COVID-19 Medical Respite Center Referral Protocol

Who can make the referral?

Emergency Rooms, Inpatient Units, and local clinics staff, local public health, Dane County jail staff, Department of Correction's staff, and homeless service providers

Who is eligible?

Patients **recommended to isolate for suspected or confirmed COVID-19 AND identified as homeless**, meaning the discharge destination will be an emergency shelter, the street, or other places not meant for human habitation. Individuals and families who are doubled up or in other unstable housing situations must be diverted from the Medical Respite Center whenever possible, as hotel units are limited. Patient should have a positive COVID19 test or a pending test and meet all clinical requirements specified in the Referral Form.

Referral Protocol

1. **Obtain consent from the patient to share information with Focus Counseling, Dane County Human Services, and Public Health Madison & Dane County.**
   Focus Counseling, Inc., in partnership with Dane County, will initially authorize the stay at the Medical Respite Center. The duration of stay will be determined based on the test results and medical recommendations by Public Health of Madison & Dane County. Therefore, the patient must agree to let the healthcare provider share necessary medical information with Focus Counseling, Dane County Human Services, and Public Health Madison & Dane County.

2. **Review the entire *Medical Respite Center Participant Agreement Form* with the patient and ask to sign.**

3. **Send the *Medical Respite Center Referral Form* and signed *Participant Agreement Form* to Focus Counseling with a subject line "Medical Respite Center Referral".**

   - Email: info@focuscounselingwi.com (via encrypted email when possible) *or*
   - Fax: 608-285-5215

4. **For patients admitted to the hospital, a discharge planner must contact the public health nurse on call prior to referring a patient to the Medical Respite Center. The on-call number is: 243-0322 and that line is answered 7am-7pm, 7 days a week.**

5. **Call to alert the Focus staff on call about the referral.** If approved, Focus Counseling staff will contact the hotel, arrange for a room, and then relay the hotel information to the referring staff. Staff will strive to respond with details within 30 minutes. **If you do not hear back within 30 minutes, call again.**

   - Call Focus Counseling 24 hours a day at: 608-618-0216
   - Emergency contact: John Dillon, Focus Counseling MRC Supervisor (608-416-0976)

6. **Arrange transportation to the hotel for the patient.** Provide a mask and ensure the patient washes their hands for the ride. The patient should be transported directly to the designated hotel from the hospital or shelter.

Public Health
MADISON & DANE COUNTY
Healthy people. Healthy places.

COVID-19 Medical Respite Center Referral Form

DANE COUNTY
DEPARTMENT OF HUMAN SERVICES

Send To: Focus Counseling (Subject: Medical Respite Center)

- Email: info@focuscounselingwi.com or
- Fax: 608-285-5215

And Call: Focus Counseling

- Phone: 608-618-0216 (24 hours a day)

Note: Self referrals are not allowed

Referred Patient Name: _____ DOB: _____

Patient contact phone or email:_____

Referring Provider Hospitals/Clinic: _____

Staff: _____

Call back phone: _____

PATIENT MUST HAVE POSITIVE COVID-19 TEST RESULT OR PENDING COVID-19 TEST

Date tested: _____

If not tested, reason to be considered:_____

Clinical requirements for discharge to the COVID MRC (All boxes must be checked):

☐ Alert and oriented ☐ Independent in ADLs ☐ Independent in mobility ☐ Continent of urine and feces -No bedside urinal	☐ Has not received benzodiazepine for alcohol withdrawal in past 24 hours ☐ Independently taking medications and using any medical equipment ☐ Does not require the use of an oxygen tank/cylinder of any size, containing liquid or compressed oxygen

Food allergies: _____

Needs interpreter? ☐ Yes ☐ No If yes, what language: _____

Other special needs: _____

The patient listed above was examined for the symptoms requiring isolation. I have reviewed the Participant Agreement with the patient and obtained consent from patient to share information with Focus Counseling, Dane County Human Services, Public Health Madison & Dane County.

Referring Provider Signature: _____ **Date:** _____

Print Provider Name: _____

COVID-19 Medical Respite Center Participant Agreement

Welcome! You are being offered a medical respite center hotel voucher to help you rest and recover while awaiting Coronavirus (COVID-19) test results or recovering from COVID-19. Your stay will be at **one of the following** locations:

The referring staff will confirm the location:

Quality Inn
Address: 1754 Thierer Rd.
Madison, WI 53704
Phone: (608) 640-4660

(OR)

Days Inn
Address: 4402 East Broadway Service Rd.
Madison, WI 53716
Phone: (608) 620-0107

Public Health Madison & Dane County will determine when you are medically cleared. You will be informed of your discharge date by onsite staff. Discharge will occur when: you complete the isolation or quarantine requirements OR it is determined you do not have COVID19. **I understand that I have the following responsibilities as a participant of the Medical Respite Center:**

☐ I am expected to practice self-isolation while using a COVID-19 Hotel Voucher, including:

- Maintaining a distance of 6 feet or more from other people
- Refraining from having any visitors
- Refraining from congregating in public spaces
- Engaging in regular and thorough hand-washing
- Wearing a mask if out of my room or healthcare staff are in my room
- Remaining in my room except for essential trips, including smoke breaks.

☐ The following **consequences** will occur if I do not adhere to the shelter-in-place order:

- If I am seen leaving the room (for non-essential trips), allowing a visitor in my room, or not maintaining social distance, I will receive a verbal warning. Any visitors will be asked to leave.
- If this happens again, I will receive a written warning that I have violated the order and staff will attempt to resolve the issue.
- If there is a third infraction, I may be required to leave.

☐ I understand that the following behaviors will result in **immediate discharge**: verbal or physical violence or threats of violence, destruction of property, possession of weapons (including knives over 2 inches), theft, selling drugs on the hotel premises, and harassment of any kind (including sexual harassment). I understand that any behavior that endangers the health or safety of guests or staff including behaviors not listed above and repeated interference with the rights of other guests to peaceful enjoyment of the facility will not be tolerated and result in being asked to leave the hotel.

☐ **Meals** will be delivered to my room at 9:00 AM, 12:00 PM, and 6:00 PM. I understand that I need to be in my room during meal times to receive the food and not leave it in the hallways.

☐ I understand that nurses may visit me as much as twice per day to complete **clinical assessments**. I will also receive calls from Focus Counseling staff to assist with non-clinical needs like clothing, substance abuse support, and mental wellness support.

☐ For fire safety reasons, **smoking** is not allowed inside the hotel or near hotel entrances. Participants are able to smoke at a designated area 15 feet away from the main entrance of the building. Please dispose of smoking materials properly.

☐ I understand that with an oxygen concentrator, there is a zero-tolerance policy for smoking, and I will be immediately discharged if I smoke in my room. I am trained in the safe use of an oxygen concentrator and am responsible for independently managing the medical device, including reaching out to my medical equipment provider if I have concerns about the function of my device.

☐ It is my responsibility to store my **medications** securely in my room. I will speak with staff if I am uncertain about how to do this.

☐ I understand that staff will supply small, bagged "**comfort kits**" containing acetaminophen for headache and high fever, cough drops, gloves, and personal use items. I acknowledge that these items are to be used at my discretion and I should ask questions about the use of any items in the bag if I am unsure. I understand that I can decline a comfort kit.

☐ I understand that **red boxes** will be placed in my room to use for safe disposal of needles and other IV-drug paraphernalia. If I need to keep the red box after my stay at the hotel, I will let on-site staff or Focus Counseling know so that the box can be replaced. I WILL NOT try to open or destroy the red box under any circumstances. New needles can be provided to me through needle exchange if needed.

☐ The staff and volunteers of Focus Counseling and the hotel are not responsible for any of **my items or belongings that are lost, stolen, or damaged**. I have been advised not to keep valuable items or large amounts of money with me at the hotel.

☐ I agree not to move or remove **furniture** from my room. I also agree not to bring furniture or other larger items into my room.

☐ Hotel staff will not be cleaning my room during my stay and it is my responsibility to place my bedding and towels in a plastic bag outside my door for cleaning, and alert the front desk that I need new linens. I will receive clean linens, and I will be responsible for making my bed, cleaning surfaces, and maintaining cleanliness of my room otherwise. I agree to refrain from collecting items. I agree to return all bed linens, pillows, and towels to hotel staff and to **leave my room clean** when I exit the hotel.

☐ If I leave the premises for **more than 72 hours**, I will be discharged from the hotel and my room will be provided to another guest.

☐ I understand that any **personal belongings** I leave behind will be stored for 7 days, then discarded.

☐ If I leave premises and I am deemed still **contagious**, shelters will be notified and I will not be allowed into any shelter setting until I am medically cleared.

☐ If staff are aware that I am facing a **medical emergency**, staff will call 911 to access medical assistance for me at my expense. I understand that staff will share the "emergency information" I provided at intake with the responding emergency personnel. This includes paramedics, fire responders, law enforcement, and any other emergency personnel.

☐ I consent to staff contacting the **emergency contact** I provided at intake. I may revoke this authorization at any time by communicating with Focus Counseling or nursing staff.

☐ In the event of an emergency, I should walk calmly to an exit, staying at least 6 feet away from all other residents, and **evacuate** the building as quickly as possible. In case of fire, use the clearly marked designated fire exits. Once everyone has reached the assembly site, everyone must report to staff so they can verify that all residents are accounted for.

☐ If I have **any needs or questions** during my stay, I will reach out to the front desk and program staff.

Serious threats or acts of violence will also lead to not being allowed to return to the Medical Respite Center in the future.

I have carefully read and fully understand all the provisions of this form. I am freely, knowingly, and voluntarily signing this form. I hereby release the facility, its employees, volunteers, and officers, as well as any of their assigns or designees on behalf of myself, my family, my estate, and anyone else affiliated or associated with me or representing me, from all liability arising as a result of my stay in the medical respite facility to the fullest extent permitted by law.

Participant Signature: _____ **Date:** _____