GUIDE

NATIONAL INSTITUTE for MEDICAL RESPITE CARE

Clinical Guidelines for Medical Respite/ Recuperative Care

Chronic Conditions

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Introduction

Chronic conditions/disease can have significant long-term impacts on a person's health. People experiencing homelessness are more likely to be diagnosed with a chronic condition, experience chronic conditions earlier than the general population, and have multiple co-occurring conditions than people who are housed (1, 2, 3). Lack of access to health care, both preventative and comprehensive, and increased prevalence and number of Adverse Childhood Experiences (ACEs), results in experiencing more long-term complications from chronic conditions and premature functional impairment (3, 4, 5). Unfortunately, in many cases, this also leads to inability to access various services, early institutionalization in long-term care facilities, and early mortality (3, 6). Individuals referred to medical respite/ recuperative care programs have likely been diagnosed with at least one chronic illness, even when this is not the primary diagnosis for referral. Medical respite/recuperative care programs may be equipped to address acute medical needs related to chronic conditions, such as recovery from pneumonia in someone with COPD, but may not consider or have the resources to address chronic disease management. However, a stay within medical respite/recuperative care may provide an opportunity for a person to address needs related to chronic conditions, including medication management and reconciliation, establishment of connections with primary and specialty care providers, and development of new skills for self and health management while in a stable environment. Medical respite/recuperative programs should utilize this guideline to consider opportunities for modifications to their programs and services to more intentionally address chronic condition management within their scope of services. This document provides guidance to increase understanding of chronic conditions, condition management, and potential interventions that may be implemented within the medical respite/ recuperative care setting.

KEY TERMS & DEFINITIONS

Chronic Conditions are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both (7). The following conditions are identified as chronic conditions and are commonly diagnosed in people experiencing homelessness:

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.

Clinical Considerations

CAUSES AND IMPACT OF CHRONIC CONDISTIONS

Chronic Conditions may be a result of medical issues such as:

- Occupational hazards
- Poor nutrition
- Smoking
- Lack of physical activity
- Alcohol use
- Family history
- Environmental exposure

Chronic Conditions may be **exacerbated by a lack of access to**:

- Adequate nutrition and diets
- Medication and supplies
- Space to store medication
- Culturally appropriate care
- Transportation
- A consistent place to sleep
- A place to shower and/or use laundry services

Chronic conditions can have several physical impacts, including impaired mobility, neuropathy, shortness of breath, chronic pain, and cognitive impairment. Additionally, chronic conditions may also cause higher rates of depression, illness-related anxiety and stress, a sense of hopelessness, impaired sense of self, and social isolation (8). Long-term complications for people experiencing homelessness can include disability, complications of symptoms and multi-organ involvement, and early mortality (3).

ASSESSMENT

In all assessment processes, it is important to implement a trauma-informed, strengths-based approach. The following can support identification and management of chronic conditions:

Motivational Interviewing (MI) can be used to assess the person's priorities and concerns regarding diagnoses and chronic conditions and support collaboration based on readiness to change. MI will support providers in respecting a person's choice and autonomy while providing education, and when the person is ready, to support the person in making an informed decision about their health, including taking medication.

History and Physical to identify comprehensive medical history, detail of symptoms and associated factors, and physical exam (with consent).

Screening for risk of falls, incontinence, depression, cognitive impairment, social determinants of health, and/or substance use and withdrawal [such as opiate withdrawal, alcohol withdrawal].

Environmental Assessment to explore contextual factors influencing condition management.

ENVIRONMENTAL STRATEGIES

- Develop a calm, healing space in collaboration with recipients in the program.
- Use universal design principles and explore needs for modifications to increase accessibility of spaces.
- Utilize trauma-informed procedures, including privacy in exams and clinical conversations.
- Allow opportunity for recreation/leisure, self-care and rejuvenation from medically-focused care.
- Provide medication storage, including personal storage options.

Diet and Nutrition

- Provide food choice, and clinically indicated and culturally relevant meals when able.
- Consider post-discharge food choices when identifying medication regimens and develop skills to address nutrition and dietary recommendations with what resources are available.
- Promote participation in daily routines involving food access, preparation, and safety.

Recommended Strategies

Strategies and treatment plans implemented should be person-centered, collaborative, and based on priorities and needs identified during the assessment process.

PERSON-SPECIFIC STRATEGIES

- Develop a relationship with the person and become an ally for their health and well-being.
- Develop a holistic treatment and self-management plan that supports the person's self-management goals.
- Health and condition education.
- Opportunity for intensive care coordination and connection to specialty services.
- Utilize peer support networks to engage people with lived experience as mentors and collaborators.

Medication Adherence

- Use motivational interviewing to provide medication education and establish a person's comfort with proposed medication regimens.
- Respect the person's choice regarding medications they are comfortable taking and provide all information necessary to support decision making.
- Simplify medication regimens and dosing schedules and reduce pill burden.
- Use medication organizers such as pillboxes, blister packs, or color-coding stickers.
- Utilize medications that promote weight loss.
- Remove food requirements for taking medications.
- Consider what is available to the person for storage of medications and prescribe accordingly.
- Develop reminder systems with the person (e.g., alarm clocks, phone alarms, visual reminders)
- Support the person in developing routines for taking medications.

Diabetes Considerations

- Minimize risk of hypoglycemia and need to check blood glucose.
- Provide education on symptoms and signs of hypo- and hyperglycemia.
- Provide glucose tabs or gel for those on insulin or other medications associated with hypoglycemia.
- Consider alternatives for insulin such as pens/pen needles.

HIV Considerations

- Assess need and readiness for treatment.
- Consider access to meals.
- Ability to tolerate side effects.

Cancer Care Considerations

- Surveillance and support while undergoing longer-term treatment such as chemotherapy or radiation.
- Provide space for recovery post-surgery.
- Provide space for person to receive hospice care services.
- Support to develop compensatory and adaptive strategies for activities of daily living (ADL).

COPD Considerations

- Control exacerbations and develop stability in symptoms.
- Educate on warning symptoms of a COPD exacerbation, steps for initial self-management with as-needed medications, and signs/symptoms that require medical evaluation.
- Develop self-management strategies and ability to manage oxygen treatment.
- Provide space for person to receive palliative care.

DISCHARGE PLANNING

Discharge planning can start when the person is first admitted to the medical respite program. Throughout the person's stay in the program, the focus is both on medical stability as well as self-management of conditions. Unfortunately, people may not be able to discharge from the medical respite setting into housing. Discharge planning should include identifying and implementing strategies for self-management within a variety of settings, including shelters, transitional housing, and returning to street homelessness.

Discharge planning for chronic conditions may include:

- Identifying strategies and connecting with community resources to manage and store medications in discharge setting.
- Identifying strategies to manage and access nutrition and dietary recommendations in discharge setting.
- Establishing warm hand-offs with primary care providers and specialists.
- Establishing transportation supports to attend primary care and specialist appointments.
- Establishing supports for ongoing care coordination.
- Identifying supports to address other SDOH that impedes access to health care supports.
- Identifying and training on use adaptive equipment or compensatory strategies for ADL and health management.

Advanced Training & Advocacy

Additional resources and training to address chronic conditions include:

- Education and training to understand the impact of ACES on health and chronic conditions.
- Training and education in harm reduction approaches to health care and self-management.
- Best practices in medication prescribing and management for people experiencing homelessness.

Advocacy efforts to improve self-management and quality of life for individuals with chronic conditions include:

- Access to primary and specialty comprehensive health services, including medical visits, prescription medications, and durable medical equipment.
- Access to nutritious foods in communities for people experiencing homelessness.
- Integration of principles of harm reduction and trauma-informed care in traditional medical settings, skilled nursing facilities, and long-term care.
- Education for shelter providers to support individuals managing chronic conditions.

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Case Examples

CASE EXAMPLE 1

Background: Gabriel is a 38-year-old female who uses they/them pronouns. Gabriel was referred to the medical respite program from a street medicine team due to worsening symptoms of diabetes, to prevent a potential hospitalization. Gabriel identified feeling very overwhelmed by their diabetes diagnosis and often presented with unused medications. Gabriel routinely stayed in an abandoned building and kept their medications on them at all times to prevent them from being stolen. Their primary source of meals was either at a meal program or from purchasing prepared foods or snacks from the nearby corner store.

At admission to the medical respite program, Gabriel showed difficulty remembering information about their medication, such as purpose of the medications, as well as following medication and diet instructions. Gabriel appeared to avoid checking their blood glucose before meals, and reported feeling dizzy or tired after meals.

Assessment: The medical provider reviewed Gabriel's prescriptions and medication bottles they brought with them to the program. It was identified that Gabriel had several old medications from previous ER visits, and including some that would be most effective with injectable insulin. The RN and occupational therapist (OT) did a collaborative evaluation of Gabriel's medication management skills to identify potential barriers to self-managing medications. A cognitive assessment also showed that Gabriel was experiencing mild cognitive impairment, especially in the area of memory.

Intervention: The provider developed a simplified medication regimen and with Gabriel's permission, discarded any old and unneeded medications. Gabriel worked with the RN to practice taking their medicine, using strategies from the OT to compensate for issues with memory. Strategies included filling a weekly pillbox, developing a routine to read medication labels and fill the pillbox one day/week, and to set phone alarms as reminders. Gabriel also practiced checking their blood glucose with the RN before meals, benefiting from repeated practice to complete all of the steps. Gabriel was also able to use a simplified medication list and a "cheat sheet" for what to do when their blood glucose readings were at various levels before meals. Gabriel practiced making various food selections that would have the most health benefits from both the meal program and convenience store.

Outcomes: At the end of a 30 day stay in the respite program, Gabriel showed improved self-management skills for their diabetes. They were able to transition to independently managing their medications and checking blood glucose. Gabriel also showed more knowledge of how different foods might interact with their diabetes and cause certain symptoms and identified feeling more confident in managing their diagnosis.

CASE EXAMPLE 2

Background: James is a 52-year-old male referred to the medical respite program following hospitalization for bilateral upper extremity wounds. Prior to hospitalization, James had been staying in a nearby encampment. While hospitalized, James was also diagnosed with HIV. James has a history of intravenous (IV) drug use as well as several periods of sobriety. James was primarily referred to the medical respite program to complete healing and treating for his wounds, but also to support HIV management. While in the hospital, James refused any medications to treat HIV and declined to meet with the HIV specialist team.

Once at the medical respite program, James engaged with the team to address his wounds but continued to decline discussions and treatment regarding the HIV diagnosis. James chose to attend peer recovery groups offered within the program and interacted much more within the peer support staff than with the medical providers. James disclosed his diagnosis to the peer support staff and that he felt "embarrassed and depressed."

Assessment: The peer support staff continued engaging with James, offering opportunities to check in individually and encouraging him to learn more about his diagnosis when ready. The RN used the time completing James' wound care to build rapport. During a routine medical visit, the medical provider used MI to identify James' concerns about his health and diagnosis. This revealed that James had perceptions regarding "the type of person that gets this disease," and that he had previously faced a lot of stigma in various health settings due to his history of substance use. James also reported fears about taking medication (especially multiple medications) and was concerned about side effects.

Intervention: James and his provider worked together to identify a medication regimen that he was comfortable starting, minimizing the number of medications taken daily. James was also encouraged to keep a log of how he was feeling to track any side effects to make adjustments as needed. James continued to engage with the peer support staff and groups. Groups included recovery-oriented support and harm reduction education. The RN set aside specific time for James to ask questions and learn more about HIV self-management strategies. James agreed to attend an initial intake with an outpatient provider for HIV management, and was accompanied by the peer support staff.

Outcome: James was able to establish care with an outpatient provider, although declined a referral to behavioral health. James was able to identify and establish a peer support group in the community. James planned to return to the encampment and felt comfortable with the medication regimen. He identified a goal to avoid substance use with peer recovery supports, but was able to identify community-based harm reduction services, such as a local needle exchange, as a resource if needed.