NATIONAL INSTITUTE for MEDICAL RESPITE CARE

Addressing Chronic Conditions in Medical Respite/ Recuperative Care

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Courtney Pladsen, DNP, FNP-BC

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

The National Institute for Medical Respite Care is a special initiative of the National Health Care for the Homeless Council.

Objectives

At the conclusion of this webinar . . .

1. Participants will be able to identify common chronic conditions in people experiencing homelessness.
2. Participants will be able to identify the impact of homelessness on chronic health conditions.
3. Participants will be able to identify the potential role of medical respite/recuperative care in chronic condition management.
4. Participants will be able to identify strategies to address chronic conditions within the medical respite setting.

What are Chronic Conditions?

Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.

(CDC, 2021)

Chronic Conditions

Diabetes

- is a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine.

Chronic Obstructive Pulmonary Disease (COPD)

- is a chronic, progressive inflammatory lung disease that causes obstructed airflow from the lungs, characterized by breathing difficulty and wheezing, among others.

Heart disease

- is a disease that affects the heart. Coronary artery disease (CAD) is the most common form of heart disease.

Human Immunodeficiency Virus (HIV)

- is a virus that attacks the body's immune system.

Cancer

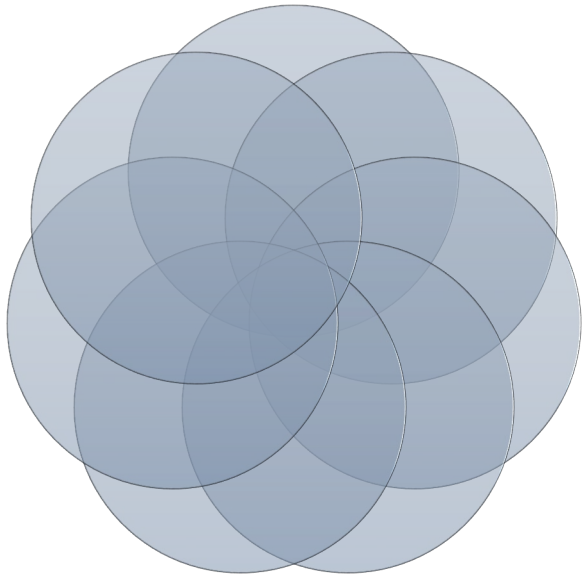
- is a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body.

Causes of Chronic Conditions: Medical

Poor nutrition

Occupational hazards

Smoking



Lack of physical activity

Family Hx

Alcohol use

Environmental exposure

(https://www.cdc.gov/chronicdisease/about/index.htm)

Exacerbations of Chronic Conditions: Situational

- Lack of access to adequate nutrition and diets
- Lack of access to medication and supplies
- Lack of ability to store medication and supplies
- Lack of access to culturally appropriate care
- Lack of transportation
- Lack of consistent place to sleep
- Lack of access to shower
- Lack of access to laundry services

Limitations in Addressing Chronic Conditions: Medication

Medications causing changes in urinary frequency and retention

- Antidepressants
- Antipsychotics
- Diuretics
- Sleeping medications
- Blood pressure medications/Alpha blockers
- Opiates

Medications causing constipation/ diarrhea

- Opiates
- Methadone
- Metformin
- Antibiotics

Cost

- Being uninsured/underinsured

Complications in regimens

- The more medications the less likely someone is to take them
- Without a consistent place to store medications they often get stolen, wet, mixed up, etc.

Impact of Chronic Conditions: Physical

Impaired mobility

- Many conditions from stroke to arthritis can cause significant gait disturbance

Neuropathy

- Decreased sensation – loss of fine motor control
- Increased risk for wounds

Shortness of breath

- Decreased exertional capacity

Chronic pain

- More likely to go untreated or undertreated in this population
- Potential source of SUD due to self medicating

Cognitive impairment

- Decreased functional capacity

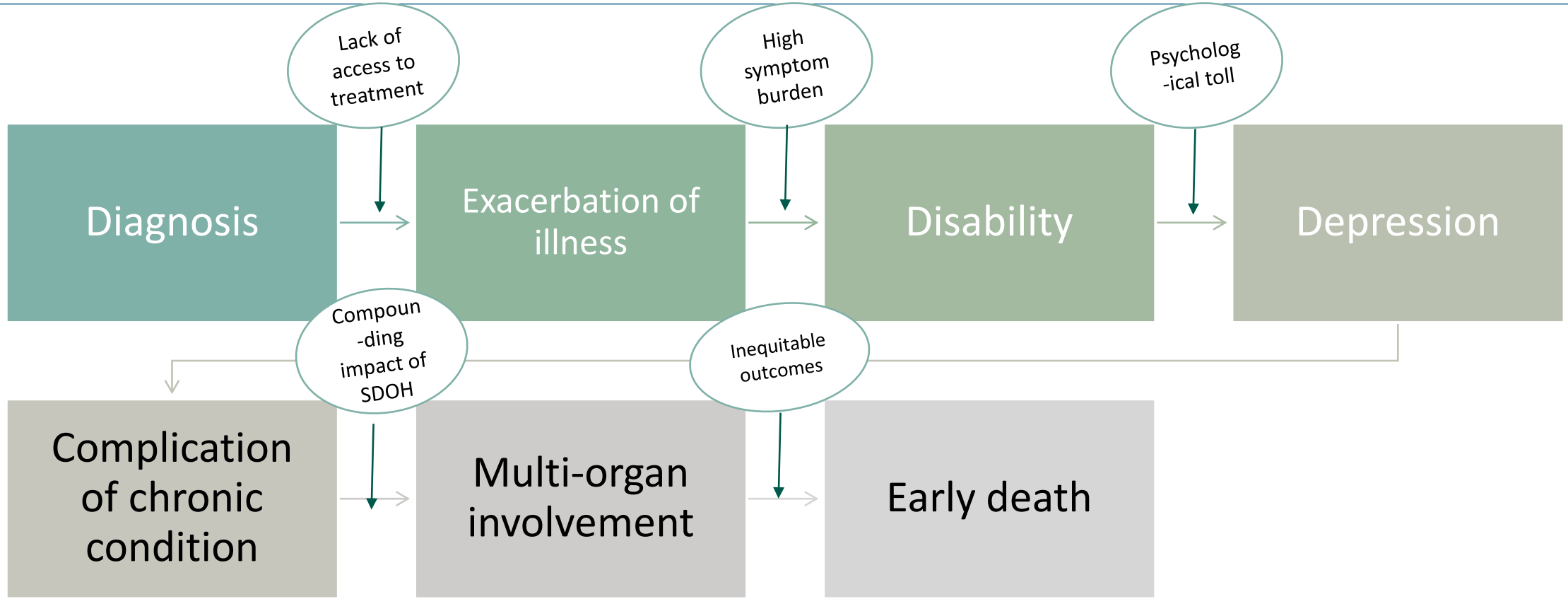
(. . .)

Impact of Chronic Conditions: Psychological

- Higher rates of depression and illness-related anxiety and stress
- Sense of hopelessness
- Exacerbates social isolation
- The chronic condition may alter their appearance contributing to impaired sense of self

(https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/#pub8)

Long-term Impact of Chronic Conditions for PEH



Acute Issues of Chronic Disease

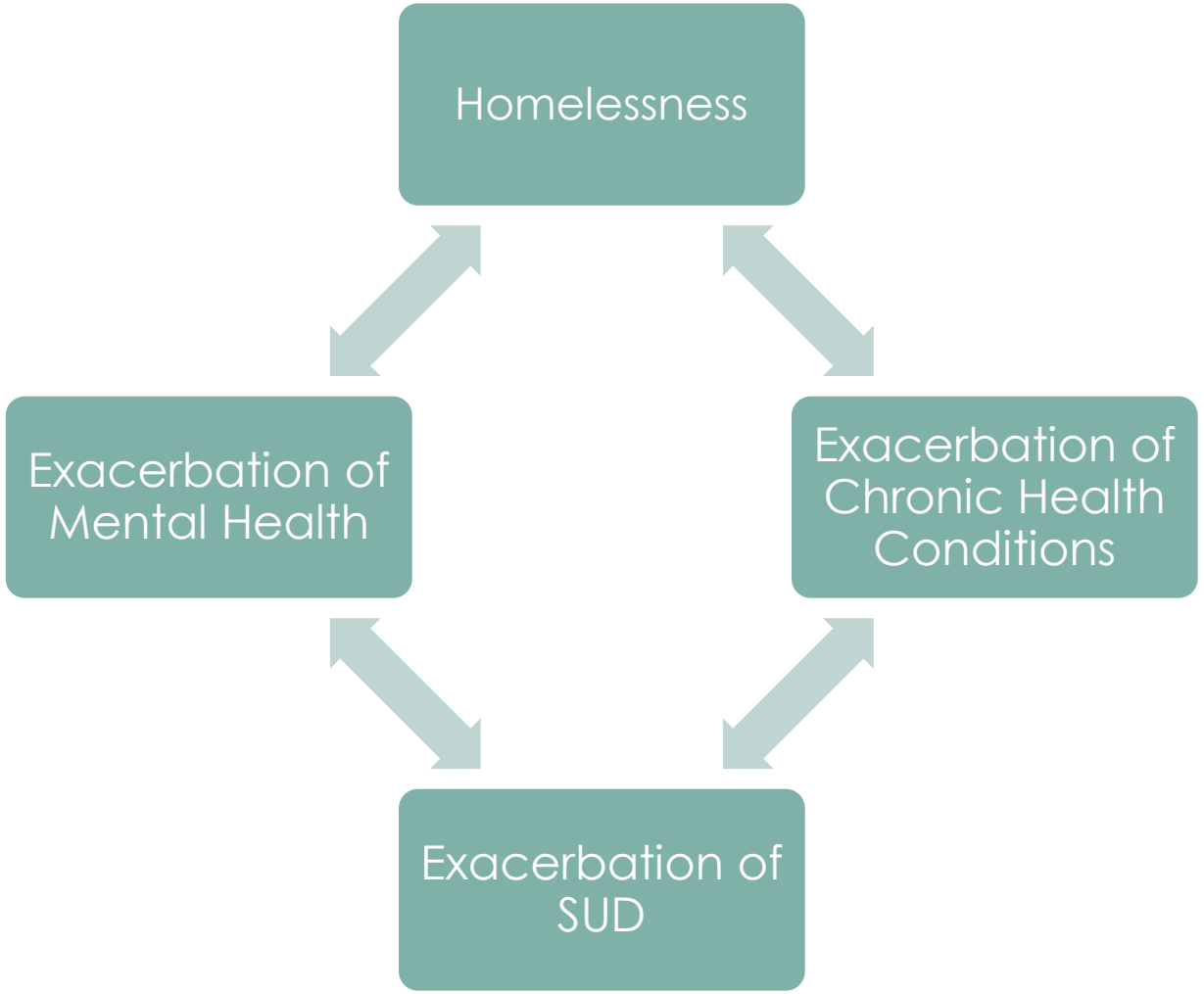
- Focused on stabilization of acute process
- Stop or decrease immediate suffering
- Examples:
  - Hyperglycemia
  - Pneumonia in a COPD patient
  - CHF exacerbation
  - CD4 count <20

VS.

Chronic Disease Management

- Identify patient's goals
- Mitigating symptom management
- Long term goal setting and habit formation to prevent end organ damage

Impact of Homelessness on Chronic Conditions



Impact of Homelessness on Chronic Conditions

Health Conditions Among the Homeless Population in Comparison to the General US Population

HOMELESS ← VERSUS → HOUSED

HOMELESS		HOUSED
18%	Diabetes	9%
50%	Hypertension	29%
35%	Heart Attack	17%
20%	HIV	1%
36%	Hepatitis C	1%
49%	Depression	8%
58%	Substance Use Disorders	16%

(National Health Care for the Homeless Council, 2019)

Impact of Homelessness on Chronic Conditions

FIGURE 2. Physical health conditions, mental health conditions, substance abuse-related loss of housing for sheltered and unsheltered adults[8]

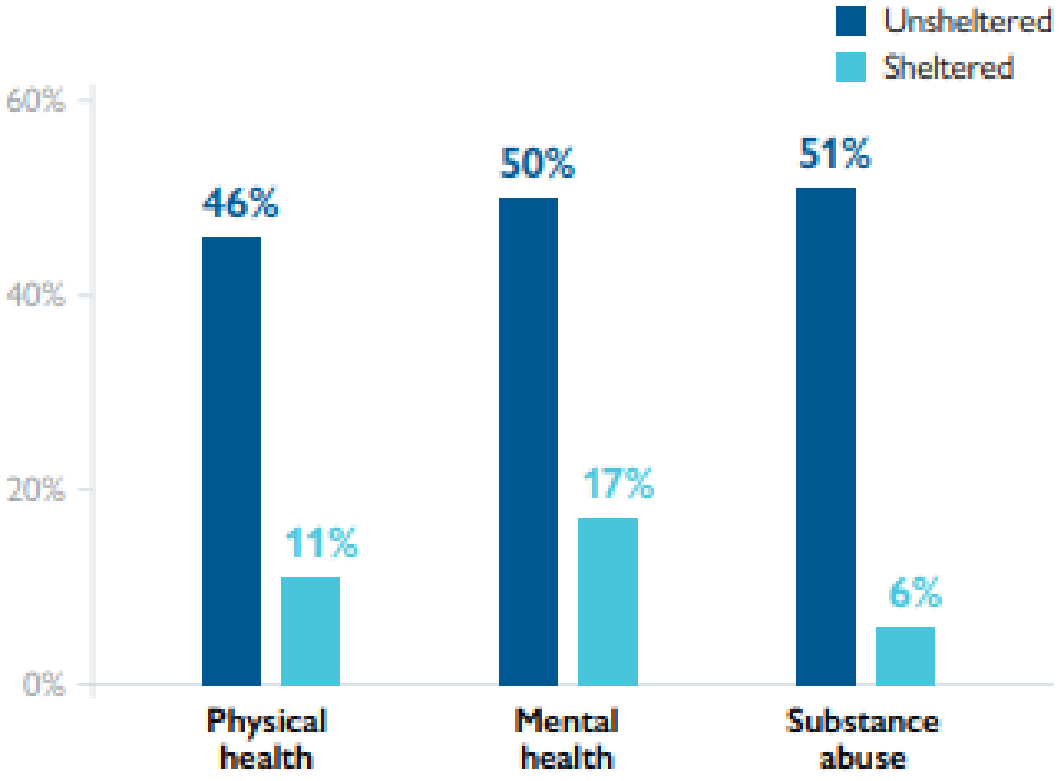
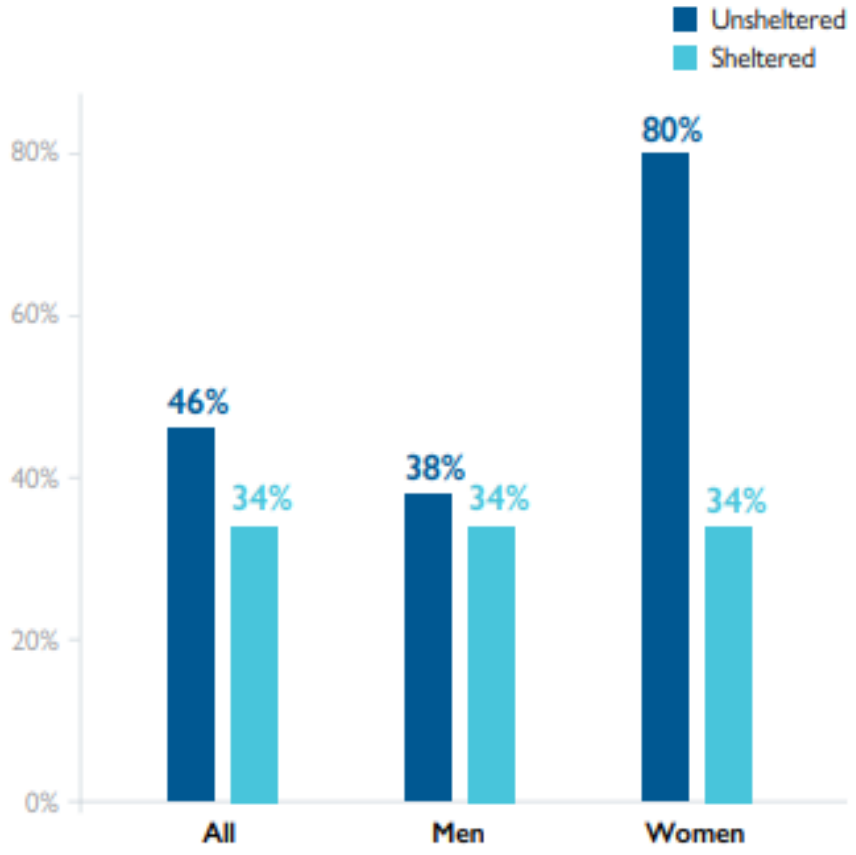


FIGURE 3. Unsheltered and sheltered adults who experienced trauma[10]



Source: California Policy Lab: Health Conditions Among Unsheltered Adults in the U.S.

Impact of Homelessness on Chronic Conditions

FIGURE 5. Physical health conditions by shelter status and length of time unstably housed[12]

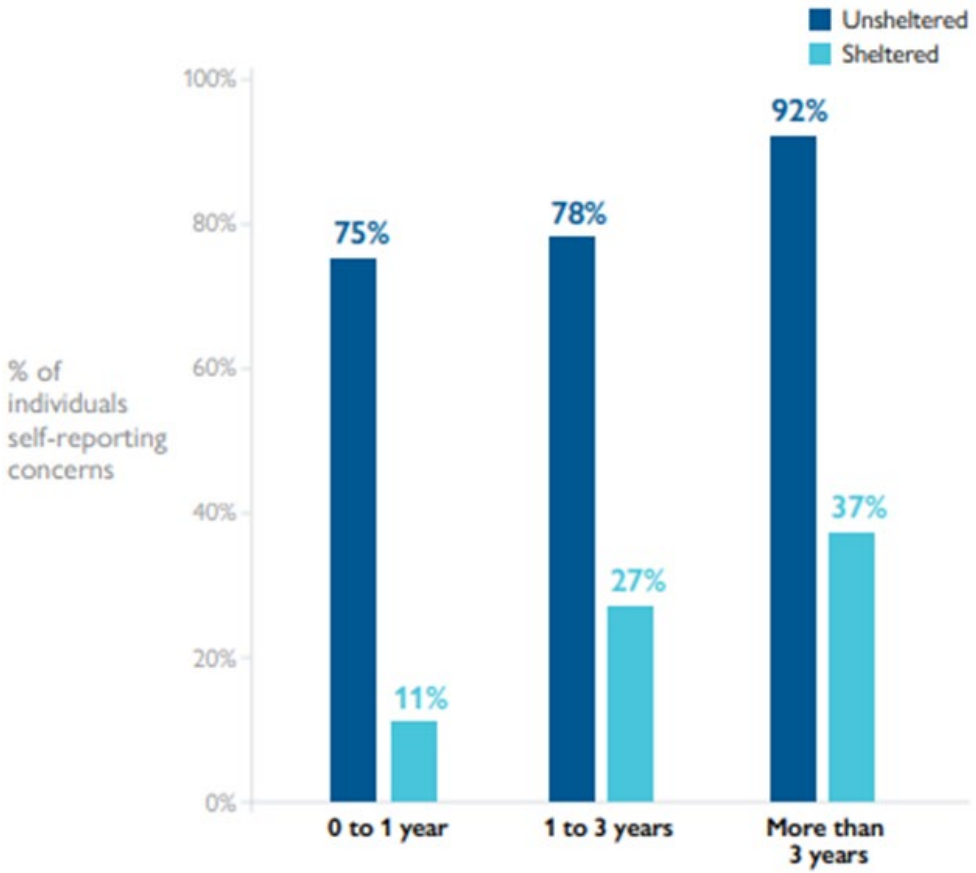
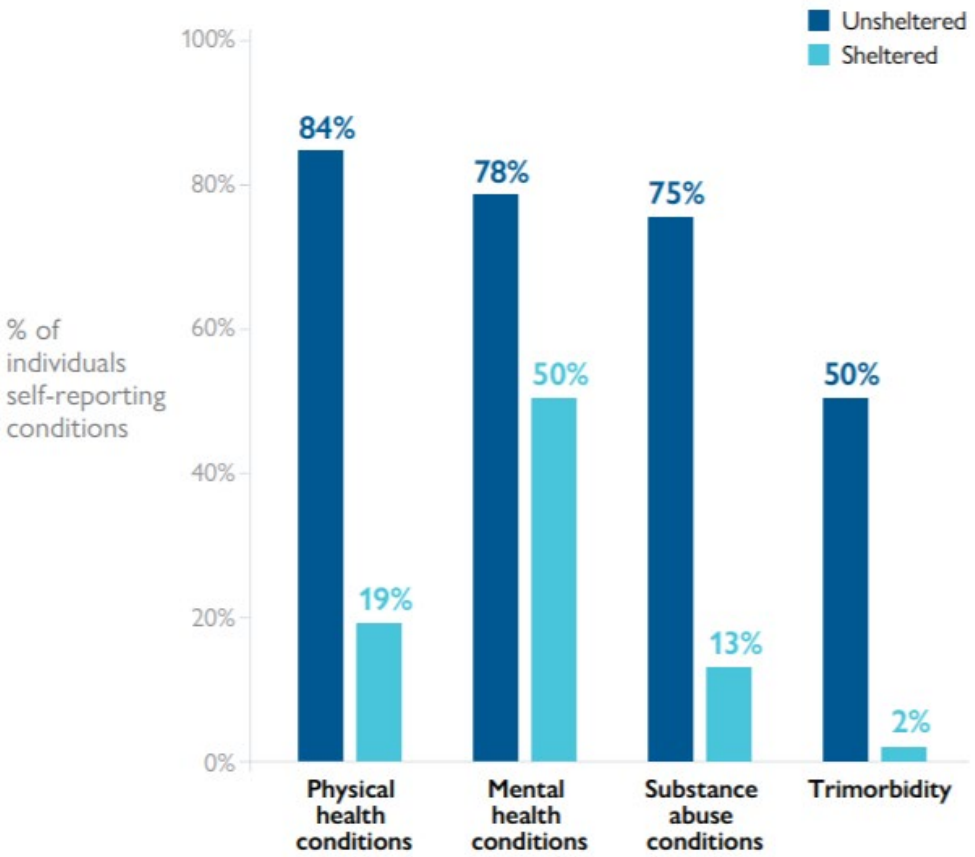


FIGURE 4. Physical health, mental health, substance abuse, and trimorbidity by shelter status[11]



Source: California Policy Lab: Health Conditions Among Unsheltered Adults in the U.S.

Chronic Conditions and Medical Respite: Barrier or Opportunity?

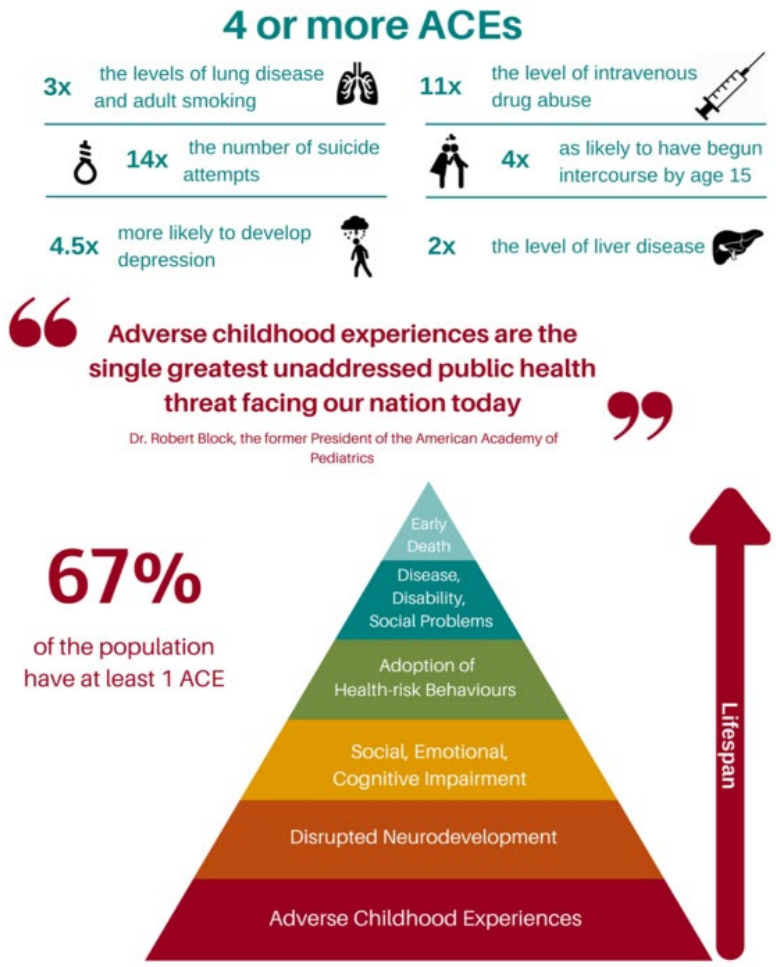
- Does the medical respite program have adequate facilities or staffing to support chronic condition management?
- Is our admission criteria specific to immediate post-acute needs, or can we be open to admissions to prevent exacerbation of chronic illness?
- Is this a health equity need or gap in our community?
- Can we take steps to address this within our setting?

Chronic Conditions and Medical Respite: Barrier or Opportunity?

- Individuals must be viewed holistically and not only as their primary or admitting diagnosis, but the program may only be reimbursed for the primary diagnosis
- For PEH this likely means a complicated combination of mental health, chronic medical conditions, and substance use disorders, which requires a multidisciplinary team
- Respite programs provide an amazing opportunity to support patient medication management, which can benefit all conditions
- Great time to simplify medication regimens
- Opportunity to establish specialty care and catch up on wellness

Approaches to Chronic Conditions Management

Approach: Engaging the Client

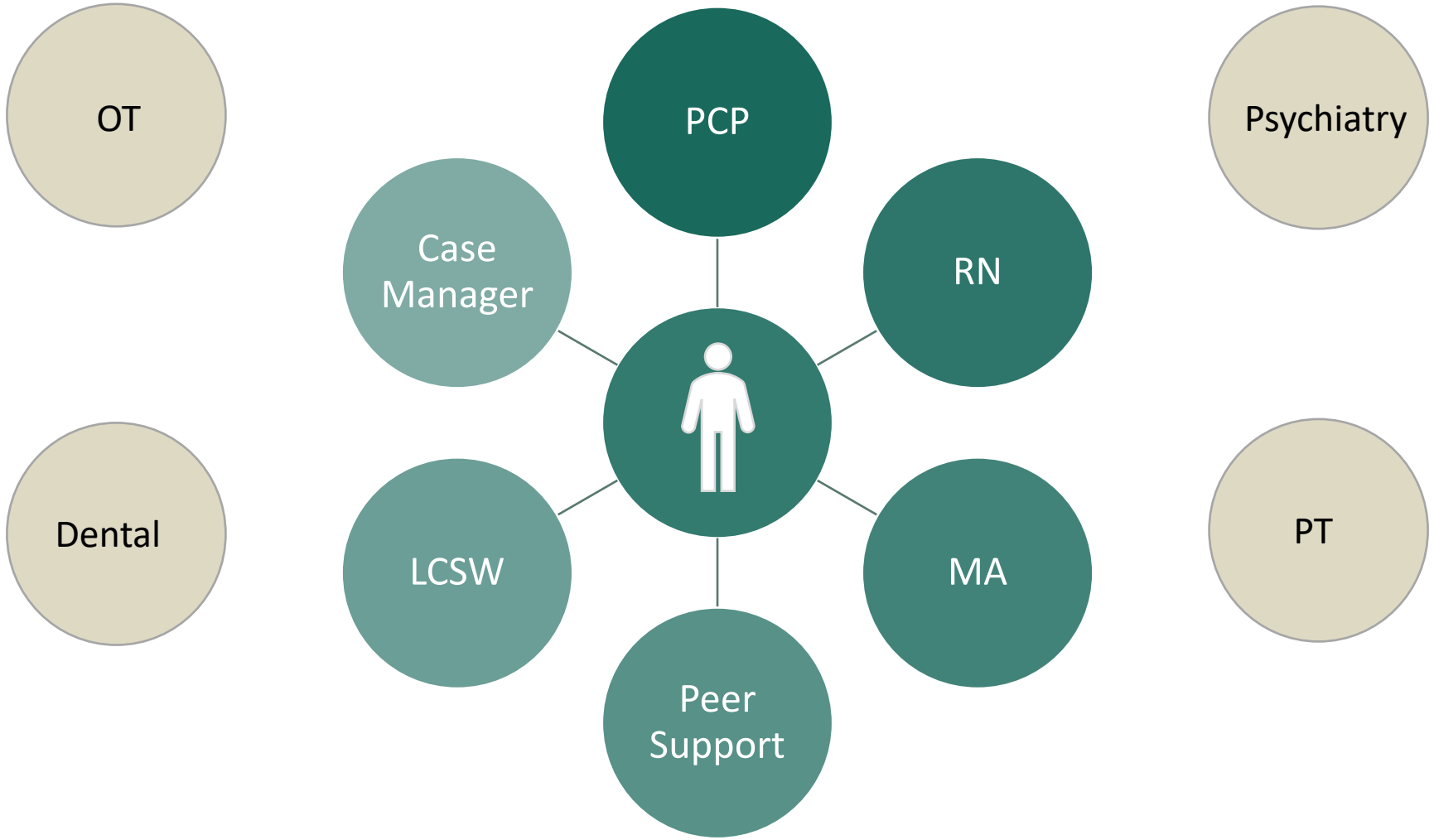


- Trauma-Informed Care is the acknowledgement of both current and historical trauma and the neurobiological impact

Trauma Informed Care

- Right to self determination
- Collaboration and Mutuality
- Safety
- Shifting Power Dynamics

Team Approach



Approach: Role of Providers and Staff

Nursing

- Ally
- Supporting patient self management
- Education – medication, disease process, navigating health systems

Medical Providers

- Ally
- Assess, diagnose, and offer treatment options
- Develop holistic treatment plan aligned with the patient's goals
- Support patient driven care team including partnering w/specialty providers
- Identify and advocate for best level of care in the short- and long-term ex: respite vs. assisted living

Approach: Role of Providers and Staff

Case Management

- Identifying patient's barriers to care and connecting to community resources
- We are not breaking down the steps, need to start small
- Screening and addressing SDOH aligned with the patient's goals

CHW/Peer

- Person with lived expertise
- Bridging the healthcare team
- Accompanying, listening, sharing the journey/burden

Behavioral Health

- Individual therapy
- Psychiatric care
- Substance Use Treatment

Approach: Assessing Needs Nursing and PCP Exam

History

Detail of symptoms and associated factors

Physical exam

Approach: Assessing Needs History and Questions

- Obtaining medical records
- Medication reconciliation
- Comprehensive intake and history taking
  - This may be an iterative process
- Physical exam
  - Comprehensive but patient driven
  - A foot exam can tell you a lot!
- Wellness
  - Immunizations
  - Cancer screening

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Approach: Assessing Needs

- Fall risk assessment
  - Johns Hopkins Fall Risk Assessment Tool
- Incontinence
  - International Consultation on Incontinence Questionnaire
- Depression Screening
  - PHQ-9
- Clinical Opiate Withdrawal Scale
  - COWS
- Alcohol withdrawal assessment
  - Clinical Institute Withdrawal Assessment of Alcohol Scale CIWA
- Substance use eval upon intake
  - Prevent dangerous withdrawal
  - Ensure needs get met
  - Frame in non-judgmental harm reduction approach
- Environmental Assessment
  - Identify barriers and opportunities to increase accessibility and perform ADL

Approach: Individualized Routines & Programs

Strength based

- Provide choices for the patient.

Clear expectations

- Develop goals with the patient and provide specific schedule and mile markers
- If a patient has a specialty appointment let them know in advance and prepare for the appointment
- People often leave respite and return to shelter. It is important to be clear and transparent with timelines around admission and discharge.

Motivational Interviewing

- Medication adherence is HARD!!! Roll with the resistance, and use harm reduction
- Stay curious. Until they feel like you truly "get" it, it'll be hard for you to convince them to change.
- Change can happen IF and ONLY IF a person wholeheartedly internalizes the **discrepancy** between their goal and behavior

Major Predictors of Poor Adherence

Table 2. Major Predictors of Poor Adherence to Medication, According to Studies of Predictors.

Predictor	Study
Presence of psychological problems, particularly depression	van Servellen et al.,[51] Ammassari et al.,[52] Stilley et al.[53]
Presence of cognitive impairment	Stilley et al.,[53] Okuno et al.[54]
Treatment of asymptomatic disease	Sewitch et al.,[55]
Inadequate follow-up or discharge planning	Sewitch et al.,[55] Lacro et al.[56]
Side effects of medication	van Servellen et al.[51]
Patient's lack of belief in benefit of treatment	Okuno et al.,[54] Lacro et al.[56]
Patient's lack of insight into the illness	Lacro et al.,[56] Perkins[57]
Poor provider–patient relationship	Okuno et al.,[54] Lacro et al.[56]
Presence of barriers to care or medications	van Servellen et al.,[51] Perkins[57]
Missed appointments	van Servellen et al.,[51] Farley et al.[58]
Complexity of treatment	Ammassari et al.[52]
Cost of medication, copayment, or both	Balkrishnan,[59] Ellis et al.[60]

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487–497.

Major Predictors of Poor Adherence

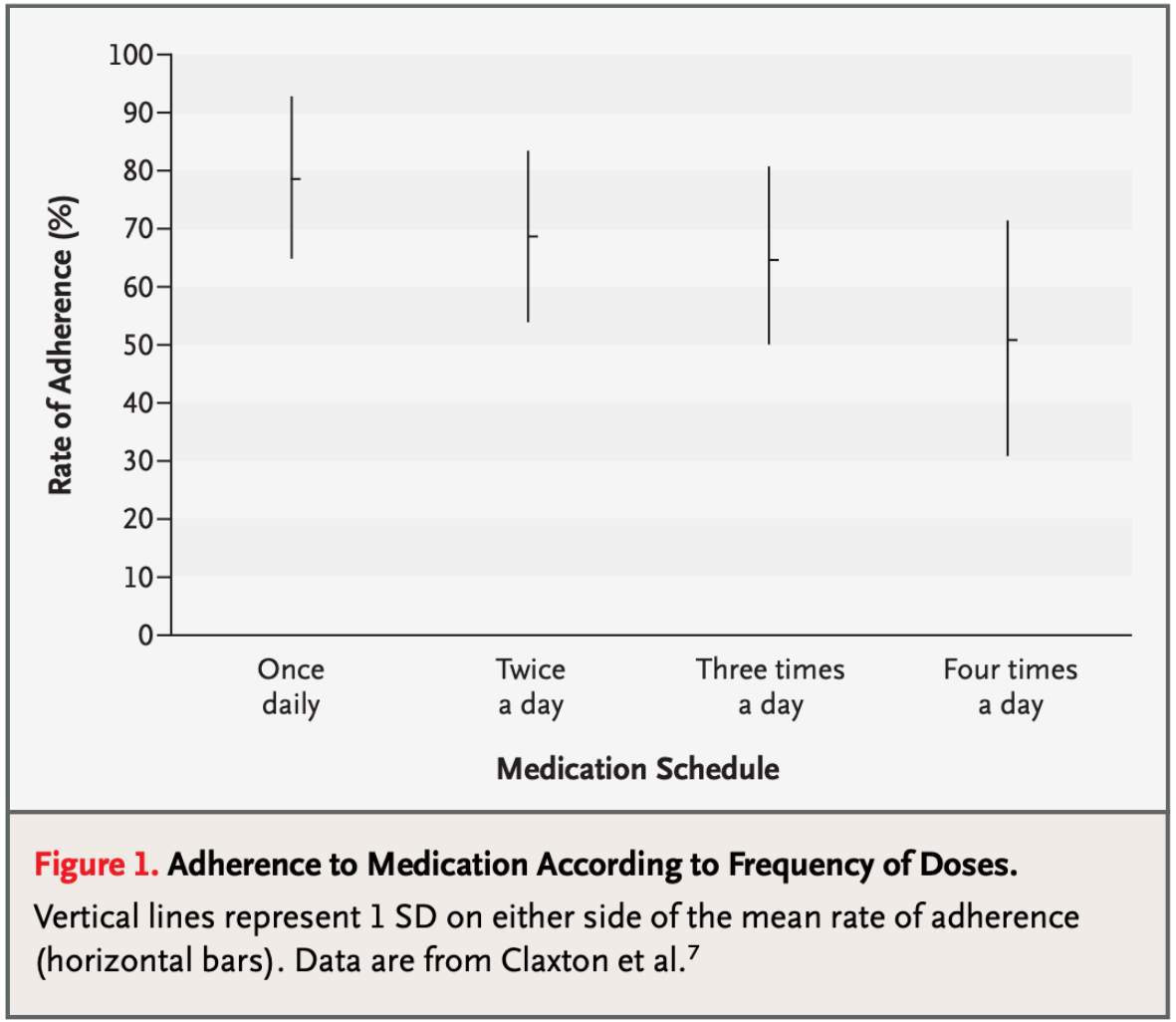


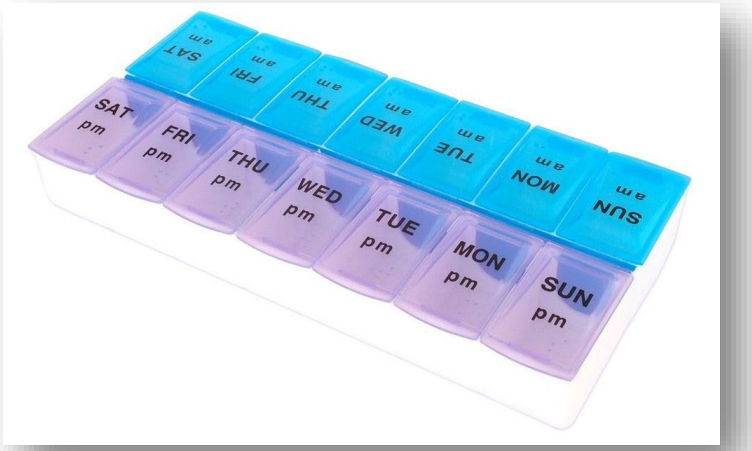
Figure 1. Adherence to Medication According to Frequency of Doses.
Vertical lines represent 1 SD on either side of the mean rate of adherence (horizontal bars). Data are from Claxton et al.[7]

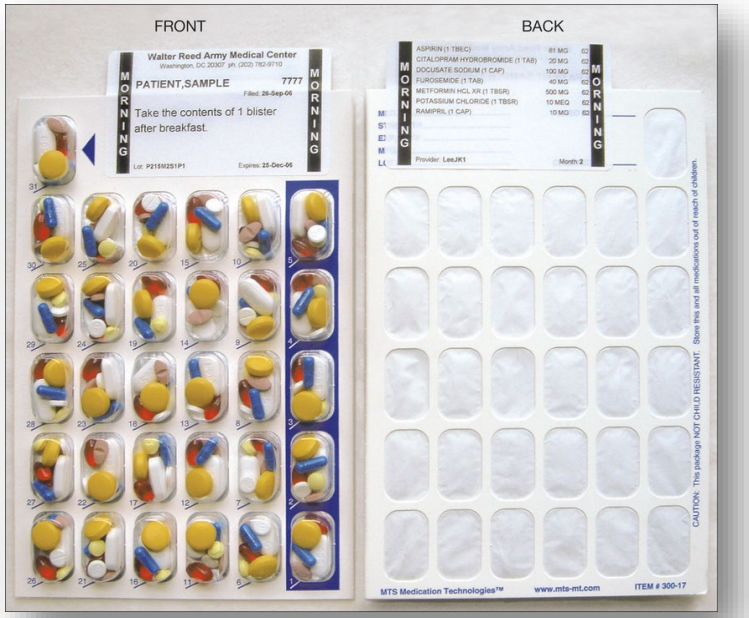
Frequency of dosing is ***inversely*** related to adherence.

Claxton AJ, Cramer J, Pierce C. A systematic review of the associations between dose regimens and medication compliance. Clin Ther 2001;23:1296-1310
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487–497.

Non-Clinical Strategies to Improve Adherence

- Placing stickers on pill bottles
- Pill box
- Blister packing medications





Clinical Strategies to Improve Adherence

- Once daily/weekly regimens
- Reduce pill burden
- Utilize medications that promote weight loss
- Remove food requirement
- Minimize risk of hypoglycemia and need to check BG
- Consider need for refrigeration
  - If insulin indicated, insulin pens/pen needles > vials/syringes.
- Support the person in developing routines for taking medication.

Example of Once Daily Regimen: Diabetes

- You have a patient experiencing homelessness who struggles to take his medications more than once daily. He has identified cognitive impairment and struggles to inject insulin. Last A1c 12.1% a couple weeks ago.
  - Xigduo XR (dapagliflozin-metformin ER) 10-1000 mg
  - Jentadueto XR (sitagliptin-metformin ER) 100-1000 mg
  - Glipizide XL 10 mg once daily (or IR with food)

Bonus: can even add on Actos (pioglitazone) if needed

Estimated A1c Reduction	
Metformin:	>1-2%
SGLT2:	>0.5-1%
DPP4:	>0.5-1%
SU:	>1-2%
Total Reduction = ~5%	

You have options!

A1C = 12.1%

- Option 1 (oral only):
  - Xigduo XR (dapagliflozin-metformin ER) 10-1000 mg
  - Jentadueto XR (sitagliptin-metformin ER) 100-1000 mg
  - Glipizide XL 10 mg once daily (or IR with food)

Estimated A1c Reduction	
Metformin:	>1-2%
SGLT2:	>0.5-1%
DPP4:	>0.5-1%
SU:	>1-2%
Total Reduction = ~5%	

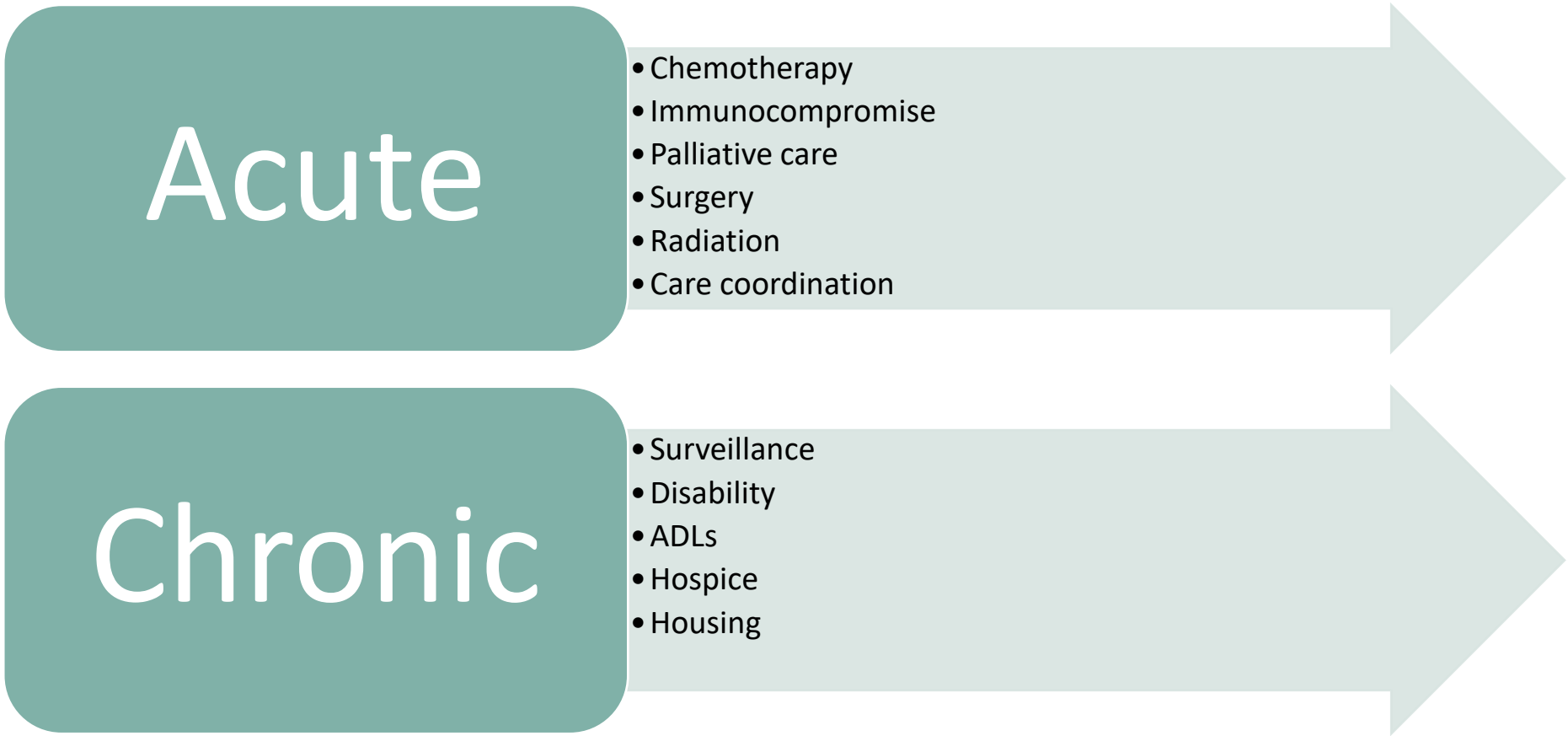
- Option 2 (once weekly + oral):
  - Xigduo XR (dapagliflozin-metformin ER) 5-1000 mg 2 tabs daily
  - Glipizide XL 10 mg once daily (or IR with food)
  - Trulicity 3-4.5 mg once weekly

Estimated A1c Reduction	
Metformin:	>1-2%
SGLT2:	>0.5-1%
SU:	>1-2%
GLP1:	>1-2%
Total Reduction = ~6%	

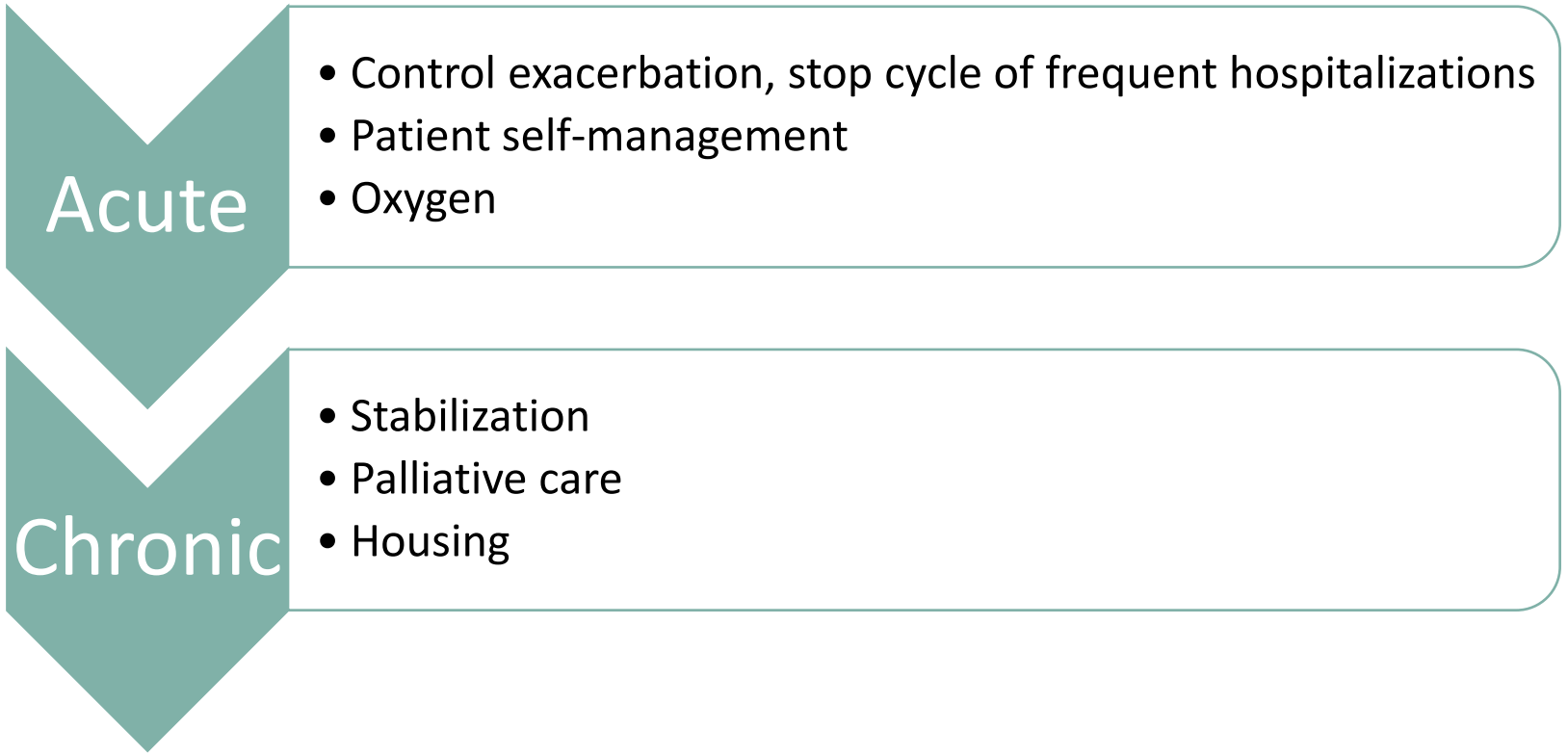
HIV Medication Considerations

- Medical respite can be helpful for a person newly diagnosed with HIV and/or with a low CD4 who is acutely ill
- Assess readiness/need for treatment
- Consider access to meals
- Side effect tolerance

Cancer Care in Respite Considerations



COPD Considerations



Standard 1 Medical respite program provides safe and quality accommodations

1. A bed is available to each patient for 24 hours a day while admitted to the program.
2. Onsite showering and laundering facilities are available to patients to promote proper hygiene.
3. Clean linens are provided upon admission.
4. The medical respite facility is accessible to people who have mobility impairments and other physical disabilities.
5. The medical respite facility provides access to secured storage for personal belongings and medications.
6. At least three meals per day are provided.
7. Medical respite programs located in congregate facilities maintain 24-hour staff presence. On-site staff (either clinical or non-clinical) is trained at minimum to provide first aid and basic life support services and communicate to outside emergency assistance.
8. Medical respite programs have 24-hour on-call medical support or a nurse call-line for nonemergency medical inquiries when clinical staff is not on site.
9. The organization has written policies and procedures for responding to life-threatening emergencies.
10. The medical respite program is compliant with local and/or state fire safety standards governing its facility.
11. The medical respite program has a written code of resident conduct or behavioral agreement that describes program policies including potential causes for early discharge.
12. The medical respite program has plans in place and staff trainings to address a) the handling of alcohol, illegal drugs, and unauthorized prescription drugs found on site and b) the handling of weapons brought into the facility, including strategies to maximize client and staff safety, and appropriate staff response to violence.

Approach: Setting up the Environment

Calm healing space

- Provide a space that is their own.
- Slippers, socks, welcome kit

Clear clinical vs. non-clinical spaces

- Respecting a person's ability to not be a "patient" all the time
- Recreational spaces
- Provide a private clinical space for sensitive conversations and physical exams

Facilitate transitions to post-respite life

- Medication storage
- Food choices

Approach: Setting up the Environment Shelter and Congregate Settings

ADA Accessibility

- Pull bars in bathrooms and showers
- Ramps, elevators

Differentiating respite vs. shelter spaces

- This can be complicated and lead to conflict
- Transparence is key

Important to integrate shelter staff into respite team

- Shared training
- Team building

Approach: Diet

Real world vs. ideal situation

- Providing clinically indicated meals (ie: low carb, DASH diet, etc.) is amazing, but often differs from what patients will navigate after respite
- Collaborate to support person's decision-making and personal preferences with available choices and recommendations

Education

- Motivational interviewing
- Culturally relevant information

Harm Reduction Approach

- What is the best choice of what is available?

Approach: Discharge Planning

Discharge Planning Starts on Day 1

Maximize time within respite

- Imaging
- Wellness
- Specialty care
- Addressing SDOH

Celebrate successes

Secure supplies for discharge

Support patient self management

Establish continuum of care following respite and make that connection while they are still in the program

Approach: Specialty Referrals

Chronic Disease Specialist

- Endocrinology
- Cardiology
- Infectious Disease
- Wound care specialists

Rehabilitation Specialist

- Physical Therapy to assess and address mobility and musculoskeletal conditions
- Occupational Therapy to assess and address functional skills and concerns

Behavioral Health

- Neuropsychiatry
- Address acceptance and management of impact of chronic health, well-being

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Questions & Discussion

Related Resources

Clinical Guidelines for Medical Respite/Recuperative Care: Chronic Conditions

Clinical Guidelines for Medical Respite/Recuperative Care: Activities of Daily Living
https://nimrc.org/wp-content/uploads/2021/07/Clinical-Guidelines-in-Medical-Respite_-ADL_Final.pdf

Pathways for Incorporating OT Services into Medical Respite/Recuperative Care Programs
https://nimrc.org/wp-content/uploads/2021/07/Pathways-for-incorporating-OT-services-into-medical-respite_final.pdf

Please complete the survey to evaluate today's webinar!
https://www.surveymonkey.com/r/mrrc_2

References

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