It is well documented that people experiencing homelessness have substantial health care needs. Moreover, connecting these individuals with a safe place to recover and recuperate after a hospital stay can be challenging for hospital discharge planners. Meeting this need, medical respite care is post-acute care for people experiencing homelessness who are too ill or frail to recover on the street or in a shelter, but do not require hospitalization. This short-term residential care allows clients an opportunity to rest and heal in a safe environment while accessing medical care and support services (e.g. case management, care coordination, behavioral health care, medication management, etc.).

While medical respite has grown exponentially in the last ten years, it is still a fairly recent addition to the homeless health care field with the earliest programs beginning in the 1980s. Only 35 states have medical respite programs and of those, only four have five or more programs in their state. To raise awareness and gain community buy-in, programs must demonstrate with evidence how medical respite care adds value to health systems and facilitates a better continuum of care for very vulnerable clients.

The integrity of a medical respite program rests on its ability to provide meaningful and quality services to a complex population. Its sustainability relies on the extent to which it can demonstrate that ability. 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.

The following outcome recommendations were developed in partnership with eight medical respite programs (Appendix A). They are intended to serve as a starting point for communities as they develop medical respite services and determine program goals. These

---


Recommendations will help programs establish a framework for service delivery that is driven both by data and quality improvement. To better illustrate areas of impact, the outcome recommendations are separated into three sections: health, social, and program.

### Health Outcomes

A client’s stay in a medical respite program is precipitated by a health-related event. Whether a client is injured or sick, their referral is connected to a medical condition. The following outcome recommendations focus on the health needs of clients and the clinical care provided by the program. Programs are encouraged to define the specific numerator and denominator for the identified measures and variables based on feasibility of data collection.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Variables</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care:</strong> Connection to</td>
<td>Identify primary care provider (PCP)</td>
<td>Medical respite staff must be familiar with the process in which clients are connected to primary care (e.g., Do they have an assigned PCP? Who is the local Health Care for the Homeless (HCH) provider?)</td>
</tr>
<tr>
<td>primary care is established or</td>
<td>Schedule primary care appointment</td>
<td></td>
</tr>
<tr>
<td>strengthened</td>
<td>If possible, verify appointment was completed/attended</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment:</strong> Assessment and</td>
<td>Assess need for health screenings based on age, history, and condition</td>
<td>The stability of a medical respite stay provides an opportunity for clients to get caught up on primary and preventive care that may have previously gone neglected. Health screenings and specialty care appointments may not directly relate to the acute condition identified at intake.</td>
</tr>
<tr>
<td>coordination of health screenings and</td>
<td>(e.g., colonoscopy, mammography)</td>
<td></td>
</tr>
<tr>
<td>specialty care</td>
<td>Assess need for specialty care (e.g., oncology, neurology, podiatry)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schedule screening/specialty care appointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If possible, verify appointment was completed/attended</td>
<td></td>
</tr>
<tr>
<td><strong>Screening:</strong> Screening for</td>
<td>Identify mental health provider</td>
<td></td>
</tr>
<tr>
<td>mental health care and substance use</td>
<td>If one is not established, assess need for mental health treatment/services</td>
<td></td>
</tr>
<tr>
<td>disorder (SUD) needs</td>
<td>Assess for previous diagnoses related to SUD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess need for SUD treatment/services</td>
<td></td>
</tr>
</tbody>
</table>
### Care Plan: Client completes care plan prior to discharge

- Admission date
- Reason for referral/primary diagnosis
- Identify health goals
- Estimate discharge date
- Establish care plan

Completion of care plan means the successful resolution of the acute condition that precipitated the medical respite stay (e.g. recovered from pneumonia, healed for minor surgery) and stabilization of chronic conditions (e.g. connected with primary care provider to re-evaluate medication for hypertension).

### Increased rate of self-reported health improvement

Complete assessments at beginning of stay:
- Medication self-efficacy
- Health changes plan
- Care transitions measure
- CAHPS Health Literacy Survey

Health education is a daily activity in medical respite and provides an opportunity to work on self-management of chronic disease.

### Decreased emergency department (ED) usage during medical respite stay and 90 days post medical respite discharge

- ED usage prior to admission date
- ED usage during medical respite time period
- ED usage 90 days post discharge date

On its own, this metric can be misleading. Clients who come to medical respite programs are sick and ED visits during and post medical respite care may be necessary. Programs should prioritize a decrease in unnecessary ED visits based on primary diagnosis. Additionally, unless the medical respite program has access to the hospital’s electronic health record (EHR), these data must be collected by hospital staff.

### Social Outcomes

A core component of medical respite care is the inclusion of case management in partnership with clinical care. Medical respite programs are uniquely positioned to coordinate care for a complex population who may otherwise face barriers in navigating and engaging support...
The following outcome recommendations focus on care coordination and connection to social supports.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Variables</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| **Enabling Services**: Connection to benefits and enabling services (e.g. health insurance, disability, food and housing assistance) | § Connection to health insurance provider  
§ Asses for income source  
§ Benefits/entitlements in place  
§ Connection to SSI/SSDI and SNAP  
§ Connection to transportation (bus pass, taxi voucher, etc.) | Most communities have local services specifically for people experiencing homelessness for which your clients may qualify. It is the responsibility of the medical respite staff to be experts on the resources available in the local community. |
| **Social Environment**: Linkages to social support    | § Connection with family or friends  
§ Connection to social support groups (e.g. cancer support, addiction support)  
§ Connection to spiritual or religious community, if requested |                                                                                                                                                |
| **Coordinated Care – Mental Health**: Connection and coordination of mental health care services | § If identified as a need, coordinate connection with community mental health provider | Medical respite staff should assist with transportation to/from any mental health appointment.                                                                                                                |
| **Coordinated Care - SUD**: Connection and coordination of substance use/treatment services | § If identified as a need, coordinate connection with treatment services | Medical respite staff should assist with transportation to/from any substance use/treatment appointment.                                                                                                 |
| **Readiness**: Client is "document ready" for housing  | § Secure birth certificate and driver’s license or ID card  
§ Complete any relevant housing applications | While it is the goal of most medical respite programs to discharge clients into housing, very few programs own or operate housing. Securing documents, completing applications, and connecting clients with coordinated entry is a meaningful step in removing barriers to housing for clients. |

---

**Recommendations for New Medical Respite Programs**

**Discharge: Connection to stable post-medical respite discharge options**

- Assess client’s preferred discharge location
- Coordinate transition from medical respite program to agreed upon discharge location
- Client provided with discharge summary

It is not always possible to discharge clients to an improved housing situation. It is possible that upon discharge, clients may return to the shelter, a tent, their care, the streets, etc.

**Program Outcomes**

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in the services provided in the medical respite program. The following outcome recommendations evaluate the delivery of medical respite services and promote program development and growth.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Variables</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| **Safety:** Program provides safe discharge options for partner hospitals | - Hospital staff is trained on admission criteria and referral process  
- Average daily program census  
- Periodic assessment of average length of stay | Bed flow management is important to keep a medical respite program functioning. For some funders, the most important metric is the availability of a bed when one is needed. |
| **Patient Engagement:** Patient feedback expressing satisfaction in their experience of care | - Administer patient satisfaction survey prior to discharge  
- Senior staff and/or board create a plan for reviewing results of patient satisfaction surveys and any patient grievance reports | |
| **Compliance:** Increased compliance with the standards for medical respite care | - Senior staff and/or program board self-audit program to determine whether the program is meeting the standards for medical respite care  
- Senior staff and/or board create plan to address | |

---

### Programmatic & Staffing:
Admission criteria and program staffing meets the evolving needs of the community

- Referral denials and reasons for denial
- Unplanned discharges and reason for discharge
- Incomplete care plans and reason for incompleteness
- Senior staff and/or board periodically review referral denials and unplanned discharges to identify trends

If a significant number of clients are leaving early or not completing their care plan, the program should evaluate whether policies, rules, or other factors can be modified to maintain client participation. Additionally, if the program is consistently denying referrals for a similar reason (e.g., client needs IV medication support), the program might consider expanding their staffing to accommodate this need.

### Data Collection & Sharing

While the above outcome recommendations are applicable for all medical respite programs, the specific outcomes a program decides to track will be influenced by contractual obligations with funders and regulatory bodies. These outcomes will likely vary based on funder, community, and population needs. As programs are negotiating a contract and referral process with funders, they should discuss what outcome measures to track and a plan for sharing that data.

It is common for medical respite programs to share data with partnering hospitals, health care providers, managed care organizations, and other community service providers. Developing a protocol for sharing data can help with continuity of care and transitions between services. Privacy concerns are often a barrier in cross-system data sharing. Setting parameters with partners for data sharing that protects client privacy under the Health Insurance Portability and Accountability Act (HIPAA) can be done in a Business Associates Agreement.

How medical respite staff collect and analyze data is dependent on resources. Some programs perform all documentation on paper forms while others have transitioned to electronic records. Electronic health record and case notes software can be expensive, so it’s common for programs to repurpose systems already in use to fit the data needs of their medical respite services. For example, medical respite programs who collect client-level data using the Homeless Management Information System (HMIS) have been able to tailor that system to include indicators of their choice.

---

9 Learn more about covered entities and business associates at: https://www.hhs.gov/hipaa/for-professionals/covered-entities
Regardless of the system a program decides to use, it is vital that a data collection protocol is in place and standardized. All medical respite staff should be trained on the program’s data collection system and process, including who has the authority to enter and edit data. Failing to maintain the integrity of data can have a devastating effect on a program’s ability to demonstrate its value and maintain funder and community partnerships.

**Demographic Data & Advocacy**

Similar to other health care services, it is standard practice for medical respite programs to collect basic demographic data as part of client intake. Programs must be intentional about what demographic data is collected and how that data will be used. Analysis of demographic data can reveal trends and gaps in care in both the program and the community at large. Collecting demographic data is not only important for better understanding clients and ensuring culturally appropriate care, it also creates an opportunity for programs to advocate for increased services and prevention strategies for people experiencing homelessness. For example:

- **Age**: A program observes that the average age of client referrals continues to increase. Additionally, the program sees an increase in cognitive impairment and reduced daily functioning among clients over the age of 60. The program uses this data to advocate for expanded long-term care facilities for people experiencing homelessness who are unable to live independently after medical respite.
- **Sex**: A 25-bed program for men opens and 6-months into operation the program is rarely at capacity. Program staff analyze demographic data from referral denials and see that 70% of denials were individuals who identified as women. The program uses this data to adjust practice, policies, and space to become a co-ed facility.
- **Race**: A program observes that the majority of their medical respite clients in the last year have identified as African American. Compared to the racial demographics of the city, program staff determine that African American clients are overrepresented in medical respite care. The program uses this data to analyze the racial demographics of their staff to ensure staff reflect the patient population being served. Additionally, the program uses this data to engage in local advocacy around health disparities in minority populations.

Collecting data on client race, ethnicity, and language is an important step in reducing health and health care disparities. However, just collecting this data is not enough; it must also be connected to a plan for improving the quality of care delivered. Programs should analyze all outcomes through the lens of their demographic data to better understand where there may be gaps in care or opportunities for growth. Reducing health care disparities is a moral and professional imperative and one that medical respite programs should pursue in their program design and delivery.

---


Conclusion

These outcome measure recommendations are intended to serve as a foundation on which medical respite programs can build their practice. They do not, however, encompass all of the work that is done with clients during a medical respite stay. Programs will undoubtedly struggle to document and measure some of their outcomes. Self-management, goal setting, confidence in the health care system, and relationship building are some examples of the philosophy of care in medical respite that is difficult to quantify and measure. Often the most sought after and challenging outcomes to track are events that were avoided due to a medical respite stay. Avoided ED services and hospital stays are frequently prioritized outcomes, but those calculations are difficult to demonstrate.

Data-driven outcome measures help medical respite programs demonstrate their value, sustain their practice, and continuously innovate based on the needs of their community. Unfortunately, not every victory in medical respite fits neatly into an outcome measure. Qualitative evidence may also be an indicator of success. There are stories of clients moving into housing, becoming more engaged in their own care, better managing their medications and finances, learning to prepare healthy meals, healing relationships with family, opening up to a case manager or therapist, or simply reporting that they feel good. Not everything in these stories is quantifiable, but they are still valuable in describing the great work and possible impact of medical respite care.

Tools

Health Outcomes
- Admission Procedure & Checklist – Center for Respite Care (pg. 10)
- CAHPS Health Literacy Survey (Modified) (pg. 11)
- Client Health Summary – Center for Respite Care (pg. 12)
- Client Medication Inventory – Center for Respite Care (pg. 13)
- Medical Intake Form – Center for Respite Care (pg. 14)

Social Outcomes
- Care Transitions Measure (pg. 16)
- Care Transitions Record (pg. 17)
- Client Authorization Form – Center for Respite Care (pg. 18)
- Discharge Planning Form – LCHC/Bridgewell RCC (pg. 19)
- Self-Administered Medication Record – Center for Respite Care (pg. 20)
- Self-Management Tool (pg. 21)

Program Outcomes
- Client Satisfaction Survey – Barbara McInnis House (pg. 22)
- Client Satisfaction Survey – Bridgewell/LCHC RCC (pg. 25)
- Performance Measure Worksheet – Central City Concern (pg. 26)
- Standards for Medical Respite Care – NHCHC
- Standards Organization Self-Assessment – NHCHC

Data Collection & Sharing
- Data Collection Protocol - Bridgewell/LCHC RCC (pg. 27)
- Informed Consent for Treatment Form – Center for Respite Care (pg. 28)
- Universal Informed Consent – Durham Crisis Collaborative (pg. 29)
Program Comparison
While all medical respite programs provide a critical service to their community, they vary significantly in their scope, design, and intensity of services. A learning collaborative of medical respite programs came together to share information about their outcome priorities and data collection practices.

<table>
<thead>
<tr>
<th>Program</th>
<th>Bethlehem Haven</th>
<th>Bridgewell/LCHC RCC</th>
<th>Center for Respite Care</th>
<th>Cottage RCP</th>
<th>Heading Home</th>
<th>Sister Mavis Jewel</th>
<th>National Health Foundation</th>
<th>Santa Clara County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Pittsburgh, PA</td>
<td>Lynn, MA</td>
<td>Cincinnati, OH</td>
<td>Santa Barbara, CA</td>
<td>Albuquerque, NM</td>
<td>Albany, NY</td>
<td>Los Angeles, CA</td>
<td>San Jose, CA</td>
</tr>
<tr>
<td>Bed #</td>
<td>29</td>
<td>14</td>
<td>20</td>
<td>10</td>
<td>30</td>
<td>17</td>
<td>98</td>
<td>20</td>
</tr>
<tr>
<td>Average LOS</td>
<td>39 days</td>
<td>70 days</td>
<td>45 days</td>
<td>90 days</td>
<td>31 days</td>
<td>45 days</td>
<td>19 days</td>
<td>31 days</td>
</tr>
<tr>
<td>Facility Type</td>
<td>Stand-alone</td>
<td>Stand-alone</td>
<td>Stand-alone</td>
<td>Shelter</td>
<td>Shelter</td>
<td>Stand-alone</td>
<td>Stand-alone</td>
<td>Shelter</td>
</tr>
<tr>
<td>Data Collection Format</td>
<td>Paper</td>
<td>Epic, Excel</td>
<td>HMIS</td>
<td>Hospital EMR, Excel</td>
<td>Paper, Excel</td>
<td>Excel, HMIS</td>
<td>Microsoft Dynamics (CRM)</td>
<td>Paper, HMIS</td>
</tr>
<tr>
<td>Primary Metrics</td>
<td>Client completes care plan</td>
<td>Connection to housing</td>
<td>Demographic data, specifically age</td>
<td>Connection to primary care</td>
<td>Bed availability</td>
<td>Connection to primary/ pharmacy care</td>
<td>Discharge disposition</td>
<td>Client discharge location</td>
</tr>
<tr>
<td></td>
<td>Connection to housing</td>
<td>Connection to housing</td>
<td>Connection to primary care</td>
<td>Connection to primary care</td>
<td>Bed night usage per month</td>
<td>Connection to health insurance</td>
<td>Progress towards internally developed &quot;path to housing&quot; scale</td>
<td>Referral source</td>
</tr>
<tr>
<td></td>
<td>Connection to supportive services</td>
<td>Connection to supportive services</td>
<td>Diabetes care and management</td>
<td>Client discharge location</td>
<td>Connection to housing</td>
<td>Connection to behavioral health services</td>
<td>Referral source, referrals, denials, and bed availability</td>
<td>Referral source</td>
</tr>
</tbody>
</table>

Notes:
- Bethlehem Haven, Bridgwell/LCHC RCC, Central City Concern, and Sister Mavis Jewel are co-located in buildings with other services.
- Center for Respite Care and Santa Clara County MRP have tailored their HMIS to meet additional data needs for medical respite services.
Admission Procedure & Checklist

The Admission Package is to be completed by the LPN in charge at the time of client admission. All forms are to be completed in their entirety and signed. Sections not completed are to be clearly communicated to the relieving nurse, who then assumes the responsibility for completing admission. All admission documents are the responsibility of the LPN, portions may be delegated to the CCA who have received adequate training and instruction and checked and countersigned by the admitting LPN.

| Client Name: ________________________________ | ID# ________________________________ |
| Date of Admission: ______/_____/______ | Time of Admission: __________________ |
| Name of Admitting LPN: _____________________________ | CCA: _____________________________ |

On arrival to the CRC, all clients are to be greeted and welcomed by the LPN and CCA, at this time the LPN should receive any medications and/or accompanying documentation from the new client.

On arrival CCA (if appropriately trained) is to complete the following:

| Orient the client to CRC (tour, provide client handbook, review & explain CRC rules | ☐ |
| Read and sign the Informed Consent for Treatment | ☐ |
| Read and sign the Client Orientation Agreement | ☐ |
| Read and sign the Authorization for Release of Health Information | ☐ |
| Search client property | ☐ |
| Complete inventory checklist | ☐ |
| Add client to Census Log form | ☐ |

On arrival LPN is to complete the following:

| Review medications & accompanying documentation | ☐ |
| Assign client ID number and enter client information in Client Log | ☐ |
| Ensure all forms R/t client have clients name, ID and DOB written on forms | ☐ |
| Complete Medical Intake form | ☐ |
| Record admission vitals on flowsheet (MUST be done by LPN on admission) | ☐ |

Once all client information has been obtained and reviewed proceed then:

| Obtain Admission orders | ☐ |
| Complete MAR and Treatment sheets pertaining to orders | ☐ |
| Administer 1st step PPD (if appropriate) | ☐ |
| Ensure client has adequate amount of ordered medication (at least 7-day supply) | ☐ |
| Place all forms under appropriate tabs | ☐ |

On arrival, Dr. Donovan will complete the following:

| Discharge notice | ☐ |
| Activities/Physician Order | ☐ |
| Health Improvement Assessment | ☐ |

*Completed form is to remain in the client’s chart as part of his/her permanent record.*

C:\Users\admin\ICT SCS\Medical Recovery\Client Admission Packet\Admission Procedure & Checklist June 2019.docx
Modified 5-item CAHPS Health Literacy Survey

During your stay, how often did the medical respite staff give you all the information you wanted about your health?

Never  Sometimes  Usually  Always

During your stay, how often did the medical respite staff encourage you to talk about all your health questions or concerns?

Never  Sometimes  Usually  Always

During you stay, how often did the medical respite staff ask you to describe how you were going to follow self-care instructions?

Never  Sometimes  Usually  Always

If you received test results during your stay, how often were the results of your blood test, x-ray, or other test easy to understand?

Never  Sometimes  Usually  Always  Not Applicable

During your stay, how often were instructions about how to take your medicines easy to understand?

Never  Sometimes  Usually  Always

If someone helped you complete this survey, please answer the questions on the back of this form.
### CLIENT HEALTH SUMMARY

**Name** ______________________________  
**D.O.B.** ______ / ______ / ______  
**ID#** __________________

**Allergies** __________________________________________________________________________________

### PROBLEM LIST: CHRONIC

<table>
<thead>
<tr>
<th>DX</th>
<th>DATE</th>
<th>DX</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>11</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>7</td>
<td>15</td>
<td>8</td>
<td>16</td>
</tr>
</tbody>
</table>

### PROBLEM LIST: ACUTE

<table>
<thead>
<tr>
<th>DX</th>
<th>DATE</th>
<th>DX</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PPD STATUS

<table>
<thead>
<tr>
<th>PPD</th>
<th>Date Given</th>
<th>initials</th>
<th>Lot #</th>
<th>Exp Date</th>
<th>Site</th>
<th>Results Indurations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Date mm initials</td>
</tr>
</tbody>
</table>

**Previous TB Positive**

<table>
<thead>
<tr>
<th></th>
<th>CXR results in chart?</th>
<th>Signature</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y □ N □</td>
<td>X________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>S/S reviewed?</td>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y □ N □</td>
<td>X________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>S/S discussed with MD or NP?</td>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Y □ N □</td>
<td>X________________________</td>
<td></td>
</tr>
</tbody>
</table>

**VACCINE ADMINISTRATION RECORD**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Lot #</th>
<th>Exp Date</th>
<th>Date</th>
<th>Time</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# CLIENT MEDICATION INVENTORY

Client Name ______________________  Client D.O.B. _____/_____/_____  Room # ________ - ______

<table>
<thead>
<tr>
<th>Date Logged in</th>
<th>Medications Logged in</th>
<th>Quantity</th>
<th>Location of Medication</th>
<th>Quantity Returned on D/C</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X ______________________________  ______________
Client Signature on Admission  Date

X ______________________________  ______________
Staff Signature on Admission  Date

Date Medications Returned to Client on Discharge

X ______________________________  ______________
Client Signature on Discharge  Date

X ______________________________  ______________
Staff Signature on Discharge  Date
MEDICAL INTAKE FORM

Date _____/_____/_____

Client Name: ______________________________________ DOB: _____/_____/____ ID: __________

Biographical/Demographic Information
Age: _______ Sex M/F Race: ☐ White/Caucasian ☐ Black/African American ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _______________

SSN: __________-____-____

Have been a client of CRC before? ☐ Yes ☐ No Date(s) ______________________ Are you homeless? ☐ Yes ☐ No ☐

Where do you stay? __________________________________________________________

What is your primary language? __________ Interpreter required Yes ☐ No ☐ Help with reading and writing? Yes ☐ No ☐

Any special needs (physical, emotional, spiritual, dietary)? ☐ Yes ☐ No

List needs: ___________________________________________________________________

Allergies (drug, food, or other) ________________________________________________

Referral Source (Physician and Facility name) ____________________________________

Reason for referral (diagnoses) ________________________________________________

Do you have a PCP? ☐ Yes ☐ No ☐ Name of Physician _____________________________

When and where were you last seen? ___________________________________________

Do you see other doctors? ☐ Yes ☐ No ☐

Physician Name & Specialty ______________________________________ Date of last visit _____/_____/_____

Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td>Heart Murmur</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
<td></td>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Problems (Hemophilia)</td>
<td></td>
<td></td>
<td></td>
<td>Poor Circulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injuries</td>
<td></td>
<td></td>
<td></td>
<td>Seizure Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes/Glucose Intolerance</td>
<td></td>
<td></td>
<td></td>
<td>Urinary or Kidney problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digestive Disorders (GERD/Gastric Ulcer)</td>
<td></td>
<td></td>
<td></td>
<td>Bowel problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis (Rheumatoid/Osteoarthritis)</td>
<td></td>
<td></td>
<td></td>
<td>Osteoporosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthmas/Respiratory Problems</td>
<td></td>
<td></td>
<td></td>
<td>Tuberculosis Disease or h/o of +PPD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A, B, C, or D</td>
<td></td>
<td></td>
<td></td>
<td>HIV/AIDS/History of STD’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Glaucoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision /Glasses/Contact lenses</td>
<td></td>
<td></td>
<td></td>
<td>Hearing problems/Hearing Aid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been hospitalized? ☐ Yes ☐ No ☐

If yes, where/when/reason? ______________________________________________________

Surgical procedures and dates? ___________________________________________________

Have you recently had any medical tests performed? ______________________________________

Have you recently received any vaccine or immunizations? ______________________________

C:\Users\admin\ICT SCS\Administration\Trish- ASM\DOCS OUT FOR INTERNAL REVIEW & MEMOS\Medical Intake Form PART 1.docx REV 7/19
MEDICAL INTAKE FORM PART II

Date _____/_____/_____

Client Name: ___________________________________________  DOB: _____/_____/____ ID: ____________

Medication Administration

Are you able to self-administer medication?  □ Yes  □ No  Does anyone assist you in taking your medication?  □ Yes  □ No

If yes, who? ____________________________________________________________________________________________

Substance Abuse

<table>
<thead>
<tr>
<th>Do you currently use any tobacco products?</th>
<th>□ Yes  □ No</th>
<th># of packs per day?</th>
<th>Age began smoking</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last time you drank alcohol?</th>
<th>Date/Day</th>
<th>Type / Amount / Frequency</th>
<th>Age began drinking</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you have a history of withdrawal related problems?</th>
<th>□ Yes  □ No</th>
<th>Explain:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Have you had any periods of sobriety?</th>
<th>□ Yes  □ No</th>
<th>When and for how long?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Have you ever used drugs?</th>
<th>□ Yes  □ No</th>
<th>Type / Amount /Frequency</th>
<th>Age began using drugs</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last use?</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you have a history of withdrawal related problems?</th>
<th>□ Yes  □ No</th>
<th>Explain:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Have you ever had periods of abstinence?</th>
<th>□ Yes  □ No</th>
<th>When and for how long?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Have you ever been in a treatment program For drugs and/or alcohol?</th>
<th>□ Yes  □ No</th>
<th>Where and when?</th>
</tr>
</thead>
</table>

Mental Health

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thoughts of hurting others  Depression
Thoughts of hurting yourself  Hear voices that others do not
Suicide attempts  See things that others do not
Anger issues or h/o violence?  Anxiety

Have you ever been hospitalized for a mental health issue?  □ Yes  □ No  If yes, where/when/diagnosis?
MODIFIED Care Transitions Measure® (CTM-3)

Survey ID: ________________________________ Date: ___________________

1. The medical respite care staff took my preferences into account when deciding what my health care needs would be when I left the program.

   Strongly disagree Disagree Agree Strongly agree Don’t know/ Don’t remember/ Not applicable

2. When I left the medical respite program, I had a good understanding of the things I was responsible for in managing my health.

   Strongly disagree Disagree Agree Strongly agree Don’t know/ Don’t remember/ Not applicable

3. When I left the medical respite program, I clearly understood the purpose for taking each of my medications.

   Strongly disagree Disagree Agree Strongly agree Don’t know/ Don’t remember/ Not applicable

*If someone helped you complete this survey, please answer the questions on the back of the form.*

Care Transitions Program®; Denver, Colorado
Please register for use (no fee required) at: www.caretransitions.org
© 2006 Eric A. Coleman, MD, MPH
### Information for Patients

**Why was I in the medical respite program? What happened to me?**

<table>
<thead>
<tr>
<th>Patient name:</th>
</tr>
</thead>
</table>

You came in to the **NAME OF MEDICAL RESPITE PROGRAM** on **DATE OF ADMISSION** and have been here for ### days. You left on **DD/MM/YYYY**

You came into medical respite care because:

<table>
<thead>
<tr>
<th>Test or Procedure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of place where test/procedure was done:</td>
</tr>
<tr>
<td>Results:</td>
</tr>
</tbody>
</table>

Here is some information about tests and/or procedures that were done while you were here:

<table>
<thead>
<tr>
<th>Test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to get the results:</td>
</tr>
</tbody>
</table>

We are still waiting to find out about these tests:

<table>
<thead>
<tr>
<th>Test:</th>
</tr>
</thead>
</table>

Your main diagnosis:
Client Authorization - To Use or Disclose Protected Health Information

Client Name: ________________________________ Birth Date: _______________ SS# ___________

I authorize the Center for Respite Care, Inc. to release/obtain the following protected health information about the above-named client.

- History and physical
- Laboratory results
- Medical reports
- Operative report
- Pathology report
- X-ray and imaging reports
- Physician orders
- My Chart
- Admission records
- Psychotherapy records
- Medication records
- Discharge records
- Consultation reports
- Referral records
- All records listed

I authorize release of the above listed information TO the following agency, individual, or organization:

Name: __________________________________________
Address: _________________________________________

FROM the following agency, individual, or organization:

Name: __________________________________________
Address: _________________________________________

Information is to be released for the following reason(s): at the request of the individual: Research Study
Or (please be specific): ____________________________________________

I understand that I have a right to cancel this authorization at any time by presenting my written cancellation to the Center for Respite Care, Inc. Medical Recovery Nurse Manager. I understand that a cancellation will not apply to information that has already been released under this authorization. I understand that the cancellation will not apply to my insurance company when the law gives my insurer the right to contest my policy or a claim made under my policy.

Unless I cancel it sooner, this authorization will expire in one year from the date of discharge or on the following date, event, or condition: _______________

I understand that authorizing the disclosure of this health information is strictly voluntary and I do not need to sign this form to obtain treatment (unless specifically related to Research Treatment).

I understand that the information to be released may include information concerning sexually transmitted disease (STD), Human Immunodeficiency Virus (HIV) testing, diagnosis, or treatment of Acquired Immunodeficiency Syndrome (AIDS), AIDS-related conditions, drug/alcohol abuse and/or drug related conditions, and psychiatric/psychological conditions.
LCHCH/ BRIDGEWELL RECUPERATIVE CARE CENTER
Discharge planning

Before you depart from the Recuperative Care Center it is important you are aware of the following policies regarding your discharge and your belongings:

You will receive this paperwork the once your discharge date is set in order to plan for your transition back to the community. All clients must be off the floor no later than 10 am unless otherwise arranged.

**MAIL:** You must inform all parties of your new address including PT-1 transportation. You must update your primary care team with your discharge address so your medical team may contact you. Resident’s mail may be held for 7 days.

**PERSONAL PROPERTY:** You are required to take your personal property with you upon discharge. Anything left will be stored at the RCC for up to 7 days. RCC will not be responsible for items left after discharge. If you need to return to collect your items you may claim your items between (9-5) Monday through Friday up till 2 weeks post discharge.

**EXIT SURVEY:** Please complete the questionnaire prior to leaving RCC and give to the Case manager.

**MEDICAL:** All clients must be seen the medical team prior to being discharged from the floor. A copy of your medication list and medications will be given to you upon discharge. Please make sure you follow up with your Primary care and Behavioral Health team for medication refills.

**SELF DISCHARGE**
**PLANNED DISCHARGE**

Follow up PCP apt. scheduled: ____________________________________________________________

Follow up Behavioral health appt. scheduled: ________________________________________________

Transportation/ PT-1 Setup for discharged appointments

______________________________________________________________________________________

Community Resources/ Case manager contacts:

______________________________________________________________________________________
| MEDICATION | TIME | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|------------|------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

Staff signature required over page. Record any notes over i.e. refusal of meds, errors, client knowledge deficits etc. All medication to be taken in the presence of staff. Medication is not to be removed from the medication room.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Initials</th>
<th>Signature</th>
<th>Initials</th>
<th>Signature</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Self-Management Support Tool**

**HEALTHY CHANGES PLAN**

The healthy change I want to make is (very specific: What, When, How, Where, How Often):

My goal for the next month is:

The steps I will take to achieve my goal are:

The things that could make it difficult to achieve my goal include:

My plan for overcoming these difficulties includes:

Support/resources I will need to achieve my goal include:
Barbara McInnis House Survey – Patient Version 1.0

**Introduction:** We would like to ask you some questions about the providers, nurses, aides, and case managers that work with you here at Barbara McInnis House. This group of people will be referred to as your care team in this survey. We would also like to ask you about the care you receive here. Please indicate how much you agree or disagree with the following statements about the care team that provided your care during this stay.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. I am satisfied with my level of involvement in decisions about my care plan and treatment goals during my stay here.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2. I can get enough time with the members of my care team.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3. My care team has the right skills to take good care of me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4. I worry that someone here might report my health information to the authorities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q5. If someone from my care team is unavailable there is someone else that can help me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q6. I can be honest with my care team if I use drugs or alcohol.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions:** For the next questions, we will ask about how the members of your care team work with each other and other health care providers. The other health care providers can be other doctors, therapists, or other providers who help in your medical care.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. My care team needs to communicate with my other health care providers more.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. My care team is working together to come up with a plan to meet my needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9. My care team has all the information they need to treat me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions:** The next questions are about the Barbara McInnis House. For these questions think about this place and the staff who are here.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. The staff here treats me with respect and dignity.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q11. My case manager helps me get resources and benefits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q12. The staff here treats some patients worse if they are here for issues related to drug or alcohol use.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q13. When I need information about my health care, I can get it easily.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q14. If I have a complaint, people here listen and try to help me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Recommendations for New Medical Respite Programs

Q15. I have to wait a long time to get help if I need it.

Q16. At this place, I have sometimes not received care because I cannot pay.

Q17. The staff here treats all patients fairly.

Q18. This place provides support and care for patients who are currently using drugs or alcohol.

Q19. This place provides support and care for patients who have used drugs or alcohol in the past.

Q20. The admissions staff explained what I could expect during my time here and answered my questions.

Q21. When I was admitted, the process of getting up to my room went smoothly.

Q22. The food options here meet my dietary needs.

Q23. This building is clean and well-maintained.

Q24. There are enough activities here that I can participate in, if I want to.

Q25. Barbara McInnis House provides convenient transportation for me to my appointments.

Q26. The visiting hours here are convenient.

Q27. The length of my stay here is appropriate.

Q28. I am worried that other patients will find out my medical information.

Q29. The policies about smoking here work for me.

Q30. I have enough access to bathrooms, showers, phones, and laundry here.

Q31. I worry that my things will get stolen while I am here.

Q32. My health is improving here.

Q33. This place tries to help me with things I might need right away, like food, shelter or clothing.

Q34. The people who work at this place seem to like working with people who have been homeless.

Q35. At this place, I always have to choose between health care and dealing with other challenges in my life.

Q36. I am involved in discussions about my discharge and follow-up care plan.

Q37. What is your gender? Male            Female          Transgender      Prefer not to say
<table>
<thead>
<tr>
<th>Q38. Where did you stay most often before you were admitted here?</th>
<th>Shelter</th>
<th>Street</th>
<th>Transitional Housing or Treatment Program</th>
<th>Doubled Up (Staying with family or friends)</th>
<th>Housed</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q39. Are you Hispanic or Latino?</td>
<td>Yes</td>
<td>No</td>
<td>Prefer not to say</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q40. What race do you consider yourself?</td>
<td>White</td>
<td>Black or African American</td>
<td>American Indian or Alaska Native</td>
<td>Asian</td>
<td>Native Hawaiian or Pacific Islander</td>
<td>More than one race/Mixed Race</td>
</tr>
<tr>
<td>Q41. What is your age?</td>
<td>_______</td>
<td>years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2020 Satisfaction Survey for People Receiving Services at Bridgewell’s Recuperative Care Center

Please circle the response that best matches how you feel about the services you received here. Thank you for your participation!

1. Staff care about me.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

2. Staff treat me with respect.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

3. Staff work with me in a way that shows me that my dignity is a priority to them.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

4. Staff work with me in a way that recognizes and values me as a human being.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

5. I consider this program to be a safe and secure environment.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

6. Staff makes my well-being a priority during the service delivery process.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

7. Bridgewell provides high quality of care to the people it serves.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

8. While at Recuperative Care I was able to advance my medical needs.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

Comments:
# MEASURING WHAT MATTERS

## PERFORMANCE MEASURE WORKSHEET

**Organizational Value/Objective:**

**Health/Wellness Goal:**

**Area of Focus (from IOM six domains)**
- [ ] safety
- [ ] timeliness
- [ ] effectiveness
- [ ] efficiency
- [ ] patient centeredness
- [ ] equitability

**Type of measure**
- [ ] structure
- [ ] process
- [ ] outcome

**Who should be involved in design?**

<table>
<thead>
<tr>
<th>check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>consumers/patients/clients</td>
</tr>
<tr>
<td>frontline staff</td>
</tr>
<tr>
<td>providers/clinicians</td>
</tr>
<tr>
<td>quality staff</td>
</tr>
<tr>
<td>IT/EHR</td>
</tr>
<tr>
<td>administration</td>
</tr>
<tr>
<td>additional category:</td>
</tr>
</tbody>
</table>

**Specific Data Point***:

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
</tr>
</tbody>
</table>

**Exclusions:**

**Plan for data collection:**

**Questions/Concerns/Ideas**
Data Collection Protocol: Currently our data is recorded using an excel workbook. The workbook has multiple worksheets. The worksheets highlight two distinctive data sets; Referrals and Admissions. All data is recorded by the program director and reviewed with the program supervisor on a quarterly basis.

The referral workbook is designed to capture every referral received and the disposition of the referral. The data recorded includes; Admit #, Individual name, Referring entity, date of referral, admission date, date of denial and reason for denial. The admission workbook is designed to capture individuals name, medical record number, DOB, age, gender, race, ethnicity, referral source, referral date, admission date, discharge date, Length of stay, discharge location, pending housing application and if housed directly from the facility.

When a referral is received at the program the program director will begin tracking data using the Referral worksheet in our statistical data workbook. The referral is reviewed by the program director and the medical director for assessment and disposition. Once a disposition is reached the program director will update the worksheet by indicating whether or not the referral was accepted or denied. If the individual is denied no further collection on that individual occurs.

If the individual is accepted the anticipated arrival date is noted on the worksheet and the individual data is transferred onto the Admission workbook. All data other than the MRN if this is a new patient is available prior to the individual arriving using our referral form and coversheet. In the event the MRN is not available prior to admission the MRN is established upon admission and the Admission workbook is updated at that time.

The data is shared monthly with our advisory board and program management to gauge historical comparisons and to monitor future goals and program trends.
Informed Consent for Treatment

Client Name: ____________________________ Birth Date: __________/________/______
(Print) MM DD YR

I have the right not to sign this consent. However, if I refuse to sign this consent, the Center for Respite Care (CRC) will not be able to treat me.

Advance Directives (please initial if applicable):

______ I have established advance directives for health care should I become too ill to communicate my wishes.

______ I have authorized a “Do-Not-Resuscitate/DNR” order through my physician.

Payment: I understand that I will not incur any expenses, or be expected to pay for any services, during my stay at CRC.

I have had an opportunity to discuss my questions and concerns regarding my health care and all previously mentioned items and have had my questions answered to my satisfaction.

I hereby authorize CRC to examine, treat, immunize, prescribe, and administer/supervise medications and provide all other required medical and social services as needed.

_________________________ / __________/__________
Client Signature Date

OR

_________________________ / __________/__________
“Mark” of Client Date Witness to patient “mark”

(If client is unable to sign, complete information on reverse side of the page)

CLIENT ORIENTATION AGREEMENT

My signature on this document affirms that the CRC Rules and my Client Rights have been explained to me, that I have received a copy of the CRC Client Handbook, that I have had an opportunity to ask questions, that I understand my rights and that I agree to abide by all CRC client rules and requirements.

_________________________ / __________/__________
Client Signature Date

Client Orientation provided by:

_________________________ / __________/__________
Staff Member Name Date
AUTHORIZATION TO RELEASE & EXCHANGE INFORMATION
WITHIN THE DURHAM CRISIS COLLABORATIVE

I, ____________________________ hereby request and authorize ____________________________

Consumer Name
to use or disclose my protected health information to Northern Piedmont Community Care and Alliance Behavioral Healthcare (Integrated Health Care Team). Information released may be verbal, electronic, and/or written and allows for a reciprocal exchange of information. Released data may include records, treatment notes and other information.

Nature of records to be released: (Please initial beside each applicable document.)

___ Medications  ___ Treatment Plans  ___ Admissions Assessments
___ Psychiatric Evaluations  ___ Psychological Evaluations  ___ Treatment Recommendations
___ Discharge Summaries  ___ Aftercare Plans/Orders  ___ Lab Results
___ Alcohol/Drug Treatment  ___ Acquired Immunodeficiency Syndrome (HIV)
___ Progress/Psychotherapy Notes
___ Other: ______________________________________________________________________

By initialing here ____________________________ I authorize *ANY and ALL agencies (*complete list on page 3) participating in the Durham Crisis Collaborative reciprocal release, exchange, disclosure, sharing and receipt of my protected health information.

OR

I authorize ONLY the agencies initialed below for the reciprocal release, exchange, disclosure, sharing and receipt of records pertaining to me among:

_____ Alliance Behavioral Healthcare MCO  _____ Carolina Outreach, LLC
_____ Central Regional Hospital  _____ Criminal Justice Resource Center
_____ ** Duke University Health System  _____ Durham Center Access
_____ Durham County Jail  _____ Department of Public Health
_____ Durham Department of Social Services  _____ Durham Police Crisis Intervention Team
_____ Durham Emergency Medical Services  _____ Easter Seals
_____ Housing for New Hope  _____ Lincoln Community Health Center
_____ Telecare  _____ Other: ________________

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. If not revoked earlier, this authorization expires automatically one year from the date it is signed. I understand that I may revoke this authorization by completing the Revocation of Authorization form.

I understand that an Authorization to Release & Exchange Information must be signed by me prior to any release authorized above.

The PHI used or disclosed may be subject to redisclosure by the recipient, in which case it may no longer be protected under the HIPPA Privacy Rule.

I understand that I may refuse to sign this or any authorization form. I understand that the Integrated Health Team will not condition the above named consumer’s treatment, payment of services, or eligibility of benefits upon receiving the consumer’s signature on this Authorization form and/or any other Authorization form.

I certify that this authorization is made freely, voluntarily and without coercion.

(Signature of Client) __________________________________________________________________
(Date) __________________________________________________________________________
Disclaimer

This publication is supported by the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,625,741, with 0% financed with non-governmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. Government. For more information, please visit HRSA.gov.