GUIDE

Pre- and Post-Operative Care: Adapted Clinical Guidelines for HCH Providers

2025

Introduction

Surgery has become a routine part of health care, and what constitutes surgery has expanded beyond the traditional concept of a major procedure completed under general anesthesia. Today, surgeries range from outpatient procedures like screening colonoscopies and wound debridement, to inpatient procedures such as joint replacements and emergency cardiac surgeries. As with all other aspects of health care, the experience of homelessness can significantly impact one's ability to qualify, prepare, and recover from surgery. Many factors impact whether a person is able to receive necessary surgery and engage in pre- and post-operative care, and these factors may not be considered by specialists or surgical teams recommending procedures. Barriers to engaging with pre- and post-surgical follow-up care may include lack of insurance or being under-insured, not having a primary care provider, lack of transportation, not having facilities to wash or perform surgical preparations, and lack of a safe place to recover. People experiencing homelessness (PEH) may also have a much harder time making it to needed diagnostic studies, pre-surgical evaluations, follow-up visits, and specialty care.[1,2] Not engaging in follow-up care after surgical interventions can result in increased complications and the need for emergency care, and may impact overall health and function long-term.[3] People experiencing homelessness encounter additional barriers to scheduling non-emergency surgeries and procedures, including meeting goals around tobacco and substance use cessation, planning for ongoing provision of medications for opioid use disorder or the management of withdrawal from alcohol or other drugs, and having a limited support system. HCH providers and medical respite programs play a vital role in supporting patients' access to surgical procedures and helping patients and care teams to plan for each stage of the process.

This adapted clinical guideline will address supporting PEH with pre- and post-operative care, including patient-centered strategies to conduct assessments, treatment, and follow-up care. The guideline covers care across health care for the homeless (HCH) settings and includes specific information for street/outreach, clinic, and medical respite environments.

Key Terms and Definitions

- **Harm Reduction:** A philosophical approach to medical care that extends beyond substance use and, in general, establishes individual agency and self-determination as central to any health intervention or efforts towards well-being. Harm reduction approaches call for the non-judgmental, non-coercive provision of services and resources to assist people in reducing harms related to chronic health conditions or health behaviors. Harm reduction-based care is collaborative, provides education on available interventions, and centers the goals of the individual in care planning.
- **Trauma Informed Care (TIC):** A patient-centered approach to care that recognizes the impacts of trauma and actively works to prevent re-traumatization and promote recovery. The principles of TIC

are grounded in establishing a trusting relationship and a safe physical and psychological space in which to address needs.

- **Elective Surgery:** Surgeries that are scheduled in advance. These surgeries can include minor outpatient surgeries or more intensive surgeries to treat a non-life-threatening condition.
- **Emergency Surgery** (or urgent surgery): Unplanned surgeries conducted to address an urgent medical condition, including those that are life-threatening.
- **Outpatient Surgery** (or same day, ambulatory, or office-based surgery): Planned surgeries done in an outpatient setting, often in a facility that is connected to but outside of a hospital. Outpatient surgeries avoid a hospital admission and require people to prepare and recover from surgery outside the hospital in the community.

Clinical Considerations

Background

Many different medical conditions can result in the need for inpatient or outpatient surgical treatment, ranging from life threatening conditions to screening protocols. Even same day outpatient surgeries and routine screenings, such as colonoscopies, require preparation, anesthesia, and the need to have a safe place to recuperate. People experiencing homelessness often forgo or are disqualified from outpatient and surgical procedures due to:

- Lack of resources to complete preparatory activities like bowel prep for colonoscopy or washing with chlorhexidine in the days before surgery.
- Difficulty navigating required pre-operative activities, such as primary care appointments and surgical clearances.
- Lack of a safe, stable place to stay and recover post-surgery.
- Lack of support and resources to complete post-operative care.
- Systems that stigmatize or exclude individuals with substance use disorders or who use tobacco products from procedures; systems that lack the resources needed to support individuals in meeting pre-surgical substance use requirements.
- Inadequate acknowledgement of the need for pain management and lack of provider coordination to manage pain pre- and post-operatively, especially for those who use substances or take medications for opioid use disorder (MOUD).
- Limited literacy or health literacy to read and follow complex preparatory guidelines.

Model of Care

- A multidisciplinary approach to care is needed to support preparation and recovery from surgery for people experiencing homelessness. Care coordination between care settings – including outreach, social service providers, primary care, behavioral health, community pharmacy, and specialty and surgical care teams can greatly improve care delivery and outcomes.
- An HCH primary care setting should serve as the hub of care delivery, working with patients and community partners to coordinate planning for pre- and post-surgical needs.

- Low barrier care, such as walk-in appointments throughout the day, the availability of telehealth appointments for primary, behavioral health, and specialty care, and service delivery at non-traditional settings, are essential elements of patient-centered care delivery. This is true for surgical care as well; patients should be able to access providers for presurgical clearances and teams should consider medical respite for preparation and recovery post-surgery.
- Health care provision should not be limited to a clinic setting. Street medicine and medical outreach to shelters and other community partners are crucial models to decrease barriers to care. Providing services beyond our walls is essential in reducing inequitable health outcomes in PEH. For example, providing assessments at street and shelter locations or offering services during early or extended hours can greatly improve access to care. Many patients will need support with accessing in-clinic services for surgical clearances and follow-up. That support can start with outreach teams.
- Focus should be placed on providing harm reduction-based and stigma-free services to encourage early intervention, frequent and convenient follow-ups, and the prevention of complications.

Assessment and Diagnosis

In all assessment processes, it is important to implement a trauma-informed, harm reduction-based approach, recognizing that people may not be ready to share their entire health history in the first encounter. A good history is key to creating an appropriate plan of care and can be built over several visits. Assessment for pre- and post-operative care should include the following areas:

Pre-Operative Procedure Assessment

- History and physical, to include:
  - Medical history
  - Behavioral Health history
  - Surgical history
  - Current housing status/sleeping arrangements
  - Any recent hospitalizations
  - Allergies
  - Immunization status
  - Diet and nutritional status
  - Any skin conditions or wounds
- Reconcile medications. Coordinate with primary care provider, specialty providers, and pharmacies to compile a complete list of medications. Include medications that the patient may be taking that were not prescribed to them (prescribed to someone else) or are over the counter, including herbal treatments.
- Access and review any recent hospital discharge, surgical, or specialty provider records.
- Assess tobacco use to identify a plan for reduction, replacement, or cessation.
- Assess substance use to identify any potential conflicts with anesthesia or the procedure and to make a pain management plan prior to procedure.
- Assess use of MOUD, for example buprenorphine or methadone, in order to plan for pre- and post-surgical medication needs.
- Assess alcohol use to establish a managed taper and any needed medication support prior to procedure; communicate with anesthesiology team.
- Establish the patient's baseline pain level(s), pain management skills and any established strategies, and understanding of modalities to manage pain.

- Complete the Mini Mental Status Exam (MMSE), or other cognitive screening test, to establish baseline of mental status.
- Establish baseline functional status and assess ability to follow medication regimens.
- Assess literacy, health literacy, and numeracy to determine supports needed to follow pre- and post-operative care instructions.
- Review pre-operative procedure instructions, including appointments and lab work to be completed, and medication, food, and beverage intake instructions.

Post-Operative Procedure Assessment

- Re-complete MMSE, or other cognitive screening test, to assess for changes in mental status post-operatively
- Physical exam and observation of incision or procedure site, any drains, etc.
- Fall risk assessments
- Assessment of activities of daily living (ADL) and impacts on function due to procedure.
- Review of post-operative care instructions and need for support to complete post-operative activities, such as dressing changes, pain management, follow-up appointments, etc.
- Assess pain control, efficacy of current pain management regimen, need for any modifications.

Assessment Tools

- **Substance Use**: Addiction Severity Index (ASI), Drug Abuse Screening Test -10 (DAST-10), Clinical Opiate Withdrawal Scale (COWS), Clinical Institute Withdrawal Assessment Scale for Alcohol (CIWA-Ar), Clinical Institute Withdrawal Assessment Scale for Benzodiazepines (CIWA-B)
- **Literacy and Health Literacy**: REALM-R Health Literacy Assessment
- **Cognitive Status**: Montreal Cognitive Assessment (MoCA)©, St. Louis University Mental Status (SLUMS), Mini-Cog, Mini Mental Status Exam ©, Medicare Annual Wellness Screening
- **Fall Risk**: Balance Assessment, Gait Assessment, Hopkins Fall Risk Assessment ©
- **Behavioral Health**: Depression Scale (PHQ9), Anxiety Scale (GAD-7)
- **Health Management:** NHCHC Health Management Assessment Guideline

Plan and Management

Individualized plans and management goals should be based on patients' own stated health goals, on the assessments above, and on the specifics of their planned surgery. The following components should be part of care plans for the management of pre- and post-operative care:

Access to Care: Support access to medical appointments, including specialty care, pre-surgical, and lab work appointments. Address transportation barriers through interventions like ride support or public transit passes. Provide calendars, scheduling support, and appointment reminders.

- Supporting access to care related to planned surgeries may include providing documentation to support the need for surgery, a patient's appropriateness for surgery and ability to manage post-operative care and obtain needed supports or planning around challenges such as substance use. Information may need to be provided to the surgical team/specialty provider or to the patient's insurance company.
- Identify transportation needs to and from procedure and if personnel will need to be available to accompany the client to the procedure and/or escort them to their post-discharge destination.
- Support the client in accessing prescribed medications prior to and after their procedure. This may include making sure prescribed medications are covered and do not have a cost-prohibitive co-pay.
- Identify any appropriate pre-surgical preparations and post-surgery placement for recovery. Consider whether medical respite is available and appropriate or if a shelter will allow the patient to remain in the building to complete bowel preparations or to rest during daytime hours after their procedure.

Housing/Homeless Status Considerations

- Where does the person usually sleep? (e.g. street, tent, shelter, couch, etc?)
- Do they sleep sitting up or laying down?
- Does the person have access to running water and bathroom facilities?
- How often do they eat and what types of meals do they have access to?
- Do they have a safe place to store medications and wound care supplies?
- Do they have access to a clean and private place to complete surgical preparations and post-surgical care?
- How do they usually spend their days – e.g. walking and carrying belongings, sitting in one place, seated in a wheelchair? Can they remain inside during the day at the place they are staying?
- What are their safety concerns?

Care Coordination: Support and facilitate health data sharing for continuity of care and pre-surgical clearance needs, including lab results, specialty consults, wound care orders, medication changes, and any ER or hospital visits. This may be done through continuity of care coverage under HIPAA as well as through signed releases of information with partner entities/agencies.

- Identify pre-operative steps to be completed, including scheduling with primary care or specialty care and completing lab work. Use care coordination to support the completion of necessary pre-operative appointments.
- Ensure all required documentation has been completed and received by the surgical team.
- Coordinate post-operative care, including communication with the medical respite team, shelter staff, and the surgical team. Support interventions for any post-operative challenges or complications, durable medical equipment needs, and other follow-up care needs.

Care coordination also includes making referrals to other needed services and following up on outcomes.

- Referrals may include specialty care, housing support, food support, help with benefits, behavioral health supports, interventions for interpersonal violence, etc.

Patient Education: Provide patient education that is timely, relevant, and meets health literacy guidelines. Adult patients should be asked how they best take in and learn information. Reinforcement, check-ins, and ongoing education may be needed.

- Review, educate, and support the client in following pre-operative instructions including:
  - What foods may/may not be eaten ahead of time, and when to stop eating.
  - What fluids are allowed and when to stop drinking fluids.
  - What medications can/cannot be taken before the procedure and when the last dose of medication should be taken. Include instructions about over the counter medications, such as ibuprofen, that may impact surgical readiness.
- Educate on expected levels of pain (acute and chronic) to be experienced following procedure and what measures will be in place to communicate about pain and manage post-operative pain.
- Educate on expected limitations in activities and diet following the procedure and how to cope given the realities of the patient's living situation.
- Educate and provide reinforcement on post-operative instructions, including:
  - Dressing and wound changes
  - Cleaning of incision or surgical site
  - Taking medications, including use of topical medications
  - Getting adequate rest
  - Managing food or fluid intake
  - Maintaining recommended position (such as elevation, propping)
  - Following mobility and weight bearing precautions

Education should also include information on self-management and self-monitoring, including the signs or a worsening acute condition, acute on chronic exacerbation, or symptoms that warrant going to the emergency room/calling 911 versus calling or visiting the clinic.

Self-Management: Patient-led self-management goals can be a powerful tool for improving health. Self-management for surgical care can include:

- Self-management of pre-surgical preparations in conjunction with any needed education and support, including skin preparation/washing, maintaining dietary restrictions immediately prior to surgery, or completing bowel prep for a colonoscopy.
- Self-management of medications and medication changes pre- and post-surgery as per instructions.
- Post-surgical self-monitoring for signs of complications at the surgical site and/or systemic complications.
- Maintaining adequate dietary intake of nutritious foods and/or supplementing with nutritional support products.
- Substance use goals, e.g. decreasing substance or tobacco use, use of nicotine replacement therapies or medications for opioid use disorder, or actively participating in efforts to abstain from use immediately prior or immediately after surgery (possibly in conjunction with a medical respite or inpatient substance use treatment stay).

Harm Reduction: A harm reduction approach seeks to reduce harms or risks associated with health-related behaviors. It is often used with substance use but can also be applied to other health behaviors,

including diet, tobacco use, or medication regimens. Harm reduction measures are driven by the individual's goals for their health and safety and are delivered without judgement or preconditions.

Harm reduction principles can be employed to reduce risks both before and following a surgery:

- Identify an appropriate post-surgery placement that will provide needed supports during recovery while also potentially allowing the patient to come and go from the site to meet social, work, or family obligations, or to engage in substance use treatment or substance use to prevent withdrawal. This could include programs that offer MOUD or Managed Alcohol Programs.
- Reduction in tobacco use, use of nicotine replacement interventions.
- Reduction in substance use; focus on strategies to decrease use or to provide medical support to allow the patient to prepare for surgery and to remain hospitalized for the recommended timeframe, if applicable.
- The use of MOUD to decrease overall use and overdose risk.
- Dietary measures to improve nutrition, including both adequate food intake and dietary supplements.
- Finding a medication regimen that a patient understands, supports, and that can fit into their lifestyle and daily schedule, for example antibiotics that can be taken only twice daily rather than four times daily.

Patient-Led Self-Management: Keys for Success

- Support the patient to determine what is important to them about their health and wellbeing, including their goals around recommended surgeries.
- Respect patient beliefs and priorities: Patient-led care and goals will go a long way towards establishing trust and working together on future health goals.
- Start with big goals and break them down into steps that are manageable and can make a difference in patients' day-to-day lives, for example "I want to get a knee replacement so I'm not in pain" might include making a plan to use nicotine replacement with the eventual goal of quitting to become eligible for the surgery.
- Remember that a patient's priorities may not always mirror those of a clinician or service provider, however they often move in the same direction.
- Support open and non-judgmental conversations about what is and isn't working with self-management and patient health goals.
- Assess what is feasible given limitations related to housing status, health insurance, cognition/memory, food access, etc., so that goals are attainable.
- Provide needed tools and supports to reach goals, e.g. weekly pill boxes, pocket calendar, behavioral health supports, frequent visits or reminder calls, shelter staff buy-in for dietary goals, etc.

Medications:

General Pre- and Post-Operative Considerations:

Medication management should be uniquely tailored to an individual's situation and needs. Consider the following when developing a pre- and post-operative medication plan:

- Consider the need for support with pre-operative medication regimens, for example bowel preparations for a colonoscopy or the use of chlorhexidine wash regimens. Some medications used in bowel preparations are over the counter and may not be covered by insurance. Patients may need support with accessing shower facilities outside of typical hours to prepare for a surgery.
- Simplify post-operative medication regimens as much as possible. It is often difficult for PEH to dose medications more than two times daily, especially if medications are stored in a shelter they cannot access during the day. Talk with patients about what dosing regimen might work best for them.
- Account for the presence of cognitive impairment and literacy levels when developing medication regimens and providing medication education.
- Reconcile medications using available resources. Pharmacies, specialty providers, and hospitals may all have components of a patient's complete medication list. Having a patient bring all of their medications into the clinic to meet with a nurse and review how they are using their medications can be a powerful tool for understanding and simplifying medication regimens.
- Use medication boxes or blister packs when possible to help patients organize their medications. Patients may need support with filling their medication boxes weekly or bi-weekly. Medication boxes can be very helpful when patients need to stop a medication a week or several days prior to their surgery or need to modify their daily medications on the day of surgery.
- Review the indication for each medication when providing medication education. Provide patients with a simple printed and dated list of all their active medications so they can share what they are taking with their surgical team and other providers. The medication list should include a way to contact clinic staff in the event of an unplanned emergency room visit or hospitalization.
- Consider medication storage issues when prescribing, reconciling, and suggesting strategies for organization. Some people may need to carry their medications at all times and are at higher risk for loss or theft of their medications. Others may store medications in their shelter and do not have access to them during the day.
- Consider the cost of medications prescribed and patients' ability to continue medication after discharge from an inpatient setting if it is not a covered product or if they are uninsured.
- Patients should be aware of potential side effects of prescribed medications and should know how to communicate with HCH staff if they experience side effects or if they lose their medication or stop treatment for another reason.

Tobacco, Substance, and Alcohol Use and Surgery:

Active tobacco, substance, or alcohol use is often a barrier to surgery. Active use of substances or alcohol can impact a patient's eligibility for surgery, can make it difficult to complete needed pre-surgical tasks and clearances, and can complicate post-operative recovery and pain management. However, tobacco, substance, and/or alcohol use should not prevent patients who want or require surgery from receiving necessary health care. Oftentimes, people who are using tobacco, substances, or alcohol may need more upfront support with planning and care coordination to get to a place where they are prepared for surgery. Following surgery, patients with active substance use will need additional

planning and support to prevent withdrawal and manage pain. Below are some considerations and strategies to support people who are actively using and need surgery.

Tobacco Use:

- Help patients develop tobacco reduction or cessation goals, and identify if full cessation is required for procedure and for what period of time.
- Identify a plan for nicotine replacement prior to surgery and while in the hospital (if admitted for surgery).
- Plan for tobacco cessation strategies to continue after surgery, especially if recommended by the surgical team to optimize healing.

Opioid Use:

- Use of opioids does not preclude someone from receiving surgical care, although planning around use is often necessary to meet surgical team requirements and optimize safety and pain management. Many times, patients who are actively using opioids purchased in the community will need to access MOUD in order to qualify for planned surgery.
- Emergency, life-saving surgeries are performed regardless of substance use. Patients who are active in their substance use and receive emergency surgery may need additional support with withdrawal management, pain control, and overdose risk following surgery.
- For patients who are taking MOUD, coordinate care with prescribing providers, the anesthesia team, and the surgical team to manage buprenorphine dosing prior to procedure.
- Buprenorphine and methadone do not need to be discontinued prior to surgery but will require coordination to identify an appropriate post-surgical pain management plan. It is important for coordinating teams to determine who will manage post-surgical pain prescribing and within what timeframe; consider having the MOUD prescriber manage pain control after hospital discharge. Anesthesiologists and surgeons are often not substance use treatment specialists, thus a clinician with expertise in substance use, harm reduction, and pain control is often best positioned to support the patient to manage their pain post-operatively. Dosing of medications for opioid use disorder may need to increase to address acute post-surgical pain and patients may need other temporarily prescribed pain medications, including opioids.
- A client with opioid use disorder may require higher doses of opioids to achieve pain control. Anesthesia teams could consider admitting the client post-operatively for pain control to leverage other pain treatment modalities like nerve blocks, ketamine, and others. This communication in advance is essential to ensuring the client receives high quality care and pain control, and can decrease stress for both the patient and hospital staff.
- Providers are encouraged to review *Acute Pain Management for the Patient on Chronic Buprenorphine,* which includes guidance and decision trees to facilitate clinical reasoning.

Alcohol Use:

- Coordinate care with the primary care, surgical, and anesthesiology teams regarding alcohol use.
- If the patient needs a managed taper prior to surgery, determine if this can be handled in medical respite care or if the patient needs to be admitted to the hospital or a detox program to complete the taper.
- Even patients undergoing a same day procedure may need a plan for alcohol withdrawal management if they typically wake up with signs of withdrawal or drink heavily throughout the day and need to maintain nothing by mouth (NPO) status ahead of a same day surgery. These patients

may need medications to manage withdrawal and prevent seizures prior to, during, and after surgery/procedures.

Stimulant Use:

- Patients who use stimulants like cocaine or methamphetamine will need a plan to abstain from use at least 5 to 7 days prior to surgery or as recommended by their surgical team. Urine drug screening on day of surgery can cause surgery cancellations for patients who use stimulants.
- For those who have difficulty abstaining from use for an extended period, a short-term inpatient stay and support directly from inpatient discharge to the hospital or surgery center can be one way to support a successful surgery.

Tools to Support Patient Education and Self-Management:

- **Motivational interviewing** techniques can help patients develop their goals and motivations for making health changes.
- **Peer Specialists or Community Health Workers** are an integral support for people who are working to change health behaviors and can often provide a peer's perspective on both challenges and strategies for success.
- **Support or Learning Groups**, for example a voluntary group of patients who meet to talk about their life with and management of substance use or living with diabetes, can be a vital support, outlet, and inspiration.
- The **NHCHC Health Management Toolkit** provides specific guidance on adaptive strategies and education to support self-management.

Potential Challenges:

The following may impact a person's ability to effectively prepare for surgery and manage post-operative care:

- Lack of access to bathrooms and washing facilities for surgery preparations, including washing with chlorhexidine or completing bowel prep.
- Limited access to transportation to and from clinic or specialty appointments; need for an escort/support person to accompany them from surgery to their destination.
- Challenges finding a location to recover from surgery, such as a medical respite.
- Shelter regulations that require people to leave the shelter during the day, making recovery from surgery while staying in shelter challenging if not impossible.
- Challenges with finding home care agencies who will visit shelters or work with patients who do not have regular access to a phone or a private place to conduct post-surgical follow-up visits.
- Limited access to medications or inability to safely store medications and wound care supplies, frequent loss of medications and supplies.
- Expensive or complicated medication regimens that are difficult to follow or are inaccessible; antibiotics started in an inpatient setting may not be covered by a patient's insurance.
- Lack of access to foods that support wound healing, such as healthy sources of protein, fruits, and vegetables.

- Health education materials that are not in alignment with health literacy and numeracy recommendations.
- Limited access to health management activities, such as taking vital signs, including temperature, completing diagnostic or follow-up tests, laboratory testing, etc.
- Limited access to internet and telephone resources.
- Limited orientation to date and time of day, making it difficult to track and attend appointments.
- Existing co-morbidities that may impact ability to manage pre- and post-surgical care, for example mental health or substance use disorders.
- Lack of access to stable housing, widely affecting a person's ability to follow or prioritize disease management recommendations across the board.

Follow-Up:

Routine follow-up is a vital component of post-surgical care. For PEH, routine follow-up can be challenging due to the realities of homelessness and poverty, including the factors listed above. Service providers and clinicians need to leverage multidisciplinary teams to support their patients in receiving needed follow-up. Consider the below strategies for follow up needs:

- Utilization of outreach teams to follow-up in the community
- Use of self-management education to support post-surgical management, for example wound care or temperature monitoring
- Utilization of nurse-led care in the community and in shelter settings to monitor health and maintain connections to providers
- Partnering with pharmacies to be alerted when patients have not picked up or may be out of medications, or if medications prescribed have a high out of pocket cost
- Ability for patients to walk-in any time for follow-up needs or complications
- Utilization of home nursing for regular needed follow-up and support, working with agencies to support access and communication with patients
- Supporting patients with obtaining and maintaining a phone to be able to complete telephone check-ins
- Using other community resources and health information sharing (through ROIs) to monitor health, for example with syringe service, outpatient behavioral health, shelters, day programs, or meal programs that have nursing or Community Health Workers on site

Site-Specific Considerations

Street/Outreach Settings:

Outreach settings can be an important contact point for people who are either preparing for or recovering after surgery. Outreach can support people and/or serve as a point of contact to organize documents or needed assessments pre- and post-surgery.

- Outreach teams may be the first to recognize an emergent situation that may require a surgical intervention, for example a wound. In emergent situations, outreach teams provide key information to emergency departments regarding history, current presentation, and concerns around care and recovery while someone is unsheltered.

- Outreach teams may also be the main point of contact for people who are unsheltered following a surgery, especially following a self-discharge. Outreach teams should be prepared to support people with post-surgical assessment, any care that can be completed in the community, and referrals and support to needed follow-up.

Medical Respite:

Medical respite care can be an opportunity for patients to complete preparatory activities for surgeries and outpatient procedures and mitigate environmental or individual barriers. Additionally, medical respite can be the ideal location for someone to recuperate from surgery in a safe, supportive environment and receive the care coordination and supports needed to heal and complete post-surgical activities.

Medical respite services include:

- Providing transportation and care coordination for admission to the medical respite program after the procedure. Ensure that instructions are handed to escorting staff or sent to the medical respite program ahead of time.
- Completing post-operative recommendations, including wound care, medication management, mobility and positioning, and any other post-surgical instructions.
- Providing support for pain management, including medication administration, support with non-medication pain management strategies, and communication with the primary care and surgical teams regarding uncontrolled or poorly managed pain.
- Coordinating care to complete follow-up care and scheduled appointments.
- Monitoring for unexpected changes in functional status, signs of infection, delirium, and post-operative complications.

Health Center:

The primary care health center serves as the coordinating point for pre- and post-surgical care.

- Health center staff should work with patients to ensure all the needed clearances and documentation have been received by the surgical team.
- Health center staff can also serve as a point of contact and coordination for outreach or medical respite teams that are providing post-surgical care and follow-up.
- Health center staff are vital in coordinating care related to substance use and surgery, including tobacco reduction and cessation measures, MOUD and withdrawal management, pain management, and admission to inpatient treatment for substance use if needed prior to surgery.

Additional Resources

- Toolkit: Creating Care and Discharge Plans for People Experiencing Homelessness Who Are Hospitalized
- National Health Care for the Homeless Council's Health Management Toolkit
- National Health Care for the Homeless Council's Assessing Health Management

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