NEW YORK STATE DEPARTMENT OF HEALTH
CERTIFIED MEDICAL RESPITE PROGRAM

Guidance on Referrals, Assessments, and Service Plans

The Department of Health (Department) adopted new regulations at **10 New York Codes, Rules and Regulations (NYCRR) Sections 1007.2, 1007.6,** and **1007.7** that define referral, assessment, and service planning standards for certified medical respite programs. This guidance document is intended to clarify and supplement the Department's regulations. **Each medical respite program must establish a referral, assessment, and service planning policy (or policies) that complies with the regulations and this guidance.**

ELIGIBILITY TO RECEIVE MEDICAL RESPITE SERVICES

To be eligible for medical respite, a potential recipient must meet all criteria identified in 10 NYCRR §1007.2 and §1007.7 and clarified in items 1 through 9, below.

1. **The individual is age 18 or older** (unless the medical respite program has received a waiver from the Department, pursuant to 10 NYCRR §1007.2(g)(3)(i) and §1007.7(a)(1)).
2. **The individual is experiencing homelessness or is at imminent risk of homelessness**, as defined by the Department of Housing and Urban Development (HUD) and summarized in Table 1.
3. **The individual has one or more qualifying health conditions that require treatment or care.**
    - A *qualifying condition* is a medical or behavioral health condition for which an individual requires temporary rest, recuperation, and/or access to medical care or other supportive services that will aid in the individual's recuperation. A qualifying condition is likely to worsen if the individual remains in, or returns to, the street or a congregate shelter setting.
    - Medical respite care may be considered clinically appropriate in circumstances including, but not limited to:
        - *Post-hospitalization*, such as following inpatient hospitalization, inpatient psychiatric hospitalization, or emergency department utilization (once the individual can be safely discharged).
            - For example: An individual may require wound dressing, ostomy care, intravenous therapy, monitoring and adjustment of medications (including medications for behavioral health or substance use disorder treatment), or physical or occupational therapy, among other types of care.
        - *Pre-procedure*, such as before a planned surgery, medical procedure, or medical treatment. Pre-procedure care is primarily designed to support individuals who

have been directed by a medical professional to follow a specific protocol in preparation for surgery or another medical procedure.

- For example: An individual may need to follow an antiseptic bathing protocol prior to surgery or may require a specialized diet or administration of medications that cannot be safely stored or consistently provided on the street or in a congregate shelter setting; or the individual may be immunocompromised and require medical respite to reduce exposure to harmful pathogens prior to treatment or surgery (such as cancer treatment or organ transplant).

4. **The individual does not require the level of care provided in a skilled nursing facility, residential drug treatment program, psychiatric inpatient program, or in a hospital inpatient, observation unit, or emergency room setting.**

5. **The individual can perform activities of daily living (ADLs) with no or minimal assistance.**
   - To meet this criterion, the individual must need no more than minimal assistance with up to three ADLs.
     - ADLs include, but are not limited to, bathing, dressing, maintaining personal hygiene (including teeth, nails, and hair), toileting, eating, and transferring.
     - *Minimal assistance* means that the individual can participate to some degree in completing the ADL while a helper performs the remainder of the activity.
   - Individuals who cannot perform ADLs with only minimal assistance may still be eligible for medical respite care **if:**
     - A licensed provider has ordered the individual personal care services in an amount and duration that will allow the individual to safely reside in the medical respite program; **and**
     - The medical respite program evaluates a potential arrangement of this kind and finds that the arrangement meets an acceptable safety standard.

6. **The individual is self-directing.**
   - *Self-directing* means the individual:
     - Is capable of making choices about the individual's ADLs and medication administration, understanding the impact of the choices, and assuming responsibility for the results of the choices; **or**
     - The individual receives supervision or direction on an interim or part-time basis as part of a plan of care in which a self-directing individual or entity (such as a local social services department, an outside agency, or other formal organization) assumes responsibility for making choices about the individual's ADLs; **and**

- There is a plan in place to ensure the recipient will have adequate assistance with medication administration.
    - For example: A self-directing representative or guardian has agreed to assist the recipient with medication administration, or the individual has a valid order to receive home health services during their stay in medical respite.

7. **The individual is able to, with direction or assistance, take sufficient action to ensure self-preservation in an emergency.**
    - Medical respite programs are required to provide reasonable accommodations to individuals with disabilities. Reasonable accommodations may include providing additional assistance to evacuate a medical respite recipient in the event of an emergency.
    - Individuals who meet all other medical respite program eligibility criteria but may require additional assistance in an emergency to evacuate should still be determined eligible for the medical respite program as long as the program can provide the appropriate assistance to the recipient and any other recipients who need such assistance in the event of an emergency.

8. **The individual does not pose an imminent risk of safety to themself, medical respite program staff, or other recipients of medical respite services.**

9. **For individuals in medical respite programs affiliated with the New York State Office of Mental Health (OMH) or Office of People with Developmental Disabilities (OPWDD), any other guidance provided by OMH or OPWDD will *also* apply.**
    - *Affiliated with* means the medical respite program is run by a facility licensed by OMH or OPWDD.

PAYOR FOR MEDICAL RESPITE SERVICES

Certified medical respite programs may fund services for recipients with internal resources and/or with resources contributed by one or more of the following payors:

- Hospital system;
- Local government;
- Charitable foundation;
- Community-based organization (CBO);
- Managed care organization (MCO); and/or
- Regional Social Care Network (SCN), using Medicaid 1115 demonstration waiver funds.
    - Recipients must meet additional criteria to qualify for medical respite services funded through the Medicaid 1115 demonstration waiver.

- For more information, see the Department's *Preliminary Guidance on Medicaid Waiver-Funded Services*.

If an individual is nearing coverage limits set by the payor but still has a qualifying medical condition that would benefit from medical respite services, the medical respite program may use funds from another payor to extend the recipient's stay.

REFERRAL TO MEDICAL RESPITE SERVICES

Role of the Referring Provider

Any of the following may act as the referring provider:

- Managed care organization;
- Primary care provider;
- Other licensed provider;
- Hospital system;
- Skilled nursing facility;
- Homeless shelter;
- Community-based organization; or
- Social Care Network.

The referring provider has primary responsibility for ensuring the completeness of the referral and should be available to consult with the medical respite program regarding the referred individual. The referring provider must also comply with any additional state regulations and/or guidelines specific to their facility type. For example:

- *Hospitals* must gather information upon admission "to assist in identifying those patients who may require post-hospital care planning" and must arrange for assessments by "health professionals whose services are appropriate to the needs of the patient to determine the patient's post-hospital care needs." (See 10 NYCRR §405.9(h)(3)(iii), (h)(3)(v))
- *Diagnostic and Treatment Centers* must provide for "referral to a health care facility or health care practitioner for service(s) not available at the center"—such as medical respite services—and must arrange for "the prompt transfer of a copy of the pertinent parts of the medical record and other information, with the patient's written consent, when the patient is referred." (See 10 NYCRR §751.5(a)(6), (a)(7))
- *Nursing Homes* must provide information on transition programs that may be available to support the resident in their return to the community (See 10 NYCRR 415.3(c)), which could include medical respite program services.

Referral Requirements

The specific referral pathway will vary depending on the referring provider, the medical respite program, and the payor. For example, a referring provider could refer an individual for medical respite services by contacting a medical respite program directly or by contacting an intermediary approved by the Department (such as a hospital system, managed care organization, health home, or Social Care Network) that then facilitates the individual's referral to an appropriate medical respite program. In all cases, the referring provider must transmit the referral and any supporting documentation in a manner that maintains the privacy and security of the information. **The referral must include all of the following:**

- **Basic demographic and identifying information**, such as:
    - Name;
    - Date of birth;
    - Social security number (if available);
    - Copies of any available government-issued documentation (such as driver's license, non-driver identification, or immigration papers); and
    - Health coverage status (including a copy of any pending application for coverage, if applicable).
- **Medical orders** for items that the individual will need for recuperation, such as:
    - 30-day supply of medication(s), either by submitting prescription(s) to a pharmacy or arranging to transfer the medication(s) with the individual;
    - Orders for personal care services (if applicable);
    - Orders for home health care services (if applicable); and
    - Durable medical equipment or other supplies.
- **Medical records** that address:
    - The individual's diagnosis;
    - Pertinent medical history;
    - Results of diagnostic tests or screenings; and
    - Current or recommended interventions, including post-acute care and medications.
- **Assessment of individual's eligibility to receive medical respite services** (items 1 through 9, on pages 1 through 3 of this guidance). The results of the assessment may be communicated in the form of medical records and/or narrative explanations, and/or a referral form and must include all of the following:
    - Information to support the provider's conclusion that the individual is experiencing homelessness or at risk of homelessness, including the individual's current living situation or situation prior to being admitted to a facility;

- Description of the individual's physical limitations, if applicable, and any reasonable accommodations that may be required of the medical respite program;
- Confirmation that the individual can perform ADLs with no or minimal assistance *or* provision of a physician order for personal care services;
- Confirmation that the individual is self-directing *or* confirmation that 1) the individual receives at least part-time supervision from a self-directing individual or entity that is responsible for making decisions related to the individual's ADLs *and* 2) there is a plan in place to ensure the recipient will have adequate assistance with medication administration during their stay in medical respite.
- Confirmation that the individual is not, at the time of referral, a threat of harm to themself or others.

MEDICAL RESPITE PROGRAM ELIGIBILITY ASSESSMENT

Before admitting a recipient, the medical respite program must conduct, or arrange for, an assessment of the individual's general eligibility for medical respite services *and* the individual's appropriateness for the specific medical respite program. The purpose of the assessment is to ensure all of the following:

- The individual is willing to be admitted to the medical respite program;
- The individual is eligible to receive medical respite services (items 1 through 9, on pages 1 through 3 of this guidance);
- The individual's clinical, behavioral, substance use disorder, and social needs do not exceed the medical respite program's capabilities, including potential needs for:
  - A reasonable accommodation, *and/or*
  - Infection control measures if the individual has a communicable disease that is subject to federal, state, or local quarantine or isolation requirements; and
- The medical respite program has a bed available for the anticipated length of the individual's admission.

The medical respite program must complete the assessment within **2 business days** of receiving a complete referral and all necessary supporting documentation. If desired, the medical respite program may *begin* the assessment before receiving a complete referral and/or all necessary supporting documentation. The assessment may be conducted at the potential recipient's current location, including in the inpatient setting.

The assessment must be conducted by an appropriately qualified employee or contractor of the medical respite program, as defined in the Department's *Guidance on Staffing, Qualifications, and Training*, and must include, as appropriate, consultation with the referring provider and review of the medical records and any other documentation received from the referring provider. **The assessment must address all of the following:**

- **Medical history and clinical needs**, including:
    - Current diagnoses and overall physical, behavioral, and substance use disorder health status;
    - Medications and medication history for the past two years, if known;
    - Expected care needs in the medical respite program including but not limited to follow-up care identified or ordered by the referring provider;
    - Infectious disease risk, including immunization history;
    - History of substance use disorder;
    - History of mental health condition; and
    - Any advance directives.
- **Psychosocial evaluation**, including;
    - Willingness and ability to comply with the medical respite program rules;
    - Willingness and ability to share space as required in the medical respite program (such as shared sleeping area, shared bathroom);
    - Ability to self-direct, and/or availability of a representative to provide direction;
    - Ability to self-administer medications and/or availability of resources to assist with medication administration; and
    - Risk of harm to self or others.
- **Physical status**, including:
    - Mobility and ability to perform ADLs with no or minimal assistance or with provision of home health services;
    - Wheelchair use or other physical disability and need for an Americans with Disabilities Act (ADA) accessible medical respite program or other reasonable accommodation; and
    - Risk factors that may require special attention from the medical respite program (such as fall risk or assistance required to evacuate in the event of an emergency).
- **Housing status and housing history**, including:
    - Potential options for discharge from the medical respite program, which may include transfer to a shelter if the individual does not qualify for supportive housing or other housing programs; and
    - Current or pending housing applications, if any.

- **Access to income or social benefits*,** including documentation or pending applications for:
    - Sources of income;
    - Health coverage;
    - Nutrition assistance; and
    - Housing supports.

  *This information should *not* be considered as a factor in determining eligibility; rather, the referring provider must include this information, if available, so the medical respite program can avoid duplicating efforts already made on the individual's behalf.

ADMISSION

The medical respite program's manager or administrator will review the assessment and determine whether an individual is appropriate for placement in their medical respite program and communicate their determination to the referring provider and the payor.

The payor will approve or deny the medical respite services and communicate its determination to the referring provider, the medical respite program, and the individual. The payor must communicate its determination both verbally (via telephone or another timely means) and in writing.

- **If the payor approves the medical respite placement but the medical respite program that conducted the assessment *cannot* accept the individual** due to capacity, staff, or other limitations, the individual's referral should be provided to other medical respite programs in the area for potential admission. The referring provider has primary responsibility for contacting other medical respite programs about their availability and capability to accept the individual for medical respite services.
- **If the payor approves the medical respite program services and the medical respite program *can* accept the individual**, the admission of the individual is contingent upon the individual or their authorized representative reviewing and signing the medical respite program admission agreement.

The admission agreement must include, at a minimum, all elements described in 10 NYCRR §1007.7(b):

- The effective date of the agreement;
- Any rules of the program related to hours of open operation and visitation;
- That the medical respite program must discharge the recipient at such time as the recipient no longer qualifies for medical respite services;
- The discharge planning process, which must be consistent with the requirements set by the Department;

- That, under certain circumstances, the medical respite program is permitted to discharge the recipient immediately, and a description of such circumstances;
- That the recipient's waiver of any provision of the admission agreement is null and void;
- The recipient's right to terminate the admission agreement and vacate the medical respite program at any time; and
- Any other provision specified by the Department, including:
    - The recipient's obligation to comply with the medical respite program's rules and procedures concerning medication storage and handling.

MEDICAL RESPITE SERVICE PLAN

The medical respite program must designate a qualified person or persons to develop a plan that identifies the services the medical respite program will provide for the recipient, either directly or through coordination with other service providers. The service plan must be developed within **72 hours** of the recipient's admission.

The service plan must be developed with the following individuals and entities, as applicable:

- Recipient;
- Recipient's primary care physician or any specialty physician who has been overseeing care for the recipient's health condition or who has been designated as the recipient's follow-up provider after a hospital discharge;
- Referring provider;
- Managed care organization;
- Health home; and
- Social Care Network.

The service plan must address, at a minimum, all of the following:

Clinical needs, including:

- Schedule for wellness checks; at a minimum, checks must occur once per day.
- Nature of wellness checks; at a minimum, checks must confirm that:
    - Recipient is responsive;
    - Recipient is eating, drinking, sleeping;
    - Recipient does not express unexpected physical or emotional discomfort given their clinical conditions;
    - Recipient is participating in medical respite program or community activities as appropriate given their clinical condition; and
    - Recipient is able to manage physical and mental health and personal stress.

- Other clinical needs as applicable to the recipient, such as:
    - Dietary restrictions;
    - Medication (including any arrangements related to medication administration);
    - Monitoring/documentation of body weight;
    - Substance-use related treatment;
    - Physical or occupational therapy;
    - Paraprofessional services;
    - Skilled nursing services;
    - Physician services;
    - Dental services; and
    - Hospital or palliative care.

Social service needs, including:

- Applying for and securing housing, including any necessary coordination with local departments of social services;
- Applying for and securing other public benefits, such as SNAP and WIC;
- Coordinating with other social service providers for specific needs, such as legal services; and
- Obtaining government-issued identification.

Behavioral and interpersonal needs, including:

- Facilitation of family and caregiver interactions;
- Supportive counseling; and
- Mental health therapy (such as cognitive behavioral therapy).

Care coordination needs, including:

- Liaising with the entities involved in the individual's care management (such as managed care organization, health home, Social Care Network);
- Facilitating access to services, including arranging, as appropriate, for:
    - Transportation to offsite medical and social service appointments;
    - Telehealth services (with the recipient's consent);
    - On-site services by licensed or otherwise qualified providers;
- Preventing duplication of services; and
- Other care coordination activities as described in the Department's *Guidance on Services*.

Recipient's goals and preferences, including:

- Incorporating the recipient's goals into the service plan, even if the recipient's goals do not align with the medical respite program's goals; and
- Prioritizing the recipient's goals and preferences according to the recipient's wishes.

Medical respite discharge plan, including:

- Indicators in the service plan that need to be achieved to discharge the recipient; and
- Anticipated discharge disposition (for example, discharge to supportive housing, family reunification, shelter, etc.).

The service plan must be reviewed regularly to evaluate the recipient's progress and achievement of any goals and/or indicators to determine whether modifications to the service plan are needed and to facilitate timely achievement of discharge indicators. The service plan must be formally reviewed **at least every 14 days**, or more often, if necessary.

SPECIAL CONSIDERATIONS FOR BRIEF STAYS

The medical respite program should make every effort to connect the recipient to services and identify appropriate and stable housing over the course of the recipient's stay in medical respite. However, this may not be possible if a recipient is admitted to medical respite for only a *brief stay* of **7 days or less**. In those circumstances, the medical respite program may adjust the scope of the service plan to include only those service goals and discharge indicators that could reasonably be achieved during the recipient's stay. The medical respite program should develop the service plan as soon as possible (but always **within 72 hours** of the recipient's admission) and should review the service plan at appropriate intervals (whenever necessary or **at least every 14 days**) to ensure the recipient is prepared for discharge.

Table 1. Department of Housing and Urban Development (HUD) Definition of Homeless*

Category 1	Literally Homeless	**1.** Individual who lacks a fixed, regular, and adequate nighttime residence, meaning: • Has a primary nighttime residence that is a public or private place not meant for human habitation; • Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, and local government programs); or • Is exiting an institution where they have resided for 90 days or less and they resided in an emergency shelter or place not meant for human habitation immediately before entering the shelter.
Category 2	Imminent Risk of Homelessness	**2.** Individual who will imminently lose their primary nighttime residence provided that: • Residence will be lost within 14 days of the date of application for homeless assistance; • No subsequent residence has been identified; and • The individual lacks the resources or support networks needed to obtain other permanent housing.
Category 3	Homeless Under Other Federal Statutes	**3.** Unaccompanied youth under 25 years of age who do not otherwise qualify as homeless under this definition, but who: • Are defined as homeless under the other listed federal statutes; • Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; • Have experienced persistent instability as measured by two moves or more during the preceding 60 days; and • Can be expected to continue in such status for an extended period of time due to special needs or barriers.
Category 4	Fleeing/Attempting to Flee Domestic Violence	**4.** Any individual who: • Is fleeing, or is attempting to flee, domestic violence; • Has no other residence; and • Lacks the resources or support networks to obtain other permanent housing.

**Adapted from a resource developed by HUD Exchange*