Clinical Recommendations for the Medical Respite Setting

National Health Care for the Homeless Council, Inc.

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Introduction

Medical respite programs provide medical care to persons (generally homeless) recovering from an acute illness or injury, whose conditions would be exacerbated by living on the street, in a shelter or other unsuitable places. These programs ensure that the medical care received in a hospital or clinic setting is not compromised due to unstable living situations. Combined with housing placement services and effective case management, medical respite programs allow individuals with acute or complex medical and psycho-social needs to recover in a stable environment while reducing potential health complications and subsequent hospital utilization.

Medical respite programs are growing nationally, with each program offering a diverse range of services to meet their patients' post-acute care needs. Federally Qualified Health Centers (FQHCs) operate nearly half of the nation's medical respite programs and are authorized under Section 330 of the Public Health Services Act to provide medical respite care as an additional health service within their scope of project. The National Health Care for the Homeless (HCH) Council with support from the Health Resources and Services Administration (HRSA) provides trainings and technical assistance to FQHCs working to improve the quality and range of health care services for people experiencing homelessness. As such, a number of resources have been published by the National HCH Council to assist FQHCs in medical respite program development. However, little has been available to assist clinicians practicing in this setting. This publication was developed in response to the growing number of inquiries received from FQHCs requesting guidance on the level of clinical care provided at medical respite programs.

A Task Force of ten medical respite program providers, convened by the National HCH Council's Respite Care Providers' Network, developed the recommendations contained in this document. Task Force members participated in interviews and met monthly as a group. The conditions selected for this publication were based on common admitting diagnoses from nine medical respite programs and do not represent the full spectrum of ailments seen in medical respite settings. Recommendations are based on the assumption that for each patient, the primary diagnosis has been treated prior to admission into the medical respite program and that ongoing clinical care and oversight is warranted for recuperation and stability. Although this document is intended to be used primarily by physicians, nurses, nurse practitioners, physician assistants, and other clinicians working in the medical respite setting, it also provides a compelling tool for describing to policy makers the recuperative care needs of people experiencing homelessness, which are often beyond the scope of acute care hospitals and homeless shelters.

For more information about medical respite care, please visit www.nhchc.org/Respite/.

What is Medical Respite Care?

Poor health compounded by lack of health insurance contributes to instability, too often resulting in unemployment and loss of housing. Without housing, health continues to deteriorate. Homelessness exposes people to the elements, the violence of the streets, communicable diseases that are rampant in overcrowded shelters, and the debilitating effects of poor diet and lack of rest. Disease management often is secondary to meeting basic needs for food and shelter, inevitably leading to emergency department use and inpatient hospitalization. Indeed, people experiencing homelessness have higher rates of emergency department use and longer lengths of stay in hospitals than their housed counterparts.[1]

Generally, hospitals discharge patients within a day or two of being treated, with instructions to rest, eat well, keep wounds and incisions clean, and complete a course of medication until fully recuperated. Unless hospitals choose to extend inpatient stays (which has cost implications), people who are without housing must attempt to follow instructions while living on the street or in shelters that lack the staffing capacity, facilities, and policies to oversee medical needs.

Recuperation on the street is extremely difficult. Local laws that criminalize homelessness prevent people from sitting or lying down in public; prescribed medications often include diuretics, which risk public urination nuisance charges. Unsanitary conditions cause open wounds to become infected, clean bandages quickly become filthy, medication requiring refrigeration is compromised, and prescribed diets and even clean drinking water are not easily available. As a result, health complications arise and patients are often readmitted to hospitals for circumstances that would have been avoidable if the individual had a home or safe and clean place for recuperation and a caregiver to provide support. Medical respite programs fill this void in the health care delivery system by providing a place where people who are homeless or unstably housed can recuperate and gain health stability.

Medical Respite programs provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. Most medical respite program participants are referred by hospitals and health centers. During their stay, homeless individuals are given the opportunity to rest in a safe environment and access medical care and other supportive services. Medical respite is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing.

The intensity of medical care offered at medical respite programs varies depending on program resources and model. For example, medical respite programs situated in motels, transitional housing facilities, or existing homeless shelters may have an onsite clinic, established hours for onsite clinician visits, or transportation to a nearby clinic. While most medical respite programs are based out of existing short term housing facilities such as those just listed, several programs in the United States are based out of stand-alone facilities dedicated to medical respite care. These stand-alone programs generally offer more intensive services for program participants.

Minimum level of care in the medical respite setting

Regardless of program model, medical respite programs provide a basic level of care to ensure adequate recuperation and to promote greater health and life stability. Medical respite care at minimum includes clinical assessment, oversight, minor clinical interventions, and 24 hour bed rest.

Clinical assessments begin either at the referral source prior to respite admission or after admission into the medical respite program. In many cases, brief assessments prior to admission occur in the hospital, where patients are seen by a medical respite provider in order to ensure program eligibility. These initial assessments prevent hospitals from referring patients who continue to need hospital care. In other cases, the hospital discharge worker may contact the medical respite program to describe the patient's needs and request a bed. Patients who arrive at the medical respite program but who continue to need hospital care may be sent back to the hospital.

Although hospitals and other health providers will have completed their own assessments and provided some level of care prior to referring patients to a medical respite program, medical respite providers need to conduct their own assessments in order to establish a treatment plan. Recommendations for conducting assessments for common conditions seen in the medical respite setting are included in this publication.

Medical oversight is core to medical respite programs. Clinicians seeing patients in these programs assess progress to determine whether or not interventions are effective. Medical oversight includes ongoing assessments of vital signs and acute symptoms as well as medication monitoring to ensure that patients are taking medications as directed by their referring provider. Additionally, clinicians are able to monitor patients over an extended amount of time which may result in the detection of other co-occurring medical conditions. Common clinical interventions performed in the medical respite setting include patient care and comfort measures (e.g. wound care and infection control, non-pharmacological pain management).

Behavioral health care in the medical respite setting

It is not uncommon for medical respite providers, who often have two weeks to a month to monitor patients, to recognize or diagnose behavioral health problems that were missed at the referring hospital or clinic. Behavioral health issues complicate physical health care and must be treated concurrently in order for the patient to gain greater health stability. As such, many medical respite programs take measures to address behavioral health issues.

Medical respite programs have employed numerous approaches to address behavioral health issues. At minimum, medical respite providers are trained to detect symptoms of mental illness and substance use disorders and link patients to appropriate behavioral health agencies. Other medical respite programs, primarily those with greater resources and innovative collaborations, have effectively integrated behavioral health care into their programs. These integrated care models often complement the services of outside behavioral health care agencies by providing support groups, interdisciplinary team meetings with patients, and onsite health care delivered by licensed clinical social workers, psychiatrists, and psychologists.

Support groups can be facilitated by an individual provider or by an interdisciplinary team of providers. Group sessions allow patients to hear about challenges and successes of other program participants, participate in a forum to reinforce disease management skills, and feel empowered by helping others who are experiencing similar life circumstances. Patients learn about the groups upon admission, either by a provider or preferably by

another program participant. Patients are asked about any personal information that they would like to keep confidential from the group and likewise are asked to keep information shared by others in the groups confidential. Patients uncomfortable with the group sessions can be offered one-on-one sessions with providers.

Many medical respite providers are trained in motivational interviewing, harm reduction, and trauma informed care. Such techniques lead to improved self-management and health outcomes particularly when physical health is complicated by addiction and/or mental illness.[2, 3, 4]

Harm reduction policies vary across medical respite programs. Some programs, especially those based out of existing homeless shelters, have strict sobriety policies. Though not condoned, other programs may allow patients to continue with the program after substance use is discovered. Programs that have strict sobriety requirements may experience a larger number of patients who leave the program before completing their treatment plan. Programs that operate under a harm reduction model continue to work with patients to help them make constructive decisions to address their substance use.

Enabling services

Enabling services is a term used to describe non-clinical interventions that increase access to and effectiveness of health care services. These interventions include case management, transportation, interpretation, outreach, and education. Medical respite programs are ideal for the provision of enabling services given the duration of time that individuals stay in the program and the emphasis on health and wellbeing.

Case management activities are integral to helping medical respite program patients access needed services and transition from the medical respite program into housing. Case managers at medical respite programs can assist patients in accessing benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), General Assistance, health insurance coverage, and food stamps. Case managers can also assist patients in completing housing applications and address barriers that have prevented housing placement and stability in the past.

Depending on the program, a case manager, social worker, or nurse may assume care coordination responsibilities. Nearly every medical respite program in the United States links patients to a primary care provider and assists patients in understanding the patient-provider relationship. Linkages are also made to appropriate behavioral health and specialty care. While in the program, case managers often transport patients to their appointments. Concurrently, medical respite clinicians work with the patients' new providers to ensure appropriate integration of care, care management, and follow up.

Health education is also an essential component of medical respite programs. Medical respite program participants often have ample time to receive health education and to practice prevention and disease management strategies. Further, other program participants may provide support and encouragement to promote healthy behaviors. The clinical recommendations outlined in this document include outcomes that should be achieved before discharging patients from the medical respite setting. The patient's ability to demonstrate appropriate prevention and disease management strategies is one such outcome, common to most of the conditions discussed in this publication.

Advanced practices in the medical respite setting

As described in the previous section, medical respite programs should, at minimum, provide some level of post-acute clinical care, linkage to behavioral health programs, a full array of enabling services, and health education. Depending on resources, medical respite programs may be able to expand services to address additional health care needs that might otherwise go unmet or result in longer hospital stays.

IV therapy and oxygen therapy

Each state defines the scope of practice for their nurses through Nurse Practice Acts (NPA), including the ability to deliver intravenous fluids and medications. All states in the U.S. have their own professional nursing boards and local legislation that regulate the practice of nursing. These boards and laws specify what services can be performed by nursing professionals. As such, staffing and partnership arrangements (e.g. with home health agencies) determine which medical respite programs are able to accommodate patients who require IV therapy.

Medical respite programs providing oxygen must implement very rigid program policies to restrict smoking near oxygen tanks. Programs that admit patients on oxygen therapy restrict smoking in and near the facility. Open flames can be a cause for program discharge. Other medical respite programs do not admit people who require oxygen therapy, rather than take the safety risk.

Emergency room and hospital diversion programs

Emergency room diversion programs have grown out of innovative partnerships between medical respite programs and local health care providers. These programs allow community providers to directly refer individuals who have certain illnesses or injuries to a medical respite program as opposed to sending them to the emergency room. Medical respite programs participating in emergency room diversion programs may have a list of diagnoses (e.g. pneumonia, cellulitis, foot problems) that the program is willing to take without a hospital referral. Patients being diverted from the emergency room to the medical respite program receive urgent care from an onsite or on-call physician or other advanced level practitioner.

Hospital diversion programs attempt to divert patients from an inpatient stay. Such programs, like emergency room diversion programs, may have a list of diagnoses that the medical respite program is willing to accommodate in order to help avert inpatient hospitalization. Hospital diversion programs may also target people who have had frequent hospital visits and who might benefit from a general assessment, health education, and care coordination services offered by the medical respite program.

Dispensing pharmaceuticals

State policies govern the dispensing of prescription medications according to facility and provider licenses. As such, many medical respite programs are not authorized to administer or hold medication. However, at minimum, medical respite programs that are not licensed to dispense pharmaceuticals can provide lockers for patients to secure their prescriptions. Some medical respite programs operating as part of a licensed medical facility may be able to hold and administer medication for patients. Medical respite administrators can check with their state Board of Pharmacy to learn about drug dispensing policies or inquire about a federal repackaging permit.

Isolation (for TB and flu)

Common infections requiring infection control include influenza, varicella, tuberculosis, Methicillin-resistant Staphylococcus Aureus (MRSA), and clostridium difficile (C. diff). Many medical respite programs are unable to accommodate patients who have infectious disease because it puts other patients, many of whom already have compromised immune systems, at risk. At minimum, medical respite programs should have policies and procedures for minimizing the spread of infectious disease. Such policies may be driven by local public health agencies. Some medical respite programs are able to accommodate individuals who carry these infections by integrating a separate isolation room into the building design, a negative pressure room for tuberculosis, or arrangements to use motel vouchers.

Training non-clinical staff to perform minor clinical interventions

Some medical respite programs do not have the resources to provide 24-hour clinical oversight. As an alternative, programs may train overnight security on when to contact on-call clinicians or call 911. A more fitting approach is to employ community health workers (CHWs) who can be trained and certified to perform certain clinical interventions. CHWs are also known as *promotores de salud,* community health advocates, peer advisors, and patient navigators, among other titles. The Department of Labor 2010 Standard Occupational Classification System describes the role of CHWs:

> *Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.*[5]

In the medical respite setting, CHWs can be a tremendous resource for patients. CHWs can assist with patient oversight, take vital signs, and test blood sugar using a glucometer. State laws determine the level of training required for community health workers. The degree of administration, certification, and training requirements for CHWs vary considerably between states. Some states have state-regulated training and certification requirements for CHWs that must be met in order to practice and receive reimbursement for CHW services. These training programs are often offered at community colleges or regional training centers and can require a year or more of classes and clinical experience to complete. The regulation of such programs also varies with state agencies, local agencies, or nongovernmental professional boards administering the program requirements. Other programs require little public certification, allowing on-the-job training instead.[6, 7]

Overview of Clinical Recommendations

The following clinical recommendations are divided into seven categories: Injuries & Conditions of the Musculoskeletal System, Conditions of the Skin and Subcutaneous Tissue, Conditions of the Respiratory System, Conditions of the Circulatory System, Conditions of the Gastrointestinal/Hepatobiliary System, Conditions of the Nervous System, and Conditions of the Genitourinary System. The conditions listed under each category are commonly seen in medical respite programs.

Each condition includes four types of recommendations: assessment, management, prevention, and outcomes. *It is important to note that these recommendations are not to be used as treatment guidelines*. Patients seen in medical respite programs are typically referred by hospitals and health centers that have already treated the acute condition. Medical respite programs provide post-acute care and oversight to patients after they have received appropriate treatment at a hospital or other community health setting. However, given the longer length of stay in medical respite programs, some recommendations may direct providers to look for signs of other conditions and behavioral health issues that might have been missed by the referral source. The four types of recommendations are:

- **Assessment:** recommendations to assist in developing a medical respite treatment plan and for establishing a base line for medical oversight
- **Management:** clinical interventions needed to ensure proper healing and stability
- **Prevention:** strategies aimed at maintaining health and preventing reoccurrence of the acute condition that warranted initial hospitalization
- **Outcomes:** criteria that can be used to determine when patients are ready to be discharged from the medical respite setting

Discussion boxes and case studies appear throughout the clinical recommendations, which elaborate on issues commonly encountered by medical respite providers and illustrate how these recommendations have been employed to care for patients in medical respite programs.

Injuries & Conditions of the Musculoskeletal System

Physical injury or trauma (lacerations, wounds, sprains, contusions, fractures, burns) are leading causes of hospitalization and mortality among people who are experiencing homelessness. [8, 9] Mental illness, substance use, poor physical health, prior victimization, high-risk behaviors, and living in high crime areas have all been linked to higher rates of physical injury. In addition to having higher rates of injury, people who are experiencing homelessness tend to have more intentional and severe injuries, longer lengths of hospital stay, and greater levels of psychological distress related to injuries than their housed counterparts. [10, 11] Medical respite programs play an important role in not only addressing the physical injury but also reducing psychological distress and taking proactive efforts to reduce future victimization. For non-accidental injuries, such as intimate partner violence, medical respite programs can take extra security precautions such as allowing extra privacy for individuals who have been assaulted and by limiting access to the facility by abusive partners.

Fractures	
Assessment	• Assess for non-accidental injury • Assess for ability to ambulate, transfer weight, and begin physical therapy if needed • Assess risk for infection around any sutures • Assess for physical distress
Management	• Wound care and infection control • Pain management • Start ambulation and physical therapy • Management of any psychological impact • Hygiene Assistance • Educate patient on appropriate use of mobility devices such as crutches and walker • Educate patient on making bed transfers
Prevention	• Educate patient on strategies to avoid victimization • Motivational interviewing/counseling for any high-risk behaviors that may have led to the fracture • Discharge patient to housing or other safe setting
Outcomes	• Proper healing • Patient is weight bearing or assistive devices are understood and properly used • No signs or symptoms of infection • Patient has regained adequate mobility to function in preadmission or discharge setting

Lacerations	
Assessment	• Assess for non-accidental injury • Assess for infection • Assess for dehiscence • Assess tetanus status
Management	• Wound care and infection control • Referral for suture or staple removal • Management of any psychological impact
Prevention	• Educate patient on strategies to prevent infection • Educate patient of signs of infection; when to go to the hospital • Educate patient on strategies to avoid victimization • Discharge patient to housing or other safe setting
Outcomes	• Proper healing • No signs or symptoms of infection

Head Injury	
Assessment	• Assess for lacerations • Assess complaints of head and neck pain • Assess focal neurologic deficits • Assess any disturbances in color or breathing • Assess for signs of internal injury
Management	• Apply wrapped/covered ice pack for 20 minutes if needed • Educate patient regarding healing time and possibility of memory loss or disorientation • Continuous frequent examination of neurologic status for 24 hours • Send to emergency room if neurologic deficits or loss of consciousness occur
Prevention	• Educate patient on mobility and fall risks • Educate patient on safety precautions • Educate patient about traumatic brain injury if needed
Outcomes	• Patient is back to baseline functional status • Coordination of resources available to assist people with traumatic brain injury

Burns	
Assessment	• Assess range of motion and physical therapy needs • Assess extent and depth of burn to establish a baseline for healing (consider using the *rule of nines* for estimating the extent of body surface that has been burned) • Assess risk for infection • Assess for psychological impact
Management	• Wound care and infection control • Pain management* • Management of any psychological consequences
Prevention	• Discuss cause of burn and strategies to prevent future incidents • Motivational interviewing/counseling on high-risk behaviors if needed • Discharge patient to housing or other safe setting
Outcomes	• No open or overt wounds • Skin has regenerated enough to cover affected area • Patient has minimized potential for infection

* Pain management can include medication monitoring as well as non-pharmacological approaches such as relaxation techniques, and cooling. Other ways to manage pain for burns include: physical therapy, eliminating friction from sheets; elevating affected limb using bed risers, and educating the patient on the effects of extreme cold and hot temperatures.

Figure 1: Pain management and addiction

Admitting patients with pain and addiction disorders is common for medical respite programs. Below are six suggestions for achieving better outcomes in patients who have pain and suffer from addiction:

1. Don't miss medical complications by making the assumption that a patient is "drug seeking" or has a "low pain tolerance"

There is no magic wand to overcome pain and addiction. Each case needs an individual and careful evaluation. It is not unusual for hospitals to discharge patients without completing a full evaluation particularly if the patient is assumed to be seeking drugs for a substance use disorder.

2. Don't miss the presence of an alcohol or drug use disorder

Every patient requires individual assessment and screening for alcohol and substance use disorders. Various screening tools are available but simply asking in a non-judgmental manner about drinking and drug use and any associated problems may be very effective in a medical respite setting.

3. If opioid analgesics are used, they should be used in appropriate doses taking into account possible high tolerance in patients with co-occurring opioid dependence

Adequate doses of long-acting medications are preferred to short-acting or PRN doses. It is not unusual for a patient to be treated with high dose opioids while hospitalized only to be discharged with a PRN medication at a much lower dose. Patients are at high risk of resuming illicit drug use and leaving medical respite if pain is not treated.

4. Adjunctive treatments--especially touch-based treatments--can be very effective in a medical respite setting

An individualized treatment plan should be developed with each patient with a goal of improving functioning.

5. Create appropriate program structure and policies to assist patients who have difficulty controlling their drug use

"Loss of control" is one of the hallmarks of addiction. A person with an addiction disorder may take more than prescribed or divert their prescribed medication to obtain their drug of choice. We can help create appropriate structure by talking to the referring physician about less abusable, less divertible medications.

Programs that are unable to hold or administer medications can ask referring providers to post-date prescriptions to be left on file at the pharmacy for serial pain medication refills (for example, refills every three days). Respite programs that do not administer medications should provide individual locked cabinets or lockers for patients to safely keep their medications.

6. Provide harm reduction-informed addiction treatment

Medical respite providers should be trained in **motivational interviewing** and basic **harm reduction** principles. One of the first principles of harm reduction is overdose prevention. Harm reduction strategies could include training staff to be able to effectively teach safer injecting or alternative ways of using drugs for a patient admitted with abscess or other infections. Every medical respite program should also be equipped to handle an overdose with staff trained to use naloxone and administer rescue breathing.

Medical respite programs are also an ideal setting to work with patients on motivating readiness to change. Many patients while in respite will be more receptive to suggestions about making changes in their drug use. Staff should be competent in understanding and recommending various avenues to change including 12-step participation, harm reduction therapy, and medications for addiction. When possible, programs should employ or partner with substance abuse counselors and others with special training in addictions.

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Conditions of the Skin and Subcutaneous Tissue

Skin diseases commonly affect people who are experiencing homelessness.[12, 13] Skin problems of the feet are particularly frequent due to walking and standing for long periods of time and poor foot care. Sleeping upright can cause venous stasis and leg edema and subsequently foot ulcers. Cold and moisture and lack of hygiene from unwashed socks and uncut toenails can result in infections. Chronic diseases such as hypertension and diabetes can also manifest into foot ulcers. Often, people who are experiencing homelessness hide skin problems to avoid being ostracized, or neglect skin problems until they become serious. Because management of skin disease requires rest, proper hygiene, and regimented cleansing and bandage changes, homeless patients who have skin disease will likely require inpatient hospital care or medical respite care until the skin problem is resolved. Without such care, homeless patients risk complications and exacerbations of skin problems. Common skin problems addressed in the medical respite setting include cellulitis, abscess, immersion foot, and skin ulcer including diabetic ulcer.

Cellulitis and Post Traumatic Wound Infection	
Assessment	• Assess for infection & determine base line stage • Assess for diabetic control or other contributing factors • Ensure necessary antibiotics have been prescribed • Assess history of cellulitis
Management	• Wound care and infection control • Medication monitoring when prescribed oral or topical antibiotics; watch for adverse reactions to antibiotics • Daily monitoring • Manage other comorbidities that affect healing • Assist patient in keeping affected body part elevated and free from trauma
Prevention	• Educate patient on recurring nature of cellulitis • Educate patient on wound care techniques (including appropriate cleansers) • Educate patient on adequate hygiene • Provide patient with packaged, clean bandages and antibiotic cream or ointment for future wounds • Provide patient with lotion to prevent dryness and cracking of skin • Educate patient on signs of infection and when to seek medical evaluation
Outcomes	• Resolution of cellulitis • Completed antibiotics

Abscess	
Assessment	• Assess size, depth, stage to determine wound care protocol or need for incision and drainage • Assess opened abscess (for exudate) – assess amount, color, and smell • Ensure necessary antibiotics have been prescribed • Review any x-ray or lab results from hospital • Assess for pain • Determine underlying etiology to address risk for recurrence
Management	• Wound care and infection control • Medication monitoring • Keep sheets and surrounding area clean (discard sheets using appropriate environmental safety protocol as determined by local policies) • Pain management if necessary
Prevention	• Educate patient on IV drug use and other causes of abscess infection • Educate patient on hygiene, using antibiotic creams with band aids • Educate patient on nutrition • Educate patient on importance of adequate rest and sleep
Outcomes	• Wound is free from infection • Site and surrounding tissue is improved • Patient is self-sufficient in wound care • Patient can describe source of infection and prevention techniques • Patient can demonstrate good hygiene and personal care

Figure 2: Educating patients on skin care measures

People who have diabetes or poor circulation need to take extra precautions to prevent skin wounds and treat any cuts or cracks in the skin promptly. People who are experiencing homelessness may have fewer opportunities and resources to take adequate precautions (e.g. acquiring vitamins and well-fitting footwear). Medical respite providers should help their patients access resources to prevent skin wounds and provide education on the following skin-care measures:

- Following up with podiatry evaluations.
- Inspecting feet daily.
- Moisturizing skin regularly.
- Trimming fingernails and toenails carefully, taking care not to injure the surrounding skin.
- Protecting hands and feet. Wearing appropriate, well-fitting footwear and gloves.
- Promptly treating any superficial skin infections, such as athlete's foot. Infections on the surface of the skin (superficial) can easily spread from person to person.
- Avoiding pressure to this site.
- Knowing how to recognize cellulitis.
- Maintaining proper diet and nutrition to improve immune system. Taking vitamins.

Skin Ulcer (including diabetic ulcer)	
Assessment	• Assess condition of skin and surrounding area • Assess size, depth, stage to determine wound care protocol • Assess exudate (discharge, pus) – assess amount, color, and smell • If chronic, requiring intense wound care, determine whether referral to hospital or wound care clinic needed • Ensure necessary antibiotics have been prescribed • Assess personal status and underlying etiology
Management	• Wound care and infection control • Remove any excess discharge • Maintain a moist wound environment • Pain management • Topical antibiotics • Keep sheets and surrounding area clean (discard sheets using appropriate environmental safety protocol as determined by local policies) • Avoid pressure to site; for foot ulcers, keep patients off their feet • Ensure adequate nutrition (consider vitamin supplements)
Prevention	• Discuss techniques to improve circulation • Educate patient on opportunities to assist with smoking cessation if needed • Educate patient on hygiene, using antibiotic creams with band aids • Educate patient on foot hygiene, including nail care • Assist with follow up for routine foot examinations if needed • Educate patient on importance of adequate rest and sleep • Offer proper foot wear, support hose, or preventive interventions
Outcomes	• Wound is improved or healed • Patient is self-sufficient in wound care • Patient can describe source of ulcer and prevention techniques • Patient can demonstrate good hygiene and personal care

Immersion Foot (Trench Foot)/ Gangrene	
Assessment	• Assess condition of skin and surrounding area • Assess impact on ambulation • Assess need for assistive device • Assess health history to determine any factors that might complicate healing (e.g., diabetes) • Assess for circulation (pedal pulses)
Management	• Keep feet clean, dry, open to air • If needed, keep foot elevated and avoid prolonged dependent positioning • If wounds are present, use proper wound care and infection control
Prevention	• Instruct patient to keep feet dry, open to air, exposed to sunlight • Encourage patients to sleep without shoes • Provide patient with a supply of new socks and proper shoes • Develop a plan to help the patient avoid being outdoors when wet outside • Educate on use of foot powder & hand sanitizer to rub between toes (4th and 5th toe which are likely to be wet) • Encourage regular foot care (e.g., trimming nails) • Offer proper foot wear, support hose, or preventive interventions
Outcomes	• Patient's wounds are dry, clean, healing well, and free from infection • Patient is able to demonstrate prevention techniques, foot care, and future plan of care • Patient is aware of resources to access clean socks and proper fitting shoes

Conditions of the Respiratory System

Respiratory disease, specifically chronic lower respiratory disease, is the fourth leading cause of death in the United States and affects people experiencing homelessness at double the rate of the general population.[14, 15] Indeed, studies looking at morbidity among homeless populations have found that nearly half of the populations studied suffered from respiratory disease.[16, 17, 18] Respiratory diseases commonly seen in people experiencing homelessness include asthma, influenza, pneumonia, upper respiratory infections, tuberculosis, and chronic obstructive pulmonary disease such as bronchitis and emphysema. High rates of respiratory disease in people experiencing homelessness are primarily attributed to smoking and unmanaged respiratory infections. Exacerbations and recurrence of pre-existing respiratory disease can be attributed to smoking, infections, general health, nutrition, environmental stress, drug and alcohol abuse, or poor access to care. Medical respite programs play an important role in recovery of acute respiratory illness, preventing spreadable infections, and long term health management of chronic respiratory illness.

Chronic Obstructive Pulmonary Disease (COPD)	
Assessment	• Assess lung sounds and respiratory rate • Assess signs and symptoms of exacerbation (wheezing, shortness of breath, chest tightness, unable to talk in sentences) • Assess for signs of secondary infection (fever, increased sputum production) • Assess for signs of depression or anxiety • Assess for oxygen saturation
Management	• Medication monitoring (controllers & relievers) • Oxygen therapy* (as needed, or continuous) • Nebulizer treatment • Monitor pulmonary function • Counseling/support group for depression or anxiety • Deep breathing exercises (incentive spirometry) • Pulmonary rehabilitation
Prevention	• Encourage smoking cessation (motivational interviewing) • Describe ways to avoid or minimize the impact of environmental triggers and allergens in shelters (dust, cockroaches, mold, exercise) • Provide or encourage annual flu and pneumococcal shot • Describe or facilitate opportunities to avoid exposure to extreme temperatures (i.e., drop-in centers that are open during the day if 24 hour shelters are unavailable) • Stress reduction techniques (mindfulness-based stress reduction, controlled breathing) • Describe actions that can be taken to avoid exacerbations (resting on a park bench during walks)
Outcomes	• Decreased shortness of breath and wheezing • Decreased use of reliever inhaler • Decreased stress • Equipped with supplies to support smoking cessation (e.g., nicotine patches) • Knowledge of support groups and other resources to assist in smoking cessation

*Some medical respite programs cannot accommodate oxygen therapy

Asthma	
Assessment	• *See assessment for COPD (p.19)* • Assess severity of asthma (frequency of symptoms and inhaler use) • Peak flow readings • Assess for presence of allergies or GERD • Review asthma control test (ACT) scores
Management	• Monitor use of inhalers and oral medications if necessary • Nebulizer treatment • Develop an asthma action plan (see Appendix A) • Offer creative ways to carry medications (e.g., fanny packs) • Monitor GERD/allergy medication • Monitor signs and symptoms to identify triggers • Monitoring peak flow trends • Keep facility and linens clean (avoid using toxic chemicals) • Ensure adequate air circulation in facility • Refer to clinic for full pulmonary function test if indicated
Prevention	• Describe asthma triggers and actions that can be taken to minimize exposure • Provide controller medication or assist in getting a prescription • Describe ways to control allergies/GERD • Encourage smoking cessation (motivational interviewing) • Provide or encourage annual flu and pneumococcal shot • If returning to a shelter, contact shelter staff and request that toxic cleaning agents be replaced with less toxic alternatives
Outcomes	• Patient demonstrates proper use of inhaler • Patient understands how to prevent secondary infections (e.g., bronchitis) • Improved ACT score • Patient decreases use of rescue inhaler

Influenza*	
Assessment	• Assess for high, persistent fever • Assess for signs and symptoms of dehydration • Assess for signs of secondary infections (ear, sinus) • Assess need for antiviral medication (within first 48 hrs. for those at high risk)
Management	• Antipyretics • Provide adequate fluids • Secure a private room for rest and isolation • Educate patient on techniques to avoid exposing others • Monitor use of antiviral medication • Ensure adequate air circulation and infection control measures if caring for a patient in shared quarters
Prevention	• Educate patient on techniques to minimize spread of the infection • Provide or encourage annual vaccination
Outcomes	• Minimized course of disease • Afebrile for 48 hours

*Admission criteria for influenza may vary depending on ability to isolate

Pneumonia	
Assessment	• Review chest x-ray • Assess blood work, complete blood count (if clinic is available onsite) • Assess lung sounds • Assess high fever and chills • Assess sputum • Conduct pulse oximetry • Assess HIV status
Management	• Medication monitoring • Rest • Provide adequate fluids • Encourage deep breathing and coughing • Monitor oxygen therapy*
Prevention	• Provide or encourage vaccination if indicated • Minimize exposure to crowds • Disease management education for other chronic respiratory diseases
Outcomes	• Resolution of course

*Some medical respite programs cannot accommodate oxygen therapy

Conditions of the Circulatory System

People who are experiencing homelessness are at higher risk for heart disease and more likely to die of heart disease than their housed counterparts. Studies in Boston and Toronto found heart disease to be the leading cause of death among older homeless men. Both studies found that homeless men ages 45 to 64 years of age are 40% to 50% more likely to die of heart disease than men in the general population.[19, 20] High rates of smoking, poor diets, and hypertension are common risk factors leading to heart disease for homeless adults.[21, 22, 23] Some studies point to alcoholism and cocaine use as additional risk factors.[24] Another study found that only 33% of hypertensive homeless men were aware that they had hypertension and only 17% were taking antihypertensive medications.[25] Such findings indicate a high prevalence of uncontrolled disease among the homeless population. Interventions delivered at medical respite programs that reduce risks and improve disease management include education on medications, linkage to smoking cessation programs and treatment programs for alcoholism and cocaine use, linkage to housing, and increasing access to nutritious food. In addition, medical respite programs would benefit from having staff members who are trained to use onsite automated external defibrillators.

Coronary Artery Disease	
Assessment	• Assess for ongoing symptoms (e.g., chest pain which may radiate to arm, shoulder or jaw; shortness of breath) • Assess for underlying risk factors (e.g., poorly controlled high blood pressure, tobacco use, obesity, poorly controlled diabetes, high cholesterol , cocaine use) • If post-operative, assess for hematoma or infection at incision site • If post-CABG, assess weight
Management	• Monitor vital signs • Help patient comply with medication regimen • Help patient control risk factors • If nitroglycerin is prescribed for management of chest pain, monitor use and measure blood pressure afterwards • If chest pain or symptoms are unresolved, determine whether patient needs to go the emergency room • Ensure non-medical staff is trained in emergency protocol if chest pain develops (medical provider should be aware of anginal symptoms or changes in pattern) • If post-operative, change inguinal dressing • If post-operative, contact cardiologist if hematoma or signs of infection appear at incision site
Prevention	• Educate patient on risk factors
Outcomes	• Stable pattern of symptoms, not getting worse, or no symptoms • If post-operative, incision is healed • Patient is able to comply with medication regimen

Hypertension	
Assessment	• Assess blood pressure • Assess for symptoms of hypertension (headaches, chest pain, visual changes, shortness of breath) • Assess underlying stress contributing to hypertension • Assess for substance intoxication or withdrawal
Management	• If symptoms or blood pressure is elevated (even moderately), consider transfer to emergency department or primary care provider office • Help patient address or resolve underlying stress • Help patient comply with medication regimen • Work with prescriber to simplify medication regimen (e.g., once a day dosing for antihypertensives)
Prevention	• Help patient avoid stimulant medications or drugs (link to recovery supports for addiction if needed)
Outcomes	• Patient is asymptomatic (consistently less than 140/90)

Peripheral Vascular Disease	
Assessment	• Assess for symptoms of claudication • Assess for peripheral pulses • Assess for blue or purple skin discoloration of an extremity • Assess skin integrity
Management	• Help patient comply with medication regimen • If bypass procedure, assess incision for infection • If symptoms persist or worsen, discuss with patient's primary care provider • If blue or purple skin discoloration of an extremity, send to emergency room • Help patient identify walking routes with numerous benches for resting
Prevention	• Educate patient on risk factors • Encourage regular exercise
Outcomes	• Symptoms are resolved or stabilized • Patient understands and can comply with medication regimen

Bilateral Leg Edema	
Assessment	• Assess severity of edema • Assess whether edema is symmetric • Assess for signs of cellulitis or skin breakdown in feet or legs, consider antibiotic or referral to primary care provider if needed • If underlying cause is unknown, refer to primary care provider for workup • Assess for shortness of breath which could be a sign of congestive heart failure
Management	• Diuretics • Help patient comply with medication regimen • Elevate legs • If chronic venostasis, consider compression stockings
Prevention	• Educate patient on keeping legs elevated once swelling is down • Educate patient on medication compliance
Outcomes	• Edema is stable • Patient understands and can comply with medication regimen

Conditions of the Gastrointestinal/Hepatobiliary System

Common gastro-intestinal related conditions seen in the medical respite setting include hepatocellular carcinoma, cirrhosis, hepatic encephalopathy, colorectal cancer, and hernia of the ventral, inguinal, and abdominal areas. Hepatitis, a precursor to cirrhosis and hepatocellular carcinoma, is prevalent among homeless populations and associated with risky behaviors such as injection drug use and excessive alcohol use. The reported prevalence of Hepatitis C is 10 to 20 times higher in some homeless sub-groups than in the general US population, ranging from 22% to 80%, with higher rates among those with a history of injection drug use.[26,27,28,29] Untreated Hepatitis can lead to cirrhosis and subsequently to hepatocellular carcinoma (HCC). Individuals in need of medical respite care are often suffering from complications of cirrhosis including infections, malnutrition, fatigue, confusion, and abdominal and leg swelling. Medical respite programs can assist patients diagnosed with cirrhosis or HCC through medical oversight, medication monitoring, coordinating follow up screenings, assistance in following proper diet, and addiction counseling and recovery support (including referral to a substance abuse treatment program).

Hernia – Ventral, Inguinal, Abdominal (generally post-operative)	
Assessment	• Assess for swelling under incision which could be sign of hematoma or infection • Assess for signs of bowel obstruction (lack of bowel signs, abdominal pain, vomiting, lack of bowl movement, flatus) • Assess for pain
Management	• Wound care • Pain management • If signs of wound infection or hematoma, contact surgeon • If signs of bowel obstruction, send patient to emergency room • Discuss activity restrictions • Address causes of chronic cough
Prevention	• Educate patients on wound care techniques (including appropriate cleansers) • Educate patient on maintaining adequate hygiene • Provide patient with packaged, clean bandages and antibiotic cream or ointment for future wounds • Provide patient with lotion to prevent dryness and cracking of skin • Educate patient on signs of infection and when to seek medical evaluation • Educate patient on signs of recurring hernia (bulging of skin or pain) and when to see their primary care provider
Outcomes	• Incision is healed • Patient symptoms are adequately controlled • Patient is having regular bowel movements

Hepatic Encephalopathy	
Assessment	• Assess mental status for signs of increasing confusion or personality change • Assess for lethargy • Assess for any known precipitating factor (signs of infection, increased dietary protein load, electrolyte disturbance)
Management	• Treat infection, electrolyte disturbance or other precipitating factors if present • Medication monitoring (may need to assist with dose titration of lactulose) • Manage underlying liver disease • Provide education regarding substances or medications that can aggravate liver disease • Refer to primary care provider if new or increased symptoms arise
Prevention	• Educate patient on importance of medication adherence
Outcomes	• Improved mental status • Normalization of serum ammonia • Correction of any precipitating factor • Stabilization of underlying liver disease • Avoidance of aggravating factors

Hepatocellular carcinoma	
Assessment	• Assess prognosis and need for end-of-life care • Assess for abdominal pain • Assess for complications of therapy
Management	• Referral to specialist to discuss treatments (resection, chemoembolization, radiofrequency ablation, ethanol injection) • Manage pain symptoms • Advanced care planning
Prevention	• None
Outcomes	• Arrangements are made to assist patient in meeting end-of-life goals • Patient has achieved optimal level of functioning (e.g., activities of daily living) • Patient is at acceptable pain level

Cirrhosis	
Assessment	• Assess for mental status changes or asterixis which could be a sign of hepatic encephalopathy • Assess for distended or painful abdomen which could be a sign of ascites or peritonitis • Assess for lower extremity edema which could be a sign of low albumin • Assess for jaundice and pruritus • Assess for black stool or coffee ground vomitus • Assess for alcohol use • Assess for viral hepatitis • Assess whether patient has had annual screening for hepatocellular carcinoma • Assess for medication compliance
Management	• If appropriate offer vaccination against hepatitis A & B • Avoidance of alcohol or other hepatotoxic drugs (including high doses of acetaminophen) • Offer treatment options if cirrhosis is alcohol-related • Maintenance of adequate nutrition (adequate protein, low-sodium) • In patients with ascites, consider sodium restriction and use of diuretics • If viral hepatitis, educate patient on transmission of virus • Prompt detection of complications; if present, referral to emergency room or specialist • Medication monitoring • Daily weight monitoring • Educate patient on how to minimize or avoid bleeding
Prevention	• Provide recovery support, including referral to a treatment program • Help patients avoid hepatotoxins
Outcomes	• Complications are minimized or stable • Patient has achieved optimal level of functioning (e.g., activities of daily living)

Colorectal Cancer	
Assessment	• Assess for rectal bleeding, which may be ongoing • Assess bowel habits • Assess for abdominal or rectal pain • Assess for anemia • Assess for weight loss • Assess for staging • Assess for connection to oncology and primary care • Assess for complications of therapy
Management	• Pain management • Consult with oncologist and surgeon • If rectal bleeding worsens, referral to emergency room • If post-resection, wound/ostomy care • If severe constipation, consult with primary care provider or specialist
Prevention	• Assist patient in self-care for any complications that may arise
Outcomes	• Patient has achieved optimal level of functioning (e.g., activities of daily living) • Regular bowel movements • Patient capable of caring for ostomy • Symptoms are controlled • Discharge to housing

Conditions of the Nervous System

Neurological disorders most often seen in the medical respite setting include epilepsy, peripheral neuropathy, and cerebrovascular accident (CVA). People experiencing homelessness experience epileptic seizures at over eight times the rate of their housed counterparts with most seizures being non-alcohol related.[30] Peripheral neuropathy is also prevalent among people experiencing homelessness due to risk factors such as poor nutrition, high rates of diabetes, alcohol abuse, exposure to toxins, repetitive physical stress, and liver disorders. Some important ways that medical respite programs can assist individuals who have neurological disorders are by providing education around safety precautions, monitoring changes in mental status, providing emotional support, and assisting in any needed physical, occupational and speech therapy.

Epilepsy, or seizure disorder	
Assessment	• Assess for stability or current management (change in seizure frequency) • Assess for medication compliance or any side effects that indicate a need to reevaluate the medication. • Assess for any injury that the patient may have sustained during seizure activity • Assess for current substance use or medications that may increase seizure frequency
Management	• Seizure precautions (avoid top bunks, use shower rather than bathtub) • Attention to medication adherence • Monitor any injuries sustained during seizure (mouth wounds, head injury) • Notify the primary care provider if increased seizure frequency • Educate/train non clinical staff in seizure precautions
Prevention	• Educate patient regarding importance of medication compliance • Educate patient regarding safety behaviors for themselves and others (precautions when driving, working at heights, using machinery, using bathtubs) • Educate regarding importance of avoiding substances that aggravate seizure disorders
Outcomes	• No medication side effects • Stable seizure pattern • Discharge to safe environment

Peripheral Neuropathy	
Assessment	• Assess for the underlying illness or cause (diabetes, nutritional deficiency, alcoholism) • Asses for stability of symptoms (rule out progression of symptoms) • Assess for potential hazards (ulcers or burns from loss of sensitivity to touch)
Management	• Pain management • Provide physical therapy and assistive devices as needed • Avoid trauma to effected areas (provide well fitted shoes, avoid friction and prolonged pressure, provide dry socks) • Periodic foot checks • Notify primary care provider if any changes or variations occur
Prevention	• Educate patient regarding underlying cause and ways to avoid progression • Educate patient regarding ways to avoid secondary injury (e.g., daily visual foot inspections for diabetics)
Outcomes	• Pain is controlled • Secondary injuries are healed • Patient understands ways to prevent recurrence or progression

Cerebrovascular Accident (CVA)	
Assessment	• Assess extent of focal neurological deficit and determine time of onset • Assess need for assistive devices for patient safety • Assess ability to perform activities of daily living independently • Assess bowel and bladder continence and skin integrity • Assess ability to communicate needs
Management	• Provide for physical, occupational, and speech therapy rehabilitation needs • Medication monitoring • Monitor vital signs for stability • Counseling and emotional support
Prevention	• Educate patient on importance of medication compliance even in absence of symptoms • Educate patient on importance of limiting risk factors (smoking, cholesterol, high-fat diet, uncontrolled diabetes, hypertension) • Educate on signs and symptoms of stroke recurrence
Outcomes	• Completion of treatment goals for physical, occupational, and speech therapy • Blood pressure, blood sugar, and lipid control • Discharge to safe environment (refer to Home and Community-based Service program if needed and eligible)

Figure 3: Advanced care planning

People experiencing homelessness often encounter end-of-life situations with minimal support and ill-conceived expectations about how decisions will be made. Studies looking at advanced care planning for people experiencing homelessness found that when provided with guidance and counseling, people experiencing homelessness tend to be more proactive in developing advanced care plans than their housed counterparts (Song, 2010).

In addition to common end-of-life concerns (e.g., loss of control), people without housing have additional concerns about dying anonymously in public spaces (Song, 2007). Advanced care planning is way of preserving dignity for people experiencing homelessness. Plans take into account a number of end-of-life decisions and ensure that spiritual and cultural needs are met and friends and loved ones are notified in the event of serious illness or death.

The medical respite setting is an opportune place to assist patients in creating advanced care plans. Medical respite providers may need to spend extra time working with homeless patients to help them reconnect with relatives or determine who best to act as a surrogate when no friend or relative is identified to help make end-of-life decisions. Once plans are completed, medical respite care providers should assist patients in getting their plans notarized and filed with the appropriate medical institution. Advanced Care Plan templates are usually available from state departments of health. A template used in Minnesota in homeless health care settings is included in the Appendix.

Sources: Song, J., Ratner, E.R., Wall, M.M., Bartels, D.M., Ulvestad, N., Petroskas, D., West, M., Weber-Main, A.M., Grengs, L., & Gelberg, L. (2010). Effect of an End-of-Life Planning Intervention on the completion of advance directives in homeless persons: a randomized trial. Annals of Internal Medicine, 20(2): 76-84.

Song, J., Bartels, D.M., Ratner, E.R., Alderton, L., Hudson, B., Ahluwalia, J.S. (2008). Dying on the streets: homeless persons' concerns and desires about end of life care. Journal of General Internal Medicine, 22(4): 435-441.

Conditions of the Genitourinary System

Conditions of the Genitourinary System more commonly seen in the medical respite setting include urinary tract infection and prostatic hypertrophy. Urinary tract infections when left untreated can lead to acute or chronic kidney infections (pyelonephritis) and as such require some oversight to ensure that the infection is eradicated before the patient is left to their own care. Prostatic hypertrophy can also create serious complications when left untreated. Bladder, urinary tract or kidney problems can arise when urine flow is blocked. Not only do medical respite programs provide medication oversight and a clean bed for recuperation after surgery, but these programs can be a tremendous resource for patients who need frequent access to restrooms.

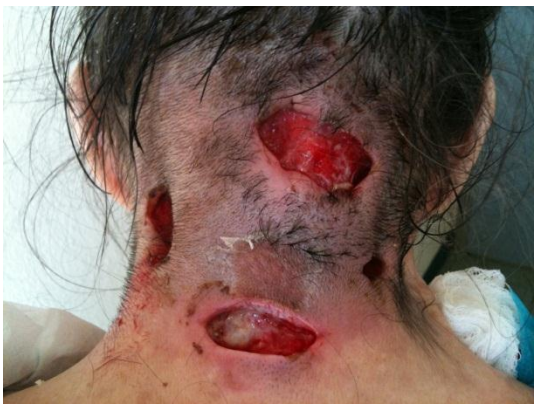
Urinary Tract Infection	
Assessment	• Assess symptoms including dysuria (painful urination), increased frequency and urgency of urination, suprapubic pain, incontinence, and/or hematuria • Assess symptoms or signs of pyelonephritis (CVA tenderness, fever, nausea, vomiting, back pain) • Assess for infection with urinalysis by either microscopy or dipstick • Perform urine culture and sensitivity (C&S) testing for patients with known or suspected UTI or pyelonephritis • Assess health history for risk of recurrent infection
Management	• Hydration • Close monitoring for patients at risk for pyelonephritis • Medication monitoring (appropriate antibiotic, check urine C&S)
Prevention	• Consider antimicrobial prophylaxis for patients with recurrent infections, when indicated • Educate patient on reoccurring nature of UTI • Educate patient on proper hygiene and other prevention measures
Outcomes	• Completion of antibiotics • No signs or symptoms of infection • Patient demonstrates understanding of preventive measures

Benign Prostatic Hypertrophy	
Assessment	• Assess symptoms including increased frequency of urination, nocturia, hesitancy, urgency, dribbling and weak urinary stream. Pain and dysuria usually not present. • Assess severity of symptoms • Assess for enlarged prostate by performing rectal exam (send to primary care provider if unable to perform this assessment at the medical respite setting) • Assess for urinary infection with urinalysis
Management	• Limit intake of fluids in the evening hours • Medication monitoring if/when indicated (e.g., alpha blockers) • Referral or follow-up with primary care provider or urology specialist to distinguish benign versus malignant • Avoid/minimize urinary retention
Prevention	• Encourage patients to avoid fluids prior to bedtime • Avoid medications that worsen symptoms
Outcomes	• Symptoms are reduced (or controlled) • Patient demonstrates understanding of preventive measures

Case Study

Homeless Adult with Abscess

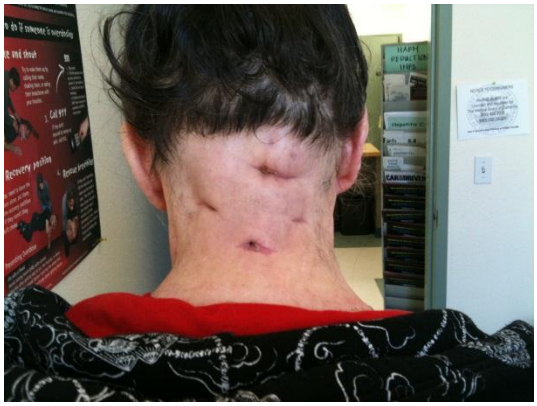
Presentation: Sarah is a 61-year-old female referred from a local hospital after treatment for an abscess that left four deep wounds on her neck. After incision and drainage at the hospital, she was admitted to the medical respite program to finish a course of oral antibiotics and for wound care.



Abscess upon admission

Social history: Sarah had been homeless for 3 years, sleeping on the streets, in shelters, and most recently on couches of friends and acquaintances. She worked as a physical therapist for 12 years before succumbing to financial difficulties complicated by untreated depression and anxiety.

History of present condition: The wounds are a result of untreated head lice acquired from sleeping on the floor in an infested hotel room. A combination of scratching and poor hygiene caused her scratches to become infected. She still had lice nits in her hair when she arrived at the medical respite facility.



Abscess at discharge

Medical respite assessment: On arrival at the medical respite site, clinical staff assessed the four wounds including size, depth, tunneling, pain, drainage and exudates and periwound areas. Medical respite staff learned that she had little to no family involvement and was not interested in reconnecting with her family at the time. She initially presented as very well-organized but later reported to medical respite staff feelings of depressed mood. She had no known history of substance abuse or addiction. During her stay at the medical respite program, staff connected her with a primary care provider (PCP) who detected signs of breast cancer.

Medical respite treatment/intervention: Sarah's treatment plan included 1) daily medication monitoring to ensure appropriate use of antibiotics, 2) wound care, 3) connection to the community wound care clinic for consult, 4) lice treatment, 5) access to mental health care, and 6) case management to assist in benefits acquisition and housing. The wounds required wet to dry packing daily. Aquacel Ag was applied daily in order to remove yellow slough tissue located on the wounds at the base of her neck. Medical respite staff aided Sarah with a permethrin treatment for lice and instructed Sarah on proper use so as not to allow any permethrin on her wounds. Staff combed out the nits in Sarah's hair. After her PCP detected signs of breast cancer, medical respite staff assisted her in getting to follow up and work up appointments and provided emotional support. Medical respite staff also worked with her PCP to communicate any cancer-related issues and to discuss needed adjustments to pain medications.

Outcome: After 1 month in the medical respite program, Sarah's wounds healed and she no longer had lice. Sarah was able to gain access to the state's Medicaid and General Assistance programs. A case manager helped her to complete a housing application and subsequently gain access to supportive senior housing (for eligible adults aged 55 and up) where a nurse and case manager are on site 40 hours a week. Sarah was also connected to a mental health care provider who she sees regularly through a local agency that serves seniors. She was also connected to diagnostics for her breast cancer and oncology follow up.

Case Study

Homeless Adult with Multiple Fractures

Presentation: Sam is a 30-year-old male who was struck by a vehicle while he was intoxicated. He sustained several fractures (acute fracture at the transverse process of the L5 vertebra, pelvic fracture of the right sacral, bilateral superior and inferior rami fractures, and bilateral L5-TP fractures). After treatment at the emergency department, he was referred to the medical respite program to begin the healing process and complete a course of pain medication with some clinical oversight.

Social history: Sam moved to Orange County from North Carolina six months prior to the accident. He had been without housing since arriving in Orange County and staying at a local shelter. Sam had an "ok" relationship with his biological father and no communication with his step-mother. He had no siblings. He refused to go into further detail about his family history. Sam had no income and usually seeks support from his father. He has a G.E.D. and some college education. Sam began drinking and using drugs at 13-years of age. His drugs of choice were: ketamine, MDMA (3,4-methylenedioxymethamphetamine), methamphetamines and alcohol. Sam was very respectful and compliant but became verbally aggressive when under the influence.

Medical respite assessment: Sam arrived from the hospital in a wheelchair and was provided with a set of crutches but was having difficulty using them. The hospital reported a head injury and subsequent memory loss due to the accident but medical respite staff found Sam to be alert and oriented. The hospital also reported a history of hydrocephalus status post shunt placement at age 15 and a history of stroke at age 28. Staff continued to monitor Sam for signs of head injury, not ruling out any complications from his past medical history.

At the hospital, Sam reported having bipolar disorder and schizophrenia. The hospital confirmed the diagnoses. At the time of his arrival, he was not linked to any mental health agency and was self-medicating with alcohol and drugs.

Medical respite treatment/intervention: Staff worked with Sam to develop treatment goals. His medical goals were to 1) keep his appointment with the Orthopedic Trauma specialist, 2) improve ambulation using assistive devices, 3) take prescriptions as directed, including enoxaparin injections, 4) keep wounds clean in order to promote healing, and 5) connect with a local agency that provides housing and mental health services. While in the medical respite program, Sam also hoped to resolve legal issues and access income.

The hospital provided Sam with several medications including benzotropine, olanzapine, oxycodone / acetaminophen, divalproex, trazodone, enoxaparin, and hydrocodone. Medical respite staff provided morning and evening reminders to assist with medication compliance. Sam received instructions for self-administering enoxaparin via injection. The Medical Respite Coordinator supervised his first injection and he was able to self-inject throughout the remainder of his stay with daily counting of his syringe supply. Sam was taking the maximum dose of hydrocodone (12-14 daily) for the first two days of recuperative care, though he was instructed to take 1 to 2 tabs every 4 to 6 hours. Recuperative care staff worked with Sam to improve adherence to his prescription instructions. After completing the hydrocodone regimen, pain was managed by NSAID.

Outcome: Sam was discharged with his leg healing well, no infection at the incision site, and successfully weaned off narcotic pain medication. He was connected to a primary care provider near the area where he planned to live. Sam also found housing through a local service that provides mental health care, psychiatric services, and housing to individuals who have mental illness. While in the medical respite program, he also secured identification and worked with a case manager to expedite his Supplemental Security Income (SSI) application. Since Sam used the medical respite facility for his address in his SSI application, he continues to follow up with the agency to get updates about his application status.

Case Study

Homeless Adult with Pneumonia

Presentation: The respite nurse found James, a 63-year-old male, while doing outreach at the night shelter. James was significantly underweight and was breathing very rapidly. After getting his permission, she assessed his vital signs and lung sounds. He was tachypneic, had a fever of 102, oxygen saturation of 93%, and had crackles at the base of his right lung. She brought him to the hospital, and he was admitted for pneumonia. He was discharged into the medical respite program after his hospital stay to recover.

Social history: James had been living in his car in rural Minnesota for over a year. He had no source of income, was estranged from his family, and suffered from major depression. He had been unemployed for several years and had depleted his savings, so he decided to seek shelter and services in a metropolitan area.

History of presenting condition: James suffered from poorly managed asthma and hypertension. He acquired pneumonia while staying in the night shelter, likely a result of (or exacerbated by) poor nutrition, chronic stress, and compromised lung function.

Medical respite assessment: During his medical respite stay, respite clinical staff monitored James's oxygen saturation, lung sounds, vital signs, and peak flows.

Medical respite treatment/intervention: The medical respite program gave James the opportunity to rest and provided three meals daily. He used oxygen as needed and was educated on how to self-administer nebulizer treatments. Staff coordinated referrals to primary and behavioral health care, and helped him with transportation to these appointments. They submitted an application for expedited health insurance and assisted him in applying for Supplemental Security Income (SSI). The medical respite nurse provided health education about his chronic conditions (asthma & hypertension). They also helped James locate and reconnect with his daughter.

Outcome: James fully recovered from his pneumonia without subsequent visits to the emergency room or hospital. He began routine medications for asthma and did not need nebulizer treatments or oxygen upon discharge from the medical respite program. His blood pressure stabilized after starting anti-hypertensives. His SSI was approved, so medical respite staff assisted James in finding an apartment close to his daughter. Medical respite staff also helped him in this transition by facilitating connection to a primary and behavioral health care clinic in that town. He remains housed and is doing well.

Case Study

Homeless Adult with Hypertension

Presentation: John is a 60-year-old alcoholic male with hepatitis C and known hypertension. He was referred to the medical respite program after an outpatient evaluation by his primary care provider (PCP) for poorly controlled hypertension.

History of presenting condition: In the month prior to his respite stay, three of John's family members passed away. Feeling sad about these losses, John allowed his antihypertensive medications to run out and experienced a brief relapse with alcohol several days prior. He presented to his PCP at a shelter-based Health Care for Homeless clinic in order to access medications for hypertension. He denied any physical symptoms but reported feeling depressed, although he was not suicidal. His blood pressure was 178/102. He had no signs of alcohol withdrawal and his physical examination was essentially normal.

Social history: John grew up in Puerto Rico and completed 10th grade before dropping out of school. He moved stateside about 30 years ago and had been homeless most of his adult life. Relationships with his family were strained and he spoke to them infrequently. He typically stayed in nearby shelters and occasionally slept outside. During periods of heavy drinking, John would consume one pint of vodka per day. He had been sober for three months prior to his recent brief relapse. In the distant past, he also smoked cocaine and injected heroin.

Medical respite assessment: John was assessed by his PCP to have severe, but asymptomatic hypertension, as well as moderate depression. His medical respite team of providers and nurses observed him closely for symptoms and signs of alcohol withdrawal and monitored his blood pressure three times per day. He was also assessed frequently for symptoms that may indicate a complication of severe hypertension, including chest pain, shortness of breath, headache, and visual changes. The team talked to John at length about his depression and assessed him again for suicidality.

Medical respite treatment/intervention: John's antihypertensive medications were restarted and he was referred to a mental health provider. Over the course of two weeks, John's blood pressure gradually improved to 140/90. Upon consultation with his PCP, the medical respite team further titrated his antihypertensive medications and with John's input, his regimen was simplified to include only once-per-day dosing. John was counseled about the effects of alcohol, cocaine, and stress on blood pressure, as well as about the complications of untreated hypertension. Medical respite nurses reviewed his new medication regimen with him a number of times. John was convinced to call and reconnect with his AA sponsor, with whom he had not spoken recently. A case manager at the medical respite program helped him obtain several documents needed to update his housing application with the local housing authority.

Outcome: After three weeks in the medical respite program, John was discharged to a local shelter while he waits for housing placement. His blood pressure was stable and normal and he left with improved spirits. He had established care with a mental health provider and was feeling more upbeat. While he remained unsure about whether he would attend AA meetings, he gained support from his sponsor.

Case Study

Homeless Adult with Co-occurring Addiction and Mental Illness

Presentation: Donald is a 64-year-old Caucasian male who was hospitalized because of multiple organ failure (including the liver and kidneys) and septic shock brought on by heavy drinking. Donald was comatose for nearly two months. During his stay at the hospital, an exploratory laparotomy found a pelvic abscess which had become extremely infected. The wound was left open and treated with a wound V.A.C. for two-months. Donald remained in the hospital for a month after waking and was referred to the medical respite program once the wound V.A.C. treatment was completed.

Social history: During Donald's hospitalization, his roommate gave away his room leaving him homeless. He lost his job as a computer technician about a year prior to his hospitalization and had no income. Donald is divorced and has two young adult daughters and one son who were not able to provide support. However, he had a good relationship with his daughters and son and looked to them as motivation to change harmful behaviors.

Medical respite assessment: Donald arrived from the hospital in a very frail state; however, his liver and kidney function was stable. The incision left on his abdomen required ongoing wound care. He was discharged from the hospital with 7 days of medications (levetiracetam, metoprolol tartrate, gabapentin, acetaminophen/hydrocodone, amitriptyline, citalopram hydrobromide, vitamin B_{12} supplement).

Donald indicated that he was interested in drug and alcohol treatment but not ready at the time. He also believed that after being in a coma for two months, he would not have difficulty refraining from alcohol. A brief neuropsychological evaluation indicated major depressive disorder; however, Donald did not want treatment from the onsite psychologist and psychiatrist other than medication.

Medical respite treatment/intervention: Medical respite staff connected Donald to a wound clinic, physical therapy, and a neurologist (for peripheral neuropathy and seizure disorder). Staff worked with him to establish a routine for taking his medications and the medical respite physician titrated his seizure medications. Though he managed his medications fairly well, he had difficulty following instructions for bed rest which put stress on his wound and necessitated referral back to the hospital for general surgery. Staff encouraged him to remain in bed to ensure proper healing.

The medical respite team (Psychologist, Psychiatrist, Internist, Respite Nurse Coordinator, and Medical Social Worker) met with Donald weekly to discuss his treatment and used motivational interviewing techniques to encourage outpatient treatment for his alcohol abuse. Though Donald did not seek treatment, he remained sober for about 5 months. Shortly before being discharged from the medical respite program, he relapsed and was sent to the hospital for injuries sustained from a fall. He returned to the medical respite program after his hospitalization and continued to attend group meetings where he was able to address his relapse. After he was discharged from the medical respite program, he continued to attend the medical respite graduate meetings. He relapsed a couple of more times before making the decision to participate in an outpatient treatment program. His decision to attend treatment was influenced in part by the encouragement of other medical respite graduates who found the treatment program to be helpful.

Outcome: Donald was discharged from the program and was able to move in with his close friend. His wound was healing well and though he refused to use a walker, he agreed to use a cane to reduce stress to his abdomen. He accessed food stamps and income through the general assistance program and was connected to a local agency that would provide intensive case management. He continues to attend the medical respite group at least monthly and works closely with the medical respite psychiatrist to treat his depression and maintain sobriety.

Conclusion

Medical respite programs play a unique role in the health care of people who are experiencing homelessness. These programs improve the quality of care for sick and injured people who might otherwise have no other recourse but to attempt to manage their health on the streets. Indeed, self-care under such adverse circumstances contributes to higher rates of illness and chronic disease, frequent hospitalizations, and earlier mortality than their housed counterparts.

Studies on medical respite programs find program participants to be 50% less likely to experience future hospitalizations than those who are unable to access this service.[31, 32] Programs that achieve such outcomes offer more than just a bed to recuperate; bed rest in coupled with high quality clinical care, oversight, and a range of supportive services.

Communities establishing medical respite programs should be aware of the level and range of clinical and supportive services needed to make these programs effective. This document describes a basic level of clinical services that should be offered in the medical respite setting and emphasizes the important role of the clinical component of these programs. The recommendations and diagnoses described in this document are not intended to be exhaustive. Indeed, medical respite programs provide services to individuals with varying degrees of health care needs and some are able to provide a broader range of services than what are described here.

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Asthma Action Plan

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE — Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Before exercise	❒ _____	❒ 2 or ❒ 4 puffs _____	5 to 60 minutes before exercise

YELLOW ZONE — Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
(50 to 79 percent of my best peak flow)

First

Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

_____ (short-acting beta$_2$-agonist)

❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour
❒ Nebulizer, once

Second

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
❒ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
❒ Take: _____ (short-acting beta$_2$-agonist) ❒ 2 or ❒ 4 puffs or ❒ Nebulizer
❒ Add: _____ (oral steroid) mg per day For _____(3–10) days
❒ Call the doctor ❒ before/ ❒ within _____ hours after taking the oral steroid.

RED ZONE — Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
(50 percent of my best peak flow)

Take this medicine:

❒ _____ (short-acting beta$_2$-agonist) ❒ 4 or ❒ 6 puffs or ❒ Nebulizer

❒ _____ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:
- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ❒ 4 or ❒ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance _____ NOW!**
(phone)

My LIVING WILL
A Health Care Directive

Identification: **The following information will be used to identify you and your family, if you experience a health crisis and are unable to speak for yourself.**

Name: _____ **Alias** (or Street Name): _____

Mailing address: _____

_____

Date of Birth (month/day/year): ____/____/____

Religion or Spirituality: _____

Marital Status: _____

Name and contact information of family members, friends, or agencies I would want notified if I were seriously ill or dying (please include phone numbers if you have them):

_____

_____

I **do not** want these people notified: _____

Things that would help emergency and health care staff to identify me: (describe)

Scars: _____

Tattoos/Piercing: _____

Birthmarks: _____

Other: _____

I receive health care at (list doctor, clinic, health plan or hospital):

_____

I (write name here)_____ understand that this document allows me to explain what I want for my health care if I cannot speak for myself and to name a person to make health care decisions for me.

Introduction: **There are three sections to this living will.**

- **Part One is for you to explain in a legal document what you would want for your health care in the event that you cannot speak for yourself.**
- **Part Two is for you to name a person you trust who could make health care decisions for you if you could not speak for yourself.**
- **Part Three will give you a chance to reflect upon your life and values; this part will help your family, friends, and health care professionals understand you better.**

You do not have to complete all three parts, and you do not have to answer every question. This living will can be a work in progress and changed at any time. To make this living will legal, you will need to sign it and have it notarized or witnessed by two people.

Part One: Health Care and After Death Care Instructions

This is what I would want for my medical treatment if I were seriously ill and there was a *good chance I would recover*.

☐ All life sustaining treatments (I want everything done to help me recover – for example CPR, a breathing machine, a feeding tube, all medications, surgery, blood transfusions, etc.)

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other_____

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

This is what I would want if I were *dying* *(for example, if you had advanced cancer and could not make decisions for yourself).*

☐ All life sustaining treatments

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other_____

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

This is what I would want if I were *permanently unconscious* *(for example, if you were in an accident that left you in a permanent coma).*

☐ All life sustaining treatments

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other_____

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

This is what I would want if *others had to completely take care of me* *(for example, if you had a stroke and you were conscious but couldn't communicate, bathe yourself, feed yourself, or go to the bathroom on your own).*

☐ All life sustaining treatments

☐ I would want everything done except the following: ☐ Feeding Tube ☐ Other

☐ I prefer to have this person decide for me: _____

☐ I would not want any life sustaining treatments

☐ Other: _____

_____ **Date/Initials**

These are my beliefs about when life would no longer be worth living.

_____

_____

This is how I feel about getting pain medication if I were seriously ill or dying.

☐ I want pain medication even if it makes me less alert or could shorten my life if I were dying
☐ I would rather be in pain than risk being less alert.
☐ I don't know, I would let others decide
Other: _____

This is where I would like to receive health care: _____

This is the doctor that I would like to provide my health care for me (if you have a preference):

_____

This is where I would like to die (at hospital, home, etc.):_____

These are other wishes or concerns I have about my care at the end of my life:

_____

These are my wishes about organ donation.

☐ I want to donate all my organs (including my eyes and skin)

☐ I want to donate all my organs except: _____

☐ I do not want to donate my organs

☐ Other: _____

These are my wishes about what happens to my body after I die.

☐ I want to be buried. This is where I want to be buried: _____

☐ I want to be cremated. This is where I want my ashes to be stored: _____

☐ These are other wishes I have about what happens to my body after I die: _____

_____

☐ **I want a memorial service. These are specific instructions I have for the service** (*for example who you want to conduct the service, where you want the service, any spiritual or religious traditions or songs you want included in the service)*.

_____

_____

_____

☐ **I do not want a memorial service.**

_____ **Date/Initials**

Part Two: Naming a Person to Make Health Care Decisions
(This person is my appointed health care agent)

This is the person I want to make health care decisions for me:

Name: _____

Relationship to me: _____

Address: _____

_____

Telephone: _____

This is another person I trust to make health care decisions for me:

(If the first person is not available)

Name:_____

Relationship to me: _____

Address: _____

_____

Telephone: _____

I give the person(s) named above the power to (please check all that apply):

☐ Consent to, refuse, or withdraw any health care treatment, service, or procedure.

☐ Stop or not start medical intervention that is keeping or might keep me alive.

☐ Choose my health care providers.

☐ Obtain copies of my medical records and allow others to see them.

☐ Choose where I live when I need health care and how to keep me safe.

☐ Decide whether or not to donate organs, tissues, and eyes, when I die.

☐ Decide what will happen with my body when I die.

These are other things I want the person I name to be able to do, or not do, for me.

_____

_____

These are the reasons I named a health care professional to make decisions for me.

(Fill this question out only if you appointed your health care provider).

_____

_____

_____ **Date/Initials**

Part Three: Maintaining My Dignity

These are the things I am most proud of in my life: *(Think about your relationships and goals, what kind of person you are, and what you've accomplished in your life)*

I would want to be remembered as a person who:

People who care for me could do the following to respect my dignity at the end of my life:

These are other values I have that are important to me for my health care at the end of my life:

These are my goals for my health and health care when I am seriously ill or dying:

These are my fears about my health and health care when I am seriously ill or dying:

_____ **Date/Initials**

These are my concerns about death:

These are my concerns about a relationship I have: _____

These are my concerns about how my health problems might affect others:

Copies of this document will be given to:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

Health Care Provider/Clinic:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

MAKING THE DOCUMENT LEGAL

There are two ways to make this document legal (<u>choose one of them</u>)

1) Sign and Date below. Find two people to witness this document and sign below.
OR
2) Get this document signed by a notary public, who will watch you sign and date below.

I am thinking clearly, I agree with everything that is written in this document, and
I have made this document willingly.

My signature: _____

Date signed: _____

Date of birth: _____

Address: _____

If I cannot sign my name, I can ask someone to sign this document for me.
Signature of the person who I asked to sign this document for me:

_____

Printed name of the person who I asked to sign this document for me:

CHOOSE EITHER OPTION 1 OR OPTION 2

Option 1: Signatures of Two Witnesses – (Cannot be any person named in Part Two)

1. _____ Date: _____

2. _____ Date: _____

Option 2: Notary Public

In my presence on _____ (date), _____ (name) acknowledged his/her signature on this document or acknowledge that he/she authorized the person signing this document so sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

_____ Notary Stamp
Signature of Notary

_____ **Date/Initials**

About the National Health Care for the Homeless Council

The National Health Care for the Homeless (HCH) Council is a home for those who work to improve the health of homeless people and who seek housing, health care, and adequate incomes for everyone. In the National HCH Council, agencies and individuals, clinicians and advocates, homeless people and housed people come together for mutual support and learning opportunities, and to advance the cause of human rights.