BACS
Bay Area Community Services

RESIDENTIAL Services

Medical Respite

BACS knows that ***nobody*** wants to be homeless.

559 16th Street
Oakland, CA 94612

510-759-4289

Patients must be independent. BACS Respite is not a medical facility, and care is not 24/7.

Bay Area Community Services (BACS) is committed to doing whatever it takes to uplift underserved individuals and their families.

bayareacs.org • 510-613-0330

BACS' Recuperative Care program offers a short-term (up to 4 weeks) safe, supportive place to recuperate after an illness and hospital stay.

Paatients experiencing homelessness are referred (by a case manager or social worker during hospital stay) to BACS' Respite program as an alternative to being discharged back to the street.

What We Do

- Nursing support and case management seven days a week including daily wellness checks, medication self- administration support, and care coordination
- Nursing Coordinators are available to Respite clients to provide access to primary care, housing support, assessment and referral case management services to link clients with community services
- BACS Respite provides Medical Care Management but, for the most part, not hands-on nursing care. Respite clients can have home health nursing, PT/OT and other visiting care providers if arranged for by the hospital prior to admission to Respite
- Three healthy meals per day
- Discharge planning to improve long-term health

Adeline Street Recuperative Care Program: Program Guidelines

What is the Adeline Street Recuperative Care Program?
Recuperative care generally provides: 1) an immediate placement option for persons who are homeless or marginally housed being discharged from an in-patient hospital or similar acute clinical setting, or street medicine setting but with acute medical condition and 2) shelter and care that prevents admission to emergency and acute care settings for people who are: 1) experiencing homelessness AND, 2) have an acute medical need with an identifiable end point (estimated at less than six weeks) [see page two for eligibility criteria].

The Adeline Street Recuperative Care Program is a medical recuperative care that will provide a safe place to recuperate, medical services, and behavioral health support. The facility is open 7 days a week, accepting patients from 8am until 3pm Monday through Friday. The program maintains 27 beds (3 first floor accessible beds and 24 beds on a second floor with no elevator). Staffing will include Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), case managers and medical providers. Although there is some staffing 24 hours a day, it is NOT a skilled nursing facility. The average length of stay is 45 days and is not to exceed 90 days. The Facility is equipped to support patients with the following conditions:

- Peripherally Inserted Central Catheter (PICC) Line (referring agency must arrange for weekend home health)
- Behavioral diagnoses with relative stability
- Oxygen and Continuous Positive Airway Pressure (CPAP) (if patient has equipment)
- Dialysis on case by case basis
- Stage 1 and 2 wounds

Up to 27 beds will be available to Alameda Health System (AHS). 0-5 beds may be used for people referred through Street Health Outreach teams. When either AHS or Street Health have not filled the beds, other referring agencies will have access to the beds.

Who can make a referral?
Referral sources approved by HCSA (e.g. AHS inpatient and emergency department, Street Health teams, TRUST clinic) will make prioritized referrals from clinical (not psychiatric inpatient) or street setting to LifeLong. AHS staff and LifeLong recuperative care staff will have weekly calls to discuss bed availability, intakes, and coordination. Referrals will be made through a mutually agreed upon system

What happens next?
Once the referral form is received, LifeLong staff will determine if the patient meets the recuperative care admission criteria. LifeLong will work with the referring agency to arrange an assessment while the patient is still at the hospital, which may be in-person. After approval of the patient is finalized, the referring agency will work with LifeLong to arrange a date and time for recuperative care admission.

Discharge to recuperative care?
Referring agency will:

1. Arrange for transportation for prospective patients to get to recuperative care directly (no stops). Late arrivals will not be accepted without previous notice from referral source.
2. Provide the patient with a minimum 10-day supply of prescribed pharmaceuticals etc. and a prescription for a minimum 30-day refill.
3. Provide the patient with assistive device for ambulation if prescribed by referring agency.
4. Complete and communicate equipment and supply orders for health needs (wound care, diabetes teaching, home health, etc.).

5. Have arranged for IHSS, Physical Therapist (PT), Occupational Therapist (OT), etc.
6. Have scheduled follow up primary care and specialist medical provider appointments as needed including any post-surgical appointments.

What is the eligibility Criteria?

- 18 or older
- Homeless (w/o options for housing)
- Alameda County resident
- if patient is eligible but not enrolled in Medi-Cal, referring agency must demonstrate that application is in process
- Alert and oriented to name, place, and situation
- Able to give consent (or have named consent giver identified)
- Able to complete all Activities of Daily Living (ADLs) independently (wheelchairs, and any other durable medical equipment (DME) devices may be accepted under conditions below):
    - Ability to use DME device safely, and understands proper use(i.e., transfers wheelchair to toilet)
    - Ability to use DME without any assistance (independently) no standby assist (SBA), no contact guard assist (CGA)
- If on oxygen or CPAP, patient must have equipment
- Be willing to see an LVN or Registered Nurse every day and comply with medical recommendations
- Have a condition with an identifiable end point of care for discharge

Exclusions

1. Patients at SNF level are not eligible for recuperative care **in lieu of SNF.**
2. Patients with acute care needs requiring daily physician oversight or 24-hour nursing support.
3. A patient with a sex offender registration requirement and residency restrictions that preclude them from living near schools, parks, etc. (meganslaw.ca.gov).
4. Patients unable to move and transfer without significant ongoing physical supports and assistance unless this level of assistance can be arranged prior to acceptance.
5. Patients conserved for medical decisions, unless they have a designated medical and/or medical decision maker identified.
6. Patients actively detoxing (i.e. alcohol, benzodiazepines). Patients will need to be stabilized prior to being referred.
7. Patients with private insurance.

CARDEA HEALTH

Fairmont Respite Referral Criteria

Background: Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs)
2. Coordination of transportation to post-discharge appointments
3. Connection to any other ongoing services an individual may require, including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment but who are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to Members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to Members on-site in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management Providers.

Eligibility
• Individuals who are at risk of hospitalization or are post-hospitalization
• Individuals who live alone with no formal supports; or
• Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.[13]

Substance Abuse Disorder	• Referrals cannot be in active substance use withdrawal. • Medication Assisted Treatment (MAT) can be supported at respite facility, including initiation of treatment.
Activities of Daily Living	• Referrals who require ADL support will be accepted if the Fairmont Medical Directors assess that ADL needs can be met by Fairmont

[13] For this population, the service could be coordinated with home modifications (which are covered as a separate ILOS) and serve as a temporary placement until the individual can safely return home.

<table>
<tr><td></td><td colspan="2">clinical staff and any community-based support available to them (IHSS, HCBA services, family caregivers). Generally, residents can be supported for toileting, transferring, and other ADL needs M-F 9a-5p. Referrals who require after-hours ADL support will be reviewed on a case-by-case basis. Every effort will be made to admit residents with ADL support needs if a care plan is in place.
• Referrals with urinary incontinence with care management plan in place are accepted.
• Residents must be able to travel independently to most appointments</td></tr>
<tr><td></td><td>Acceptable</td><td>Not Eligible</td></tr>
<tr><td></td><td>• Portable oxygen use
• Need for CPAP
• Bowel prep or pre surgical procedures
• Chemotherapy, radiation or other outpatient oncology treatment
• IV infusion: PICC line must be placed before admission
• Insulin dependent diabetics
• Wound care
• Wound VAC</td><td>• Need for isolation precautions (respiratory, contact or droplet)
• Severe cognitive impairment including dementia, sundowner syndrome
• Requirement of 24-hour monitoring or SNF level care</td></tr>
<tr><td>Cognitive Requirements</td><td colspan="2">• Alert and oriented without risk of wandering or other disorientation related safety risks</td></tr>
<tr><td>Medication management</td><td colspan="2">• Insulin Dependent Diabetics: referrals must be able to check blood sugar and administer insulin with minimal assistance
• Fairmont respite offers medication reconciliation, education and assistance with medication organization. Fairmont respite staff will conduct medication prompting for residents who require adherence coaching.
• Directly Observed Therapy: referrals requiring observed therapy of limited course of medication (HCV, LTBI, antibiotics) are acceptable.
• Residents who require assistance with medication management will be supported with medication prompting, med adherence coaching, and use of lockboxes (to remain in the resident's possession).
• Residents who are dependent for medication administration will be assessed on a case-by-case basis and accepted at the discretion of the medical directors if a care plan for medication administration is in place.</td></tr>
<tr><td>Behavioral Health Needs</td><td colspan="2">• Referrals expressing current or recent suicidal ideation must have psychiatric screening before admission
• Residents must be psychiatrically stable enough to accept and receive care and not interrupt the care of others</td></tr>
</table>

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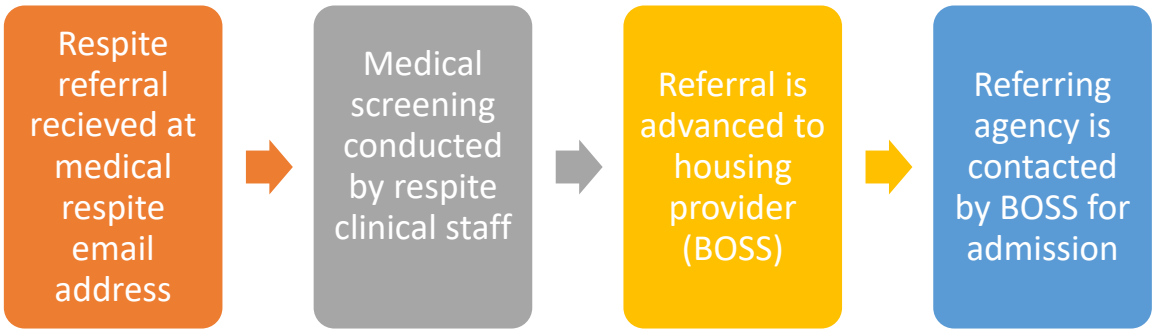
CARDEA HEALTH

Fairmont Respite Referral Criteria

Email completed referral forms to: Fairmontrespitereferral@acgov.org

Referrals are first screened for clinical appropriateness and then will advance to the Fairmont Respite Housing Provider for screening and arrangement of transportation and logistics.



Referring agencies will receive a same-day response if the referral is submitted by 12:00pm on a business day. Referrals submitted after 12:00pm will receive a response no later than the following business day.

Referring agencies:

- Street teams
  - Bay Area Community Health
  - Tiburcio Vasquez Health Center
  - Abode Services
- Hospitals
  - Eden Medical Center
  - St. Rose Hospital

Referrals can be submitted by partner agencies any time, but respite admissions are limited to Monday-Thursday 10am-4pm and Friday 10am-3pm.

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