Medical Respite Care Referrals & Trauma-Informed Admissions

August 2023

Case Example 1: Clarissa

Initial Referral

Clarissa (she/her) was admitted to Regional Memorial Hospital with a fracture of her left foot after falling from a retaining wall near her encampment. Surgical intervention was required to repair the fracture, and after three days in the hospital post-surgery, a social worker on Clarissa's care team faxed a referral packet to a local medical respite care (MRC) program for further rest and recuperation. The MRC program falls most closely under the Coordinated Clinical Care model, with onsite care coordination and housing navigation provided by two case managers, and limited clinical support provided by one full-time registered nurse (RN).

The MRC program RN received the referral packet and completed a preliminary review. She first confirmed that the release of information and informed consent form had been signed by the patient. She then noted that, while the social worker included the admission note for the hospitalization and a post-operative note, no other progress notes were included from the past 72-hours. The hospital social worker indicated on the referral form that the patient could perform her activities of daily living (ADLs) independently and would require a boot and crutches. However, specifics around the patient's mobility, independence, and durable medical equipment (DME) were unclear. Accompanying the patient's medication list was contact information for a pharmacy in a neighboring community, and a box on the MRC program's referral form requesting that a 30-day supply of medications be provided was left unchecked.

Discussion & Follow-up

The RN discussed the referral and her initial concerns with one of the case managers on the MRC team. They agreed that this referral seemed promising overall, and that Clarissa would likely benefit from an opportunity to spend some time recovering in a stable and supportive environment. Together, they developed a list of clarifications/requests for the referring social worker to ensure that the needs of the patient could be adequately met, and to facilitate a positive transition from the hospital to the program:

1. *Please provide any progress notes, as well as physical therapy (PT) and/or occupational therapy (OT) notes, from the hospitalization.*
2. *Please confirm that the hospital can provide a 30-day supply of the patient's medication, wound care supplies, and the DME needed to ambulate safely.*

3. *Please confirm that the patient was provided with the MRC program's informational brochure outlining key features of the program, photos of the facility, and some of the fundamental guidelines and expectations of the program* (this brochure was carefully developed to be as accessible as possible, using numerous pictures and written at a seventh-grade reading level).

The RN called the hospital social worker to discuss the points listed above. The social worker was happy to fax progress notes and PT/OT notes for the MRC team to review. The social worker reported that the hospital's standard protocol is to call in prescriptions to the pharmacy listed in patients' medical records. However, the MRC RN explained that picking up medications from a pharmacy several miles away would be a significant barrier for this patient due to her complex social and medical issues. The social worker agreed to request a 30-day supply of medications for the patient to receive upon discharge, as well as all necessary DME and wound care supplies. Finally, the RN emailed a copy of the MRC program's informational brochure for the patient because the social worker did not have this resource on file.

The RN made note of her conversation with the hospital social worker on the coversheet of the referral packet, per the MRC program's standard operating procedures.

Date & Time	Communication Details	Notes	Status
January 17th at 10:30am	*Phone call with Nicole K. – Social Worker*	*Requested progress notes and PT/OT notes. Hospital supplying medications, DME, etc. Provided brochure for patient to review.*	*Pending*

Outcome

The progress notes indicated that Clarissa had improved quickly after her surgery and was clinically appropriate for discharge. PT notes demonstrated that Clarissa had transferred safely to/from her bed and the toilet with only standby assistance, and that she could ambulate 300+ feet with crutches.

The MRC program RN called the hospital social worker to accept Clarissa, and the social worker arranged an Uber to transport her to the program site that same afternoon. The RN ensured that Clarissa's name and information was added to a list of expected arrivals so the resident support specialists at the front desk would be prepared to welcome her when she arrived.

Unfortunately, Clarissa did not arrive at the expected time. Instead, the program received a phone call at 4:30pm from a staff member at a nearby daytime drop-in center reporting that they were closing for the evening, and that Clarissa was there. Clarissa had been dropped off outside the MRC program site earlier but became confused and overwhelmed by the multiple entrances to the unfamiliar building. Rather than going inside, she decided to walk to the more familiar drop-in center where she frequently ate lunch, showered, and received other services.

One of the MRC case managers walked the two blocks to the drop-in center and escorted Clarissa back to the MRC program. She was given a warm and hospitable orientation to the program, and her anxiety quickly faded.

During the next day's MRC team meeting, staff members debriefed this incident and discussed opportunities for improvement to avoid such confusion for new arrivals in the future. They decided to pursue three initial strategies:

1. *Edit the informational brochure provided to patients in the hospital to include a photograph of the main program entrance with clear, written instructions.*
2. *Create larger, clearer signage for the main entrance that is visible from the sidewalk in front of the facility.*
3. *Add a question to the MRC program's existing client satisfaction survey related to clients' experience during transitions from the hospital to the program (including any recommendations for improvement).*

Case Example 2: Arturo

Initial Referral

Arturo (he/him) presented in the emergency department and was admitted to Community Teaching Hospital with bronchitis and acute exacerbation of chronic obstructive pulmonary disease (COPD), resulting in severe difficulty breathing. Arturo's respiratory symptoms stabilized relatively quickly while inpatient, but his hospital stay was extended while his care team medically managed/monitored his withdrawal symptoms from alcohol use. Additionally, his care team was concerned that he might quickly decompensate if discharged to his former living situation (alternating between the street and a local overnight shelter) because of the cold winter weather, a lack of a stable place to safely store and administer his medications, and his alcohol use.

With his permission, the team decided to refer Arturo to a local medical respite care (MRC) program operated by a HRSA-funded health center site, co-located in a transitional housing facility. This MRC program aligns most closely with the Integrated Care model, offering onsite access to a prescribing provider, nursing support, behavioral health services, and case management. Because the teaching hospital and the health center have an established working relationship and share the same electronic health record (EHR) platform, the social worker on the care team was able to submit a referral electronically, along with read-only access to all the clinical information from Arturo's hospital stay.

Assessment & Conversation

An RN-case manager from the MRC program arranged to meet Arturo in the hospital the following day. After introducing herself and learning a bit about Arturo, the RN-case manager provided an overview of the purpose and expectations of the MRC program. She asked Arturo what questions and/or concerns he had, and Arturo expressed ambivalence about participating, specifically:

1. *He felt reluctant to be separated from his boyfriend.*
2. *While he had a desire to stop or significantly reduce his drinking, he wasn't sure he could do it.*

The RN-case manager did her best to address both of Arturo's concerns. She provided a detailed explanation of the MRC program's policies around visitors, assuring Arturo that he could add his boyfriend to the approved visitor list so they could spend time together during designated hours. She also used Motivational Interviewing to help Arturo mobilize his internal strengths and identify reasons for hope around making positive changes to his alcohol use.

Arturo agreed to "give it a try," and the RN-case manager documented their conversation, including Arturo's concerns and priorities, for the MRC team in their EHR. She also preemptively reserved an appointment on the MRC behavioral health clinician's schedule (as this provider is only onsite twice per week) to ensure that Arturo could begin treatment as early in his MRC stay as possible. In this behavioral health referral, she included key information about Arturo's self-reported alcohol use and other mental health symptoms that he had described.

Outcome

The RN-case manager met briefly with the hospital social worker following her meeting with Arturo. They discussed care transition logistics and agreed that Arturo would be discharged (with his nebulizer and other medications) to the MRC program once his Clinical Institute Withdrawal Assessment for Alcohol (CIWA) score indicated that it was safe to do so. The next afternoon, the social worker contacted the MRC program to inform them that Arturo would be leaving shortly, and they called a taxi for him.

When Arturo arrived at the MRC program, the resident support specialist signing him in discovered that, in addition to the medications provided by the hospital, he had numerous other medications (some duplicates and others unique) from various prescribers. Arturo expressed that he was confused and unsure of which medications he should discontinue and which he should resume taking. He also noted that the type of nebulizer he had been provided upon discharge was slightly different than the one that he had been trained to use in the hospital, and he was nervous about inadvertently using it improperly.

Although Arturo's formal, clinical intake meeting was scheduled for the next morning, the resident support specialist identified this situation as a time-sensitive concern. He asked the RN who was approaching the end of her shift to assist Arturo, and the RN met with Arturo to perform an initial medication reconciliation and provide education. Arturo signed a waiver permitting the MRC program to safely discard outdated medications, and he successfully practiced using his new nebulizer. The RN documented the interaction and Arturo's full medication list for the provider to review the next morning.

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