DENVER SEATTLE CENTER OF INNOVATION
FOR VETERAN-CENTERED & VALUE DRIVEN CARE

Challenges of Providing End of Life Care for Homeless Veterans

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GOALS AND OBJECTIVES

1. Characterize existing approaches to the care of homeless veterans at EOL
   - **E-mail survey** of programs serving either homeless or EOL populations at Veterans Affairs Medical Centers (VAMCs)
2. Understand barriers and facilitators to providing excellent EOL care for homeless veterans
   - **Site visits**: 1 pilot, then 4 cities
   - **Site selection criteria**
     - Substantial homeless population
     - VAMC with either strong EOL or HV program or both
     - 2 multi-disciplinary focus groups of EOL and homelessness care providers in and outside VA
3. Develop a program framework for meeting their needs that can be tested and replicated across the nation

BACKGROUND

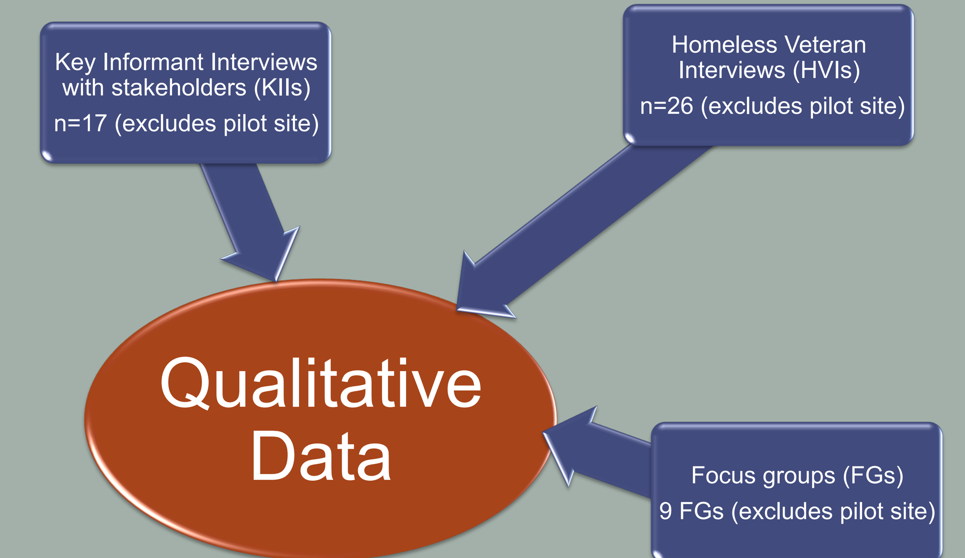
- More than 76,000 US veterans are Homeless (HV)
- Mean age at death: 34-47
- Cancer and heart disease are the leading causes of death over age 45
- Homeless Veterans who are at end of life (EOL) do not fit easily into programs designed for either group

RESULTS

- 50/152 VAMCs responded to e-mail survey
- Average of 9.4 HV at EOL annually per responding VAMC

Qualitative Results from Site Visits Revealed 6 Themes:

Theme	Supportive Quotes	
In spite of HV's declining health, which prevents independent living or realistic plans to abstain, current housing options are too often limited to places that insist on functional independence and a 'clean and sober' lifestyle.	If they are independent whenever they first come on to service…[usually] they're profusely capable of living by themselves for a while, however that becomes more and more problematic as they begin to deteriorate. (FG, Site C)	So they're not allowed to get to certain recovery beds, you know, if what they want to do is die clean and sober I want to help them do that… but if they have a palliative care … it's very common they just want to get off cocaine but they have a legitimate need for other things. The programs don't differentiate. (KII, Site D)
Symptom management within the context of addiction, unstable housing and behavioral health problems is challenging	When it started to get worse and more painful, [my provider] didn't want to up… my meds, and I'm like, 'Dude, you know this is a progressive disease, you know it's getting worse for me'…His problem is I have long hair and he thinks I'm out…selling the…damn things. I'm like, 'Look, dude, like, nobody's gonna buy… Nobody's gonna do that, and I'm not gonna give them…away…I'm not gonna sell it. (HVI, Site E)	There are usually issues of substance dependence. If you're trying to relieve their pain with pain medication there is concerns about diversion…And then compliance is an issue, …I mean, just being able to be compliant with their regimen, because if they don't have stable housing…where do they store this medication? It can be stolen from them, and then it is out on the streets somewhere…and pain medications [are] gold, basically. (KII, Site C)
Discontinuity of care between systems restricts EOL care delivery.	I hope that eventually it's going to happen...that we're going to have to have a platform that we can share medical records with the community and vice-versa. You know, if you'd like to have strong partnership, that's what you need." (KII, Site A)out, and like I said, it was three months later before I finally got an appointment. (HVI, Site A)	You often hear this in the VA about silos and groups working very hard, but not always aware of each other. So I think sometimes…in palliative care I don't always know what's going on, or understand very well what's going on in the broader homeless resources and broader services for homeless veterans. (KII, Site B)
VA regulations pose significant challenges to collaboration with community providers, to the detriment of frail, vulnerable homeless Veterans.	It's like, 'we can't house you, we can't take you here because of your, you know, your medication conditions.' We're not a clinic, we're not 24/7 and we don't have the nursing staff. So we can't provide medical services for a lot of these folks who are incontinent… (KII, Site A)	(On a medical respite location): "Even though it meets the City and the State...fire and safety codes, it does not meet the federal So in order for us to contract with them, they would have had to put in a sprinkler system and fire doors, which would have cost them an exorbitant amount of money, and they said [no]. So, because we couldn't contract with them, we cannot place our veterans there. (FG, Site B)
Dedicated homeless and EOL program staff collaborate informally.	It's been really helpful to have this connection to hospital facilities... In the middle of the night [when my facility's pharmacy is closed], I could go across the pharmacy across the street [at the safety net hospital] and they know me in the inpatient pharmacy [and can help me]. (KII, Site A)	If they're non-service connected there's really no VA resources, payment sources for that...If they have a less than six month life expectancy then I can bring them into the nursing home and care for them under our CLC hospice programs, and we've done that. (KII, Site D)
Promising models include maximization of VA-community partnerships and use of peer support by formerly homeless Veterans.	[The peer support specialist]…helps me out because there's a lot of things I didn't know. (HVI, Site C)	Ideally a peer support specialist is a veteran...who has either experienced homelessness or substance abuse/ mental health issues themselves, or has had a close working relationship with people who have. And they are really kind of ... a go-between between the VA case manager and the veteran, to…put them in contact with more non-traditional resources out in the community...they're more likely to talk to a peer support specialist. (FG, Site A)



CONCLUSIONS

- Multiple personal, clinical, and structural factors impede care of homeless veterans at EOL.
- Facilitating appropriate rehousing is critical.
- Access to expert management of pain and functional decline will be essential.
- Improving care will require effective collaboration across multiple disciplines and care systems

NEXT STEPS

The National Program and Policy Development Forum, comprised of national leadership and focus group representatives, is developing policy enhancements, pilot programs, cross-silo education and communication to improve care for HV at EOL

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