the hospital readmission rate and length of stay for people without homes.
4. To provide medical care to patients residing at medical respite program.
5. To increase enrollments for Medicaid and access to resources for patients with case management to secure housing, primary care, mental health care, and benefit enrollment.

## 4. Medical Respite Model

### FQHC Services:

1. Onsite case management/care coordination
  - Coordination and transportation to offsite medical appointments
  - Referral or connection to community case management services
  - Completion of case management and supportive services onsite as applicable
2. Connection and transition to primary care provider/health home before discharge
3. Onsite clinical services include:
  - Daily evaluation (or as indicated by plan) by clinical provider
  - Provision of medical clinical services within scope of license and as indicated by discharge instructions and clinical care plan



- Medication management which may include:
  - Medication reconciliation
  - Medication monitoring
  - Education and skill development to self-manage and administer medications
  - Identification and implementation of strategies to support independence in medication management
- Chronic condition management
- Medical management and treatment
- Behavioral health
  - Screening & assessment
  - Ongoing behavioral health care and therapy
  - Connection and transition to long-term community behavioral health
  - Group therapy
- Substance use treatment
  - Recovery-focused individual therapy
  - Recovery-focused group education
  - Referral and transition to community-based recovery programs
  - Group education
- Care coordination with home health and home-based clinical care services
  - Client has space to engage with home-based clinical services not offered onsite (e.g. home health, home nursing care, physical therapy, speech, occupational therapy)

#### **Hospital Support:**

1. Data sharing agreement for monitoring and evaluation to measure impact
2. Coordination of specialty services
3. Agreement on admission and exclusion criteria and readmission and coordination/support in negotiating contracts for placements at skilled nursing facilities
4. 24/7 nurse advice line
5. One dedicated medical respite staff in hospital for care coordination and referrals
6. Agreements on what hospital sends with patient (DME, medications) and planned coordination with specialty care

#### **General Medical Respite Facility Operations:**

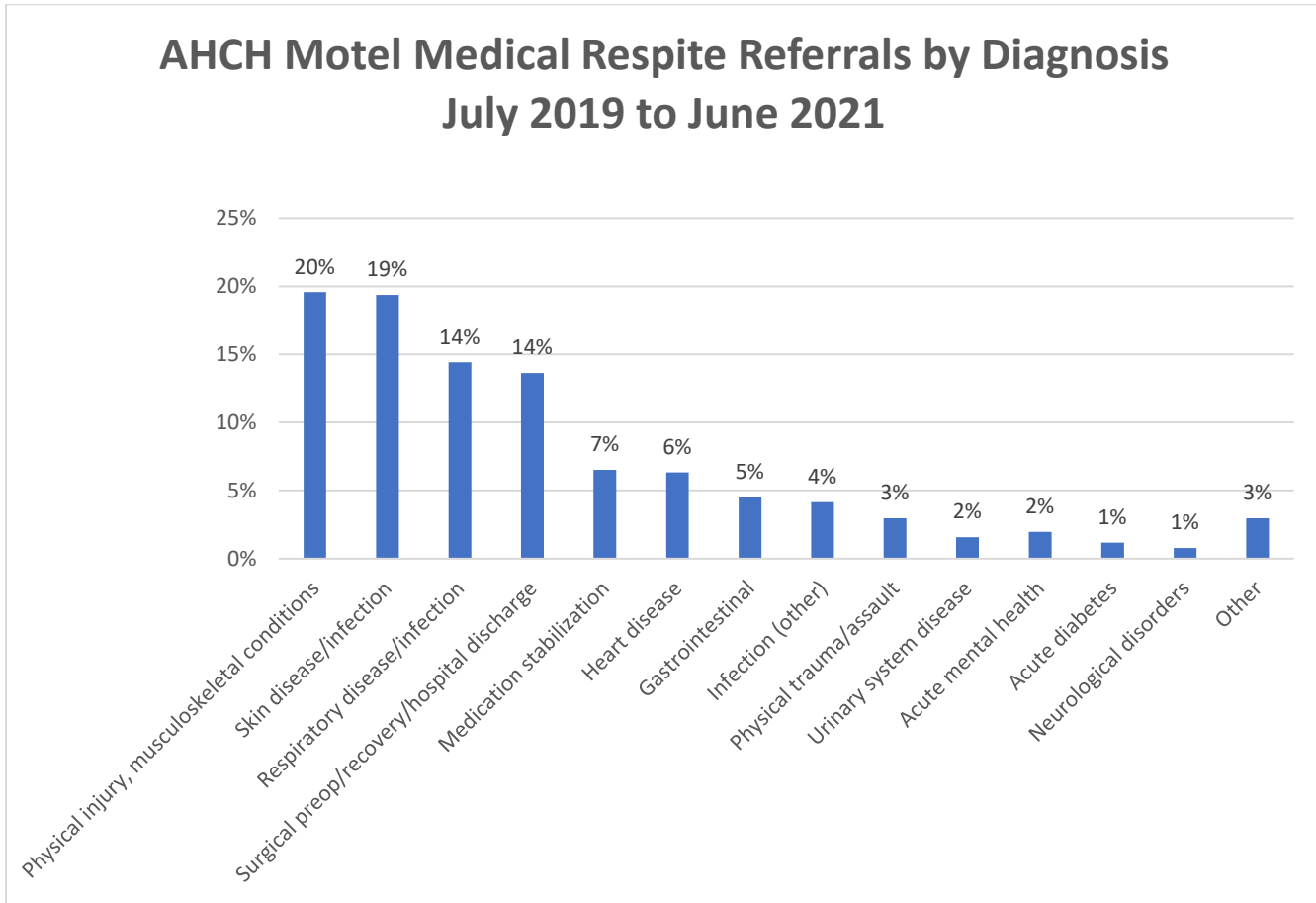
1. 24-hour access to a bed
2. 3 meals/day
3. Transportation to any/all medical appointments
4. Access to a phone for telehealth and/or communications related to medical needs
5. Safe space to store personal items
6. Wellness check at least 1x every 24 hours by medical respite program staff (clinical or non-clinical)
7. OT/PT and medical consultation room space
8. BH Group room space
9. Private, single person bathrooms



## 5. Level of Care

### 5.1 Medical Need and Acuity

The Albuquerque Medical Respite Work Group used proxy data to determine level of medical need in medical respite from Albuquerque Health Care for the Homeless motel respite data.



Of 531 motel medical respite stays:

- median age - 47 years old
- 56% male
- 44% female

Physical injury or trauma such as lacerations, wounds, sprains, contusions, fractures, and burns are leading causes of hospitalization and mortality among people who are experiencing homelessness.<sup>v vi</sup> Most medical respite programs nationally treat injuries and trauma with patient care and comfort measures (e.g. wound care and infection control and non-pharmacological pain management).<sup>vii</sup>

National research indicates that in addition to physical injury or trauma, the following conditions are most commonly seen in the medical respite setting:



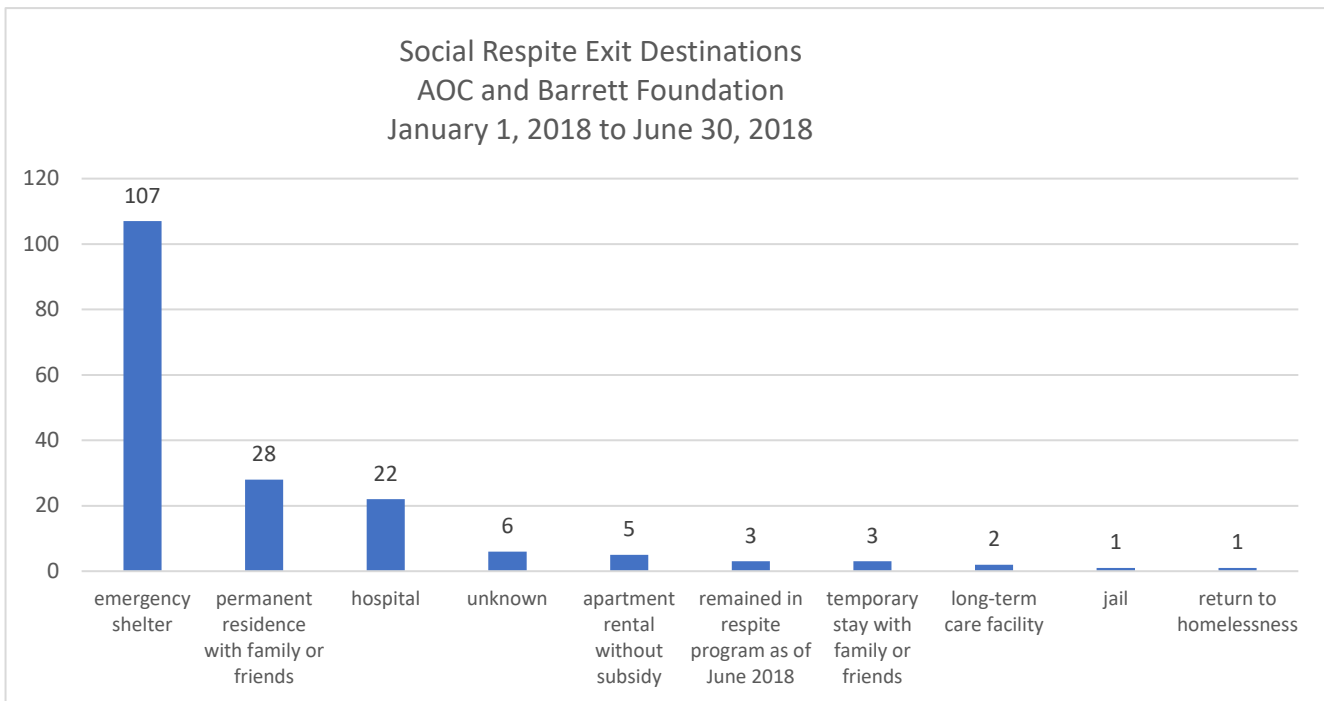


- skin diseases including cellulitis, abscess, immersion foot, and skin ulcer including diabetic ulcer;
- respiratory disease including asthma, influenza, pneumonia, upper respiratory infections, tuberculosis, and chronic obstructive pulmonary disease such as bronchitis and emphysema;
- heart disease;
- gastro-intestinal related conditions including hepatocellular carcinoma, cirrhosis, hepatic encephalopathy, colorectal cancer, and hernia of the ventral, inguinal, and abdominal areas, and Hepatitis;
- neurological disorders including epilepsy, peripheral neuropathy, and cerebrovascular accident (CVA); and
- conditions of the Genitourinary System including urinary tract infection and prostatic hypertrophy.<sup>viii</sup>

**Nationally, the average length of stay is 42 days and the median length of stay is 30 days.<sup>ix</sup>**

**Level of Care Gaps Addressed:**

- Ability to accommodate infectious diseases (if private rooms are included in design)
- Multi-directional referrals into medical respite beds (homeless shelters, FQHCs, etc.) to decrease ED visits
- Daily onsite medical care to decrease 30-day hospital readmissions
- Focus on exit to housing to improve patient health, decrease ED visits, shorten inpatient hospital stays, and decrease 30-day readmissions (address current exits to shelter)





## 5.2 Behavioral Health Care

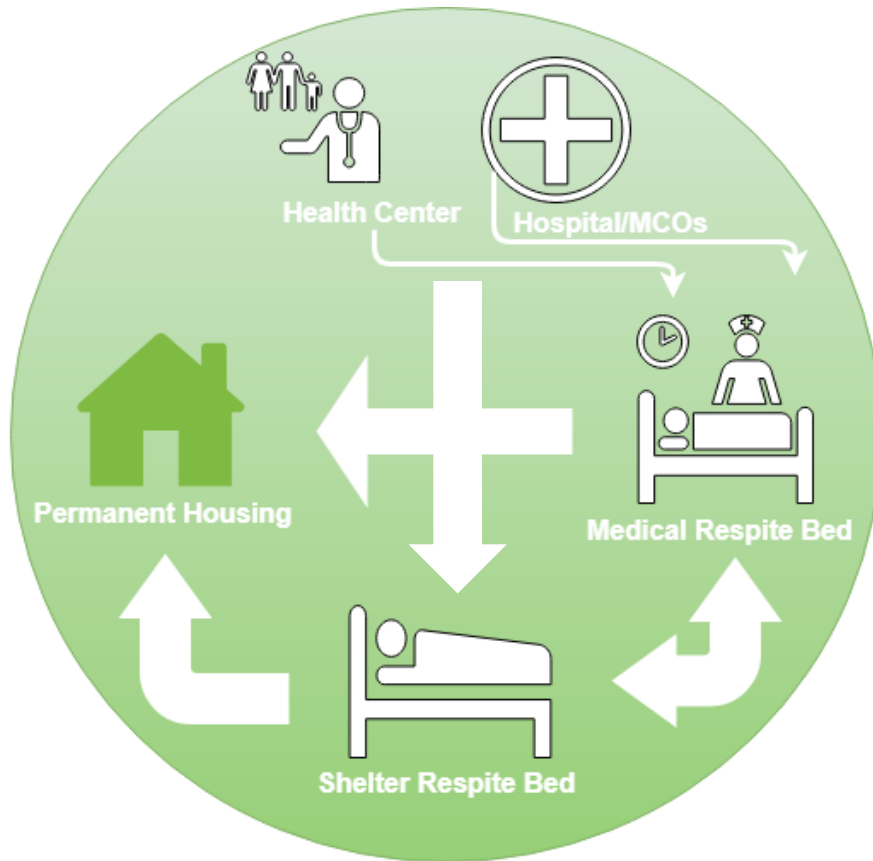
The primary reason for a referral to medical respite will be a medical diagnosis. However, it is not uncommon for medical respite providers to recognize or diagnose behavioral health problems that were missed at the referring hospital or clinic. Co-occurring behavioral health or substance use disorders will complicate medical care and must be treated concurrently to maximize health stability. Medical respite providers are trained to take measures to address behavioral health issues and can detect symptoms of mental illness and substance use disorders and link patients to integrated behavioral health care in their programs. These integrated care models can include providing support groups, interdisciplinary team meetings with patients, onsite care delivered by licensed clinical social workers, psychologists, psychiatric nurse practitioners, etc., and/or connecting patients to outside behavioral health and substance use disorder treatment agencies.

## 6. Housing

Medical respite is a high-impact and powerful solution to ending homelessness because, and only as, an exit to housing. Housing and medical respite must be addressed together to achieve the intended impact of medical respite care. Exit to housing is an essential outcome measure for Medical Respite and success will only be achieved if new housing vouchers are available to the Medical Respite program. Based on 25 beds and a median length of stay of 30 days, 300 individuals can be expected to be served in a year. While not all individuals will best be served by a permanent supportive housing voucher, we can estimate that approximately 80% will be, with a need for 240 additional permanent supportive housing vouchers per year. Rapid rehousing, public housing, and 30% housing subsidies and resources will also be utilized.



## 7. Albuquerque Medical Respite System



Post Hospital	Pre-Admission	Perioperative	Hospice
<ul style="list-style-type: none"> <li>- Acute medical needs</li> <li>- At risk for clinical deterioration</li> <li>- Possible wound care needs</li> <li>- Possible medication management</li> <li>- Possible medication reconciliation</li> <li>- 30-45 day average length of stay</li> </ul>	<ul style="list-style-type: none"> <li>- Prevent admission to hospital</li> <li>- At risk for clinical deterioration</li> <li>- Possible wound care needs</li> <li>- Possible medication management</li> <li>- Possible medication reconciliation</li> <li>- 30-45 day average length of stay</li> </ul>	<ul style="list-style-type: none"> <li>- Provide better conditions for patients before operation</li> <li>- Preparation for elected procedures such as colonoscopy</li> <li>- Preparation for invasive procedures like heart surgery</li> </ul>	<ul style="list-style-type: none"> <li>- Quality, compassionate care for people facing a life-limiting illness or injury</li> </ul> <p><b>Phase II</b></p>

**Direct Link to Housing through Housing First and Intensive Case Management**



### **Based on Community Needs**

Medical Respite services will be developed based on established needs of the community and on data from AHCH Community Needs Assessment, Albuquerque Medical Respite Community Needs Assessment, and hospital utilization data.

### **Person-Centered and Trauma-Informed**

Development of Medical Respite programming, facilitates, and services rooted in evidence-based best practices and built upon person-centered and trauma-informed approaches to health care. The scattered site model may best support these values with more specialized attention, smaller numbers, and a more therapeutic setting. Medical respite program will comply with national *Standards for Medical Respite Programs* from the National Health Care for the Homeless Council.<sup>x</sup>

### **Housing Pipeline**

Medical Respite will be centered around Housing First approaches with immediate connection to permanent housing. Medical respite offers a viable and high impact solution for ending homelessness, with sustainable exits to housing.

## **8. Policy Opportunities**

1. Pursue Statewide Medicaid benefit through 1115 Waiver for medical respite care
2. Examples of Promising Medicaid policy change:
  - i. California: Preparing a very large change to their Medicaid plan, called [Cal-AIM](#). In it, they identify medical respite (they call it recuperative care) as an “in lieu of” service. Page 195. This example of a large state moving forward on financing medical respite through Medicaid.
  - ii. Washington: Legislative language in the 2021 session required the state to do a study. Budget language/page189: \$25,000 of the general fund—state appropriation for fiscal year 2022 and \$25,000 of the general fund—federal appropriation are provided solely for the authority to develop an implementation plan to incorporate medical and psychiatric respite care as statewide Medicaid benefits. The plan must include an analysis of the cost effectiveness of providing medical and psychiatric respite care benefits for Medicaid enrollees. In developing the plan, the authority shall consult with interested stakeholders, including Medicaid managed care organizations, community health centers, organizations providing respite care, and hospitals. Amounts provided in this subsection may be used for staff support and one-time contracting. No later than January 15, 2022, the authority shall report its findings to the relevant committees of the legislature, the office of the governor, and the office of financial management.
  - iii. Minnesota: Pursuing 1115 Waiver to include medical respite in Medicaid Plan.
  - iv. New York: Moving forward with plans to include medical respite in Medicaid Plan.

## 9. Standards for Medical Respite Care

Medical Respite will follow the National Institute for Medical Respite Care Standards for Medical Respite Care Programs.<sup>xi</sup>

**Standard 1:** Medical respite program provides safe and quality accommodations.

**Standard 2:** Medical respite program provides quality environmental services.

**Standard 3:** Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings.

**Standard 4:** Medical respite program administers high quality post-acute clinical care.

**Standard 5:** Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services.

**Standard 6:** Medical respite program facilitates safe and appropriate care transitions out of medical respite care.

**Standard 7:** Medical respite care personnel are equipped to address the needs of people experiencing homelessness.

**Standard 8:** Medical respite care is driven by quality improvement.

## References

<sup>i</sup> Doran, Kelly M. & Ragins, Kyle T. & Gross, Cary P. & Zerger, Suzanne. "Medical Respite Programs for Homeless Patients: A Systematic Review." *Journal of Health Care for the Poor and Underserved*, vol. 24 no. 2, 2013, pp. 499-524. Project MUSE, [doi:10.1353/hpu.2013.0053](https://doi.org/10.1353/hpu.2013.0053).

<sup>ii</sup> Salit, SA, Kuhn EM, Hartz AJ, Vu JM, Moss AL. Hospitalization Costs Associated with Homelessness in New York City. *NEJM*;1998, 338(24):1732-40.

<sup>iii</sup> Assessing Shelter Capacity and Dynamics for Accommodating the Homeless Population in Albuquerque NM Report Prepared for the City of Albuquerque, Department of Family and Community Services, November 2019, <https://www.cabq.gov/family/documents/assessing-shelter-capacity-final-report.pdf>.

<sup>iv</sup> <https://community.solutions/analysis-on-unemployment-projects-40-45-increase-in-homelessness-this-year/>

<sup>v</sup> Kramer, C.B., Gibran, N.S., Heimbach, D.M., Rivara, F.P., & Klein, M.B. (2008). Assault and substance abuse characterize burn injuries in homeless patients. *Journal of Burn Care & Research*, 29(3), 461-7.



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<sup>vi</sup> Ferenchick, G.S. (1992). The medical problems of homeless clinic patients: a comparative study. *Journal of General Internal Medicine*, 7(3), 294-7.

<sup>vii</sup> National Health Care for the Homeless Council. (2011). *Clinical Recommendations for the Medical Respite Setting*. Nashville, TN: Edgington, S. (Ed.). Available from [www.nhchc.org](http://www.nhchc.org).

<sup>viii</sup> Ibid.

<sup>ix</sup> Ibid.

<sup>x</sup> Respite Care Providers' Network, National Health Care for the Homeless Council, *Standards for Medical Respite Programs*, <https://www.nhchc.org/standards-for-medical-respite-programs>, October 2016.

<sup>xi</sup> National Institute for Medical Respite Care, *Standards for Medical Respite Care Programs, 2021*, [https://nimrc.org/wp-content/uploads/2021/09/Standards-for-Medical-Respite-Programs\\_2021\\_final.pdf](https://nimrc.org/wp-content/uploads/2021/09/Standards-for-Medical-Respite-Programs_2021_final.pdf)

# Standards for Medical Respite Care Programs

2021

## Introduction

Medical respite care is acute and post-acute medical care for people experiencing homelessness who are not ill enough to remain in a hospital, but are too ill to recover on the streets or in regular shelter settings. It is short-term residential and person-centered care that allows people experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services.

Medical respite care is offered in a variety of settings including freestanding facilities, homeless shelters, motels, nursing homes, and transitional housing ([National Institute for Medical Respite Care, 2021](#)). While all of these programs provide a critical service, they vary significantly in their scope and intensity of care. The Standards for Medical Respite Care Programs (the Standards) create a foundation for program operations that can be applied to any model of medical respite care. Despite the variances in service delivery, the person remains the central focus of the care provided.

### Using the Terms Medical Respite Care and Recuperative Care

The terms “medical respite care” and “recuperative care” are used interchangeably to describe the same service. Programs may identify themselves as medical respite or recuperative care depending on their founding organization, location, and local governance. The [National Institute for Medical Respite Care \(NIMRC\)](#) represents all medical respite and recuperative care programs, and the Standards are equally applied to all program models.

## History of the Standards for Medical Respite Care Programs

The earliest medical respite care programs were established in the 1980’s. As the need for medical respite care for people experiencing homelessness has grown, communities have responded by developing their own unique programs using the resources available to them. At the times of this publication, there are over 120 medical respite care programs in the United States, located in 35 of the 50 states and in Washington D.C.

### Development of the Standards for Medical Respite Care

In 2011, the Steering Committee of the Respite Care Providers’ Network addressed the need to establish standards for medical respite care in order to improve quality and consistency across a range of programs and to improve opportunities for research and federal funding for medical respite care. A Task Force of medical respite care experts was charged with developing standards that (1) align with other health industry standards related to patient care, (2) reflect the needs of the patients being served in the medical

respite setting, (3) promote quality care and improved health, and (4) are achievable for a range of medical respite programs with varying degrees of resources.

The 2011 Task Force developed the medical respite standards to reflect and respond to the following circumstances:

- People experiencing homelessness suffer profound disparity in health and mortality compared to the general population.
- Hospital lengths of stay are generally decreasing across all medical conditions and acute and post-acute medical care is increasingly being delivered on an outpatient basis.
- People need a safe, stable, and supportive place to recover from illness and injury.
- Recovery is extremely difficult on the streets; shelters generally are not equipped to support people who are sick or injured.
- Homelessness itself causes and exacerbates existing medical conditions and makes adherence to treatment plans more difficult.
- Medical respite programs promote connections to primary and behavioral health care and decrease hospital utilization; thus, improving efficiency and reducing costs in health systems.
- Medical respite programs are critical to community efforts to end homelessness.

As a result of this task force, the 2016 Standards for Medical Respite Care Programs were published.

To remain responsive to changes in medical respite care, health care practices, and policy, the RCPN formed a workgroup in 2021 to review and revise the Standards. Regular and consistent review ensures the Standards reflect the growth, changes, and newly established evidence to guide best practices in medical respite care. Information and feedback of 30 programs across the United States were used to guide the revision process.



## Acknowledgements

The National Health Care for the Homeless Council (NHCHC) thanks the members of the 2021 Medical Respite Standards Development Workgroup for its work in developing these standards:

- Brandon Cook, HCH Program Director, New Horizon Family Health Services
- Leslie Enzian, MD, Harborview Medical Center
- Elizabeth Locatelli, LCSW, ACM, CCM, CCPT, Peninsula Health Care Connection New Directions Program
- Brooks Ann McKinney, MSW, Cone Health and Hospitals/Triad Health Network ACO
- Miriah Nunnaley, RN, Colorado Coalition for the Homeless
- Caitlin Synovec, OTD, OTR/L, National Institute for Medical Respite Care/National Health Care for the Homeless Council
- Ivy Tuason, PhD, RN, FNP-BC

The National HCH Council would also like to thank the previous task force members involved in developing the first editions of the Standards: Sabrina Edgington, MSSW; Leslie Enzian, MD; Henry Fader, JD; Jessie Gaeta, MD; Joanne Guarino, Consumer; Nancy Hanson, MSW; Tim Johnson, BA, BBA; Brooks Ann McKinney, MSW; Alice Moughamian, RN, CNS; and Dawn Petroskas, RN, PhD.

Additional gratitude is expressed to the following individuals and programs who provided review and feedback of the 2021 Standards for Medical Respite Care Programs:

- Respite Care Providers' Network Steering Committee
- Consumers and National Consumer Advisory Board members via focus group
- Individual medical respite program providers via survey
- Circle the City (Phoenix, AZ)
- Edward Thomas House (Seattle, WA)
- Hennepin County Health Care for the Homeless (Minneapolis, MN)
- LTHC Medical Respite (LaFayette, IN),
- PHMC Medical Respite at Serenity Court (Philadelphia, PA)
- The Poverello Center (Missoula, MT)

## Using the Standards for Medical Respite Care Programs to Guide Service Delivery

The following Standards serve as a framework to help medical respite care programs operate safely, effectively, and seamlessly with local health care systems, and to promote program development and growth. Each of the Standards includes descriptive criteria, which guides programs in determining whether or not they have met the Standard. These criteria are used to inform and support development of program policies, procedures, and practices. Although programs present with diversity in staffing, facility models, and partnerships, the Standards for Medical Respite Care Programs help to ensure that care delivered within each of these models is high-quality and person-centered.

### Applying the Standards with program partnerships and collaborations:

These Standards are written to accommodate program services delivered through formal partnerships or affiliations. Many medical respite programs constitute partnerships between two or more organizations that together provide the services referenced in this document. All of the Standards should be met, but the organization responsible for meeting the criteria is determined by the partnership. For example, a medical respite program may be jointly operated and administered by a housing provider and health center. In such cases, facility standards might be met by the housing provider while health care-related standards might be met by the partnering/affiliated health care entity.

Key considerations for applying the Standards for Medical Respite Care Programs:

- In the case of partnering organizations, there should be a clear delineation of which entity is responsible for certain aspects of care, and have established policies, procedures, and safety measures established accordingly.
- Partnering organizations should have written agreements clarifying each entity's roles and responsibilities for meeting certain standards and/or criteria.
- This document does not replace local, state, and federal regulations related to health and safety. Medical respite programs are expected to meet all applicable local, state, and federal regulations.

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## Standards for Medical Respite Care Programs

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Standard 1: Medical respite program provides safe and quality accommodations.

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Standard 2: Medical respite program provides quality environmental services.

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Standard 3: Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings.

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Standard 4: Medical respite program administers high quality post-acute clinical care.

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Standard 5: Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services.

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Standard 6: Medical respite program facilitates safe and appropriate care transitions out of medical respite care.

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Standard 7: Medical respite care personnel are equipped to address the needs of people experiencing homelessness.

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Standard 8: Medical respite care is driven by quality improvement.

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**Standard 1: Medical respite program provides safe and quality accommodations.**

Medical respite programs provide patients with space to heal rest and perform activities of daily living (ADLs) while receiving care to recover from acute illness and injuries. As such, the physical space of medical respite programs should be habitable and support physical functioning, hygiene, and personal safety.

**Criteria:**

1. A bed is available to each patient for 24 hours a day while admitted to the program.
2. Onsite showering and laundering facilities are available to patients to ensure access and ability to maintain hygiene.
3. Clean linens are provided upon admission.
4. The medical respite facility is accessible and usable to people who have disabilities, including but not limited to mobility impairments and other physical disabilities.
5. The medical respite facility provides access to secured storage for personal belongings and medications. When the program is not authorized to store/dispense medication by applicable governing bodies, the program will ensure other mechanisms for patients to securely store and access medications.
6. At least three meals per day are provided. Food services meet applicable public health department guidelines for food handling.
  - a. Non-congregate settings (including private and semi-private rooms in apartments or motels) may provide unprepared food if a fully equipped kitchen is available to the patient. If a kitchen is made available, it is safe and hygienic and includes proper refrigeration and disposal of trash.
  - b. Patients are provided education on dietary recommendations, based on diet available at medical respite and the diet available at the anticipated post-respite disposition.
  - c. Food services are culturally appropriate, as needed.
7. Medical respite programs located in standalone and/or congregate facilities maintain 24-hour access to staff. On-site staff (either clinical or non-clinical) is trained at minimum to provide first aid and basic life support services and communicate to outside emergency assistance.
8. Medical respite programs have 24-hour on-call medical support or a nurse call-line for non-emergency medical and behavioral health inquiries when clinical staff is not on site.
  - a. On-call medical support may be implemented through a partner or community organization.
  - b. The medical respite patient has knowledge and access to on-call medical support information.
9. The medical respite program has written policies and procedures for responding to life-threatening emergencies.
10. The medical respite facility is compliant with local and/or state fire safety standards governing its facility.

11. The medical respite program has a written code of resident conduct or behavioral agreement that describes program policies including potential causes for early discharge. This document is shared with and acknowledged by the patient at admission and is readily available throughout the medical respite stay.
12. The medical respite program has policies and staff trainings to address safety, which include:
  - a. The handling of alcohol, illegal drugs, and unauthorized prescription drugs found on site;
  - b. The handling of weapons brought into the facility;
  - c. Strategies to maximize client and staff safety;
  - d. Trauma-informed de-escalation;
  - e. Appropriate staff response to threatening behavior or violence;
    - i. Staff and consumers have opportunity to receive support or debrief after incidents,
    - ii. Threatening behavior is clearly defined and based on observable actions.
  - f. Patient visitors entering the medical respite facility;
  - g. A written procedure for managing, reporting, and responding to incidents, including patient falls. This procedure includes steps to determine changes to prevent future related incidents;
  - h. Emergency planning and procedures should be considered, e.g. outbreak of infectious disease, state of emergency, disaster response, and inclement weather plans.

**Standard 2: Medical respite program provides quality environmental services.**

Like other clinical settings, medical respite programs must manage infectious disease and handle biomedical and pharmaceutical waste. Medical respite programs should follow applicable local or state guidelines and regulations related to hazardous waste handling and disposal, disease prevention, and safety. Written policies and procedures described below should reflect all applicable local, state, or federal guidelines and regulations.

**Criteria:**

1. The medical respite program has a written policy and procedure for safe storage, disposal, and handling of biomedical and pharmaceutical waste, including expired or unused medications and needles.
2. When patient medications are stored and/or handled by staff, the medical respite program follows state regulations for the storage, handling, security, and disposal of patient medications.
3. The medical respite program has a written protocol for preventing and managing exposure to bodily fluids and other biohazards.
4. The medical respite program has written protocols in place to promote infection control and the management of communicable diseases (including but not limited to scabies, Methicillin-resistant *Staphylococcus aureus* (MRSA), enteric pathogens, influenza, and Covid-19). Protocols in alignment with local health department and Centers for Disease Control (CDC) guidelines include:
  - a. Process for screening communicable diseases at admission and/or if patient presents with symptoms while within the medical respite program.
  - b. Process for isolating patients with communicable diseases within the medical respite program or referring the patient to an appropriate facility where isolation precautions can be implemented.
  - c. Process for access and use of personal protective equipment (PPE) for staff and patients, including what PPE should be used based on diagnosis and/or positive screen.
5. The medical respite program follows applicable reporting requirements of communicable diseases for local and state health departments.
6. The medical respite premises and equipment are cleaned and disinfected according to policies and procedures or manufacturers' instructions to prevent, minimize, and control infection or illness, according to CDC and local health department guidelines.
7. A pest control program is implemented and documented.

**Standard 3: Medical respite program manages timely and safe care transitions to medical respite from acute care, specialty care, and/or community settings.**

Care transitions refer to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions, levels of acuity, and care needs change. Care transition initiatives aim to improve quality and continuity of care and reduce the chances of medical errors that can occur when patient care and information is transferred to another provider or between settings.

**Criteria:**

1. The medical respite program maintains policies and procedures for screening & management of referrals, which include:
  - a. Written admission criteria. Admission criteria and screening processes:
    - i. Are equitable: Within the context and restrictions of site/program location and scope of services, do not screen out or bias against particular groups, optimizes access for underrepresented, historically marginalized groups, and reflect the various identities within populations of people experiencing homelessness;
    - ii. Strive to offer low-barrier\* access to services.
  - b. Description of the program services are available to patients being referred, follow health literacy guidelines, and include:
    - i. Description of program facility and staffing;
    - ii. Services offered;
    - iii. Equitable access and availability for all groups;
    - iv. Parameters guiding length of stay;
    - v. Post-respite disposition planning;
    - vi. Program participation expectations (for example, attending clinical care visits);
    - vii. Program expectations regarding substance use;
    - viii. Weapons management;
    - ix. Management of personal possessions;
    - x. Are available in the patient's preferred language (when possible).
  - c. Collection of pertinent referral information:
    - i. Point of Contact and phone number for referrals;
    - ii. Confirmation that the patient is agreeable to transitioning to respite care;
    - iii. Clinical summary, including medication list;
    - iv. Screening for known active risks for suicidal, homicidal, or assaultive behavior.
  - d. Review for clinical appropriateness. Each referral is reviewed as an individual new case, even if the person has previously been referred or admitted to the program.

- e. Assessment of the patient’s psychosocial needs and ability to be met by current program support.
  - f. Referral process such as including referral decision time and return communication.
  - g. HIPAA-compliant communication and adherence to local and state privacy laws.
2. The medical respite program maintains standards for admitting practices which include:
- a. Each admitted patient has a designated referring medical provider (such as the hospital physician or primary care provider);
  - b. The patient is introduced and oriented to the program and staff;
  - c. Admission agreements are reviewed and signed by the admitting patient;
  - d. The medical respite program screens for possession of weapons and partners for safe storage to ensure safety of patient and the other patients in program.

Additional admissions practices may include:

- e. Medication information is gathered, verified, and coordinated. Patient has discharge medications, applicable prescriptions, and a medication list or history from the discharging hospital or organization.
- f. The patient is transported safely and in a timely manner.
- g. The medical respite program screens for and honors existing advance directives.
- h. The medical respite program provides naloxone kits in conjunction with patient education on decreasing risk for and the management of overdoses, when indicated.
- i. The medical respite program notifies existing primary care providers (if established) about a patient’s transition into the program.

\*Low-barrier is defined as removing as many preconditions to entry as possible and responding to the needs and concerns of people seeking shelter. Expectations placed on guests should be minimal, transparent, and reasonable ([United States Interagency Council on Homelessness](#), 2017).



**Standard 4: Medical respite program administers high quality post-acute clinical care.**

In order to ensure recuperation from illness and injury, medical respite programs must provide an adequate level of clinical care. Medical respite programs need qualified personnel to assess baseline patient health, make ongoing reassessments to determine whether clinical interventions are effective, and determine readiness for program discharge. High quality clinical care identifies and responds to the patients' needs and goals and promotes interdisciplinary teamwork.

**Criteria:**

1. Care provided to patients reflects trauma-informed care\* practices.
2. With each patient, an individualized care plan is developed and may include:
  - a. Identification of patient goals and priorities and specifying treatments and plans to support goals.
  - b. Focus on optimizing medication adherence, which may include medication education or identification and provision of supports and adaptations for taking medications.
  - c. Screening for and treating communicable diseases such as HIV, tuberculosis, syphilis, hepatitis, and sexually transmitted infections.
  - d. Offering indicated immunizations to include, at minimum, influenza vaccination, COVID 19 vaccination, and/or other age-appropriate vaccinations.
  - e. Screening for social determinants of health (SDOH).
  - f. Disposition planning and an initial timeline for the medical respite stay.
  - g. Screening for and supporting patient's obtainment of disability or other benefits, if applicable.
  - h. Connection to long-term medical, behavioral health and case management services, as is applicable. As possible, these services should be initiated during a patient's medical respite stay to enhance the likelihood of post-respite engagement.
  - i. Discharge indicators.
  - j. Disposition planning and an initial timeline for the medical respite stay.
3. Appropriate medical respite staff conducts a baseline assessment of each patient to determine factors that will influence care, treatment, and services using standardized and non-standardized measures. For each patient, the baseline assessment may include:
  - a. The person's understanding and knowledge of their health status.
  - b. Current diagnoses, pertinent history, medication history (including allergies and sensitivities), current medications, and current treatments.
  - c. Medication reconciliation.
  - d. Gender identity and sexual orientation.
  - e. Physical and mental health status.

- f. Behavioral health needs, including substance use and screening for suicidal and homicidal ideation.
  - g. Active symptoms.
  - h. Fall risk.
  - i. Overdose risks.
  - j. Immunization status.
  - k. Cultural needs and considerations.
4. Clinical encounters are conducted based on individualized care plans or changes in patient conditions to ensure current acuity is being supported.
5. Program and affiliated staff involved in direct patient care are trained in and services provided reflect avoidance of stigmatizing language, and services provided reflect avoidance of stigmatizing language.
  - a. Program has a written procedure for managing discriminatory behavior that might arise on the medical respite unit among staff and patients.
6. Clinical and affiliated staff are BLS certified and trained in the administration of naloxone.
7. A medical record is maintained for each patient and its content, maintenance, and confidentiality meet the requirements set forth in federal and state laws and regulations.

*Note: Medical records may be maintained by an off-site health care organization that assumes responsibility for the clinical care of patients while in the medical respite program provided all privacy laws are followed in the sharing of patient information and access to such information.*
8. Patients receive at least one wellness check every 24 hours by medical respite or program-affiliated staff (clinical or non-clinical).
  - a. Affiliated staff roles and responsibilities are formally documented and communicated.
  - b. Medical respite and/or affiliated staff will report notable changes in the patient's condition or notable incidents to respite staff members working the oncoming shift.
  - c. Respite staff will communicate changes in patient's condition or patient concerns to the designated medical provider, when indicated.
9. When various professional disciplines are involved in the care plan, care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner.
10. Patient has access and actionable support for offsite medical appointments and telemedicine.

\*Trauma-informed care is defined as “A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.” ([Substance Abuse and Mental Health Administration \[SAMHSA\], 2014](#))

**Standard 5: Medical respite program assists in health care coordination, provides wrap-around services, and facilitates access to comprehensive support services.**

Medical respite programs are uniquely positioned to coordinate care for a complex population of patients who may otherwise face barriers to adequately navigate and engage in support systems. Case managers can improve coordination of care by brokering linkages to community and social supports in order to help patients transition out of homelessness and achieve positive health outcomes. Wrap-around support services may also be referred to as enabling services\*.

**Criteria:**

1. A plan for care coordination and related needs is established with the patient, including:
  - a. Client goals and priorities;
  - b. Identification of available care coordination supports within the medical respite program;
  - c. Identification of community supports and services to address identified goals and priorities.
2. The medical respite program designates staff to coordinate health care. Care coordination activities include:
  - a. Supporting the patient in developing self-management goals. Self-management goal setting is a collaborative, culturally appropriate approach and individualized/tailored to meet each patient's needs, to help patients increase understanding of actions that affect their health, and to develop strategies to live as fully as possible;
  - b. Identify barriers to accessing health care and related services outside of the medical respite program;
  - c. Helping patients navigate health systems and establish an ongoing relationship with primary care providers/patient-centered medical homes;
  - d. Coordinating and/or providing transportation to and from medical appointments and support services;
  - e. Facilitating patient follow up for medical appointments and accompanying the patient to medical appointments when necessary, to aid the patient in addressing their conditions and symptoms and advocating for preferences for care;
  - f. Ensuring communication occurs between medical respite staff and outside providers to follow up on any changes in patient care plans;
  - g. Providing access to local phone service during the medical respite stay;
  - h. Making referrals and coordinating follow-up to substance use and/or mental health programs, as needed;
  - i. Referral placed for long-term case management, when appropriate and available;
  - j. Connection to and engagement with community health workers and peer support services, as indicated.
3. The medical respite care team provides wraparound services as appropriate, including transitional and community-based services to address social determinants of health. The services may be

provided internally, contracted for, or provided through community collaboration. Wrap-around services may include:

- a. Facilitating access to shelter or housing when appropriate and/or available, such as: emergency and interim shelter, transitional or permanent supportive housing.
- b. Identifying culturally appropriate community resources to address basic needs and provide a safe space for drop-in services, as indicated.
- c. Submitting applications for SSI/SSDI, food stamps, Medicaid, and/or other federal/state benefit programs.
- d. Referrals to legal clinics as indicated.
- e. Providing access to available social support groups, including: onsite peer and patient groups, health education, and outside support groups (e.g., cancer support, addiction support, religious and spiritual groups).
- f. Incorporating onsite peer services as part of medical respite staff or volunteers.
- g. Facilitating family/caregiver or support system interaction at the direction and preference of the patient.

\* [The Federal Health Center Program](#) uses the term *enabling services* to describe wrap-around support services. Per Section 330(b)(1)(A)(iv), enabling services are non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.

**Standard 6: Medical respite program facilitates safe and appropriate care transitions out of medical respite care.**

Medical respite programs have a unique opportunity to influence the long-term health and quality of life outcomes for individuals experiencing homelessness. A formal collaborative approach to the transition of care when patients are discharged from medical respite will optimize outcomes achieved in the medical respite stay.

**Criteria:**

1. The person is engaged in the discharge planning process, including:
  - a. Identifying discharge indicators and timeline.
  - b. Patient is informed of the discharge policy and procedures.
  - c. Patients are provided with options for placement after discharge from the medical respite program. Within the confines of available resources (or options) at the time of discharge, every effort is made to transition the patient to an acceptable disposition location and appropriate level of care and environment.
2. Medical respite program maintains clear policies for discharging patients back into the community. These include:
  - a. A written discharge policy.
    - i. The policy specifies the personnel authorized to make discharge decisions;
    - ii. Discharge policies are reviewed to ensure equitable transitions and discharge practices.
  - b. Patients are given a minimum of 24 hours' notice prior to being discharged from the program (exceptions for administrative discharges as determined by admissions, discharge, and program safety policies);
  - c. The medical respite program respects the patient's self-determination in the event the patient requests to be discharged from the program. Planned and standard discharge procedures are followed;
  - d. The medical respite program has a policy that addresses non-routine discharge, including but not limited to death and leaving against medical advice (AMA) or absent without official leave (AWOL).
  - e. Storage of patient belongings after discharge from the medical respite program, including length of time belongings will be stored and how belongings may be accessed (including both planned and unplanned discharges).
3. The medical respite program maintains standards for discharging procedures:
  - a. Discharge is based on patient's care plan being met, availability of discharge placement, and the patient's view of program stay and assessment of goals completion.
  - b. In a planned discharge, a discharge summary is made available to the patient and the patient is given an opportunity to discuss information listed. The discharge instructions are written to be easily understood by the patient and include the following:
    - i. Written medication list and medication refill information (i.e., pharmacy);

- ii. Medical problem list, allergies, indications of a worsening condition, and how to respond;
  - iii. Instructions for accessing relevant resources in the community (e.g., shelters, day centers, transportation);
  - iv. List of follow-up appointments and contact information for medical providers;
  - v. Special medical instructions (e.g., weight bearing limitations, dietary precautions, wound orders);
  - vi. List of follow-up appointments and contact information for community case management and related resources, and where to follow up regarding pending applications (e.g., housing navigators, social service agencies).
- c. In the event of an unplanned or administrative discharge, the discharge summary may be available to the patient within a reasonable time frame or at their request and contain all available information.
- d. A discharge summary generated by the medical respite clinical team is forwarded to the primary care provider. *Note, if the medical services are provided by a contracted or partner organization, there is an agreement with the respite program to generate and share the discharge information with the primary care provider if the clinical provider is not the ongoing PCP.*

The summary includes:

- i. Admitting diagnosis, medical respite course, and disposition;
  - ii. Allergies;
  - iii. Discharge medication list;
  - iv. Follow up instruction list;
  - v. Any specialty care and/or primary care follow up appointments schedule;
  - vi. Patient education/after care instructions;
  - vii. List of pending procedures or labs that require follow up;
  - viii. Communicable disease alerts;
  - ix. Behavioral alerts;
  - x. Any pain management plan;
  - xi. Any follow-up actions needed as a result of health insurance applications or other benefits initiated while at the medical respite program;
  - xii. Contact information for treating providers and assigned long-term case managers;
  - xiii. Exit placement.
- e. For patients returning to the hospital, a clinical summary is generated by the medical respite clinical team to describe the reason for return.
- f. Adequate protocols are in place for transferring patient information (or access to e-record) to appropriate community providers to meet HIPAA compliance and other state and federal guidelines.

**Standard 7: Medical respite care personnel are equipped to address the needs of people experiencing homelessness.**

The integrity of a medical respite program rests on its ability to provide meaningful, trauma-informed, and quality services to a complex population. As such medical respite programs have policies and procedures in place to ensure that their personnel, both direct and indirect staff, are qualified and effective in providing services to people experiencing homelessness.

**Criteria:**

1. The medical respite program establishes a training plan to equip employees, volunteers, contractors, and affiliated staff with direct patient contact, with necessary skills to maintain a safe and quality-oriented environment. Training topics should include:
  - a. Health information privacy and HIPAA regulations;
  - b. Trauma-informed care;
  - c. De-escalation and conflict resolution;
  - d. Non-discrimination, cultural humility, and non-stigmatizing language;
  - e. Diversity, Equity, and Inclusion and/or Antiracism;
  - f. Sexual harassment;
  - g. Bloodborne pathogen exposure;
  - h. Incident reporting;
  - i. Timely and complete documentation of clinical care.Additional training topics may include:
  - j. Social determinants of health and adverse childhood experiences (ACEs)
  - k. Drivers/causes of homelessness
  - l. Harm Reduction
  - m. Interprofessional collaboration
  - n. Health topics related to the specific patient population represented in the program.
2. Staff have access to adequate equipment to complete their job function and roles.
3. Self-audits and/or peer reviews are conducted at least annually as part of maintaining quality clinical care. Self-audit and peer reviews are regular reviews of client files to ensure that appropriate standards are maintained in the provision of care.
4. The medical respite program implements explicit procedures to remove bias and discrimination, including:
  - a. Embedding principles of Diversity, Equity, and Inclusion in hiring and compensation practices, training, personnel reviews and audits, and volunteer recruitment;
  - b. Procedures to address and respond to episodes of or concerns of bias and discrimination in the workplace;

- c. When possible, respite program staff should strive to be representative of the patient population (throughout the hierarchy) and feel valued and included in the workplace.
5. Staff employed by the program have written job descriptions and meet the qualifications required by such job descriptions. The job description defines the competencies of employees involved in patient care, treatment, or services.
6. The credentials of licensed and certified professionals (employed, contracted, and volunteer) are initially verified and subsequently reviewed at least every two years per program policy.
7. To the extent the program or organization utilizes volunteers in providing care, treatment, or services, there will be written procedures in place to screen volunteers to ensure patient safety. All clinical volunteers are credentialed per programs' credentialing process for their relevant scope of practice.
8. The agency administering medical/clinical care employs or appoints a Medical Director to oversee the medical aspects of the program. The Medical Director is a licensed provider (e.g. NP, PA, MD, DO).
9. Performance reviews are conducted annually for all employees pursuant to written human resource policies. For clinical staff, the performance review includes an evaluation of the quality of clinical care provided.



**Standard 8. Medical respite care is driven by quality improvement.**

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in the services provided in the medical respite program. The program develops a quality improvement plan to provide a formal ongoing process to identify objective measures to monitor and evaluate the quality of services. Clearly defined outcome measures and data collection protocols are imperative to help programs tell the story of how their services have positively impacted the lives of their clients.

**Criteria:**

1. The program establishes and annually updates a quality improvement (QI) plan. The QI plan includes essential information on how the program will implement and monitor high quality clinical and enabling services. The QI plan should include the following:
  - a. A systematic process with identified leadership, accountability, and dedicated resources, and includes stakeholders such as direct staff and consumers.
    - i. The continuous process is adaptive, flexible, and responsive to changes in the community or shifts needs of the patient population.
  - b. Use of data and objective measures to determine progress toward relevant, evidence-based benchmarks and outcomes.
    - i. Outcomes should include both quantitative and qualitative data, including patient satisfaction and feedback surveys.
    - ii. Metrics and outcomes used should be race-conscious to identify potential disparities in populations referred, care, and outcomes.
  - c. Data collected is reported and analyzed to determine if goals are met and outcomes are improved.
  - d. Clearly define methods to evaluate improvements and goals including:
    - i. Frequency of data collection, review, and reporting;
    - ii. How services were improved;
    - iii. How improvements addressed identified problems.
  - e. Developing an action plan to improve outcomes.
    - i. Program improvements may reflect environmental/facility updates or adding in new interventions, supports, and services.
    - ii. Provide staff training to adjust services to address needs and changes identified.
2. Program establishes a framework for service delivery that is based on the QI plan findings and outcomes. To illustrate areas of impact, the outcomes should reflect health and social outcomes.
  - a. Program establishes outcomes that are focused on the health needs of clients and the clinical care provided by the program. This may include:
    - i. Assessment of and coordination of health screenings.
    - ii. Care planning before client's discharge.
    - iii. Client's report of self-improvement.

- iv. Connection to primary care, connection to specialty care including mental health and substance use disorder (SUD) treatment as appropriate.
      - v. Decreased emergency use.
    - b. Program establishes outcomes that focus on coordination of care for a complex population who may otherwise face barriers in navigating and engaging support. These social outcomes may include:
      - i. Enabling services (i.e., connection to insurance).
      - ii. Linkages to social support, coordination of care to mental health services and SUD treatment.
      - iii. Client readiness for transition and placement at discharge.
    - c. Every client has an opportunity to complete an experience of care survey prior to discharge or as part of discharge process, include forms/surveys and individual interviews.
    - d. The medical respite program has a written patient grievance policy and procedure.
      - i. Programs should incorporate a process to immediately respond to grievances.
      - ii. Grievances should also be reviewed at structured intervals to identify programmatic improvements.
- 3. The medical respite program implements procedures to protect patient information in all data collection processes.
  - a. Data is kept in a secure location and meets regulatory guidelines for information security.
  - b. Data that is shared with outside organizations is de-identified so that no patient is identifiable based on information shared, or information is aggregated so that no one person can be identified by data sharing.
  - c. Data is only collected and/or reported to meet guidelines or established metrics. Sensitive and personal data is only collected and shared with consent of the patient or for mandatory reporting guidelines as stipulated by the local health department.
- 4. The medical respite program has a written plan and signed contract for any data and information sharing capacities with hospitals, health systems, and continuums of care (CoC).
  - a. The medical respite program meets the guidelines for data collection and reporting as stipulated by contracts with funders, which may include hospitals, managed care organizations, and local health systems.
- 5. Outcomes shared by the program accurately reflect the data collected and can be concluded by information available.
  - a. Data and outcomes are calculated by appropriate and qualified individuals.
  - b. If the program uses consultative services for data analysis, procedures are followed to protect patient information.
  - c. Outcomes are reviewed and compared to determine differences and disparities among patients served within the medical respite program, including race and gender.

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