Bringing it to the Streets: A Novel Approach to Improve Palliative Care for Homeless Adults

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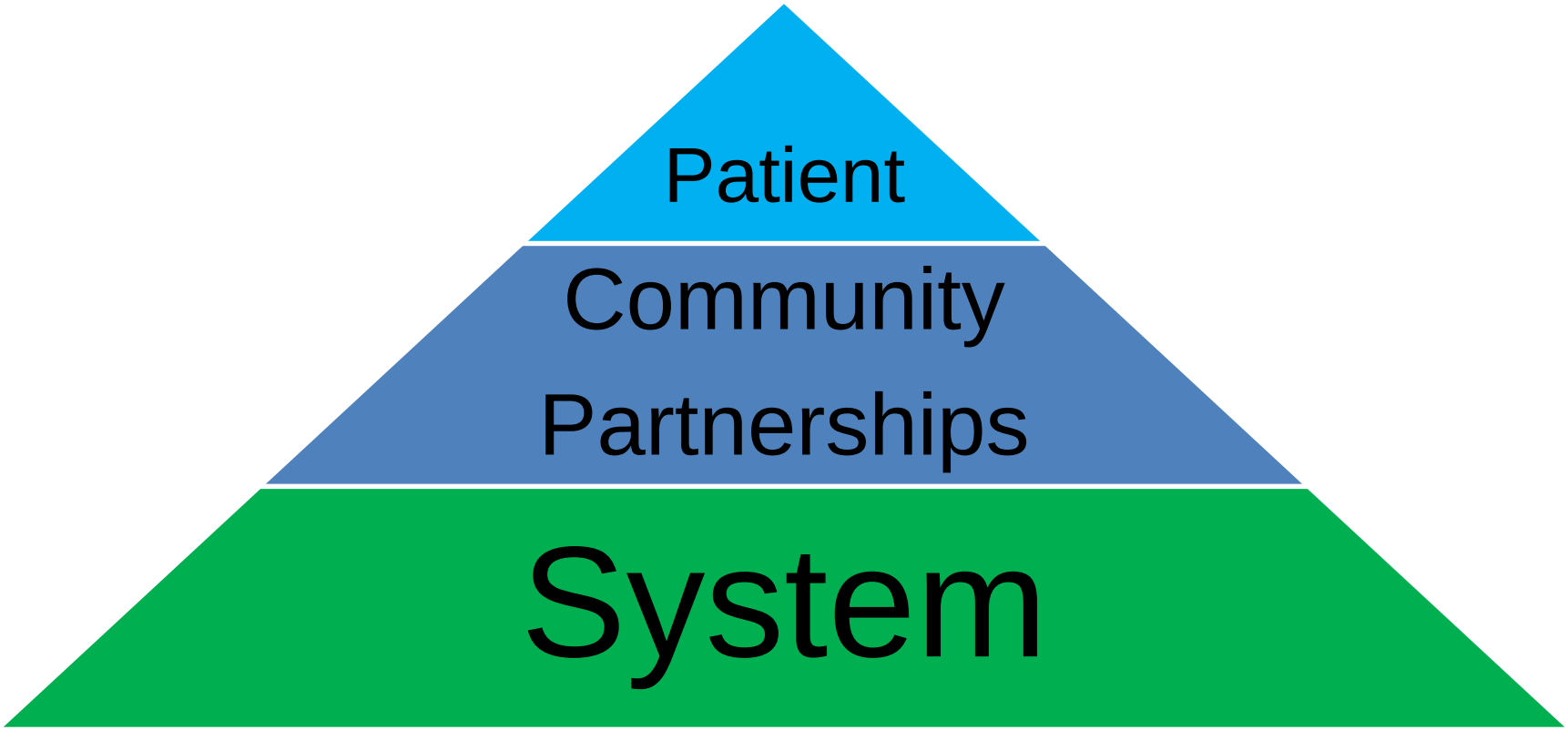
Objectives

- Identify concerns and barriers for homeless patients who need palliative care in an urban setting
- Identify challenges for providers who care for seriously ill homeless patients
- Describe different models for addressing the~~se~~ needs of these patients
- Describe strategies you can implement in your own clinical practice

Approach to Palliative Care for Homeless Adults



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Approach to Palliative Care for Homeless Adults

- Patient-level interventions
  - Cultural competence and cultural humility
  - Leverage community relationships
- Community-level interventions
  - Community care conferences
  - Education for homeless community advocacy organizations
- System-level interventions
  - Develop new effective models
  - Train other providers

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Randy Hays

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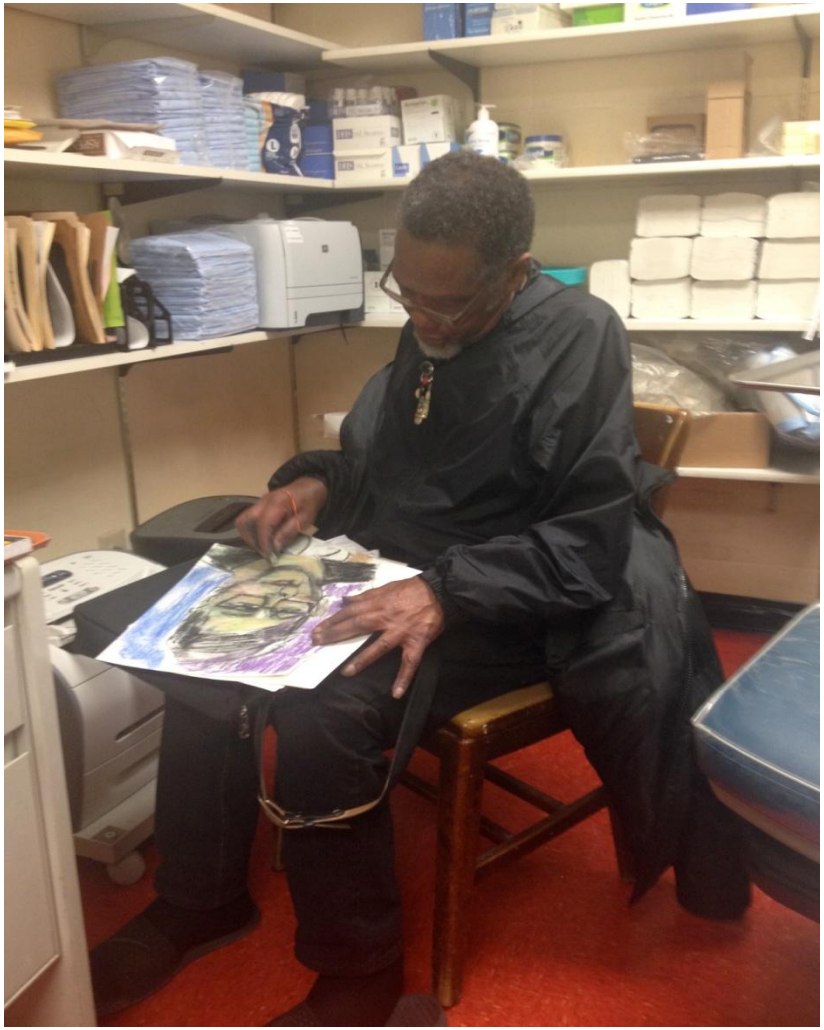
Stanley Glover



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Palliative care for homeless patients

How can we help these men get palliative care they deserve?

How is palliative care different for these patients?

What are the challenges providers face in delivering gold standard palliative care for these patients?

What interventions can you easily implement in your existing teams to address these issues?

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Homeless patients

Identify concerns and barriers for seriously ill homeless patients in an urban setting.

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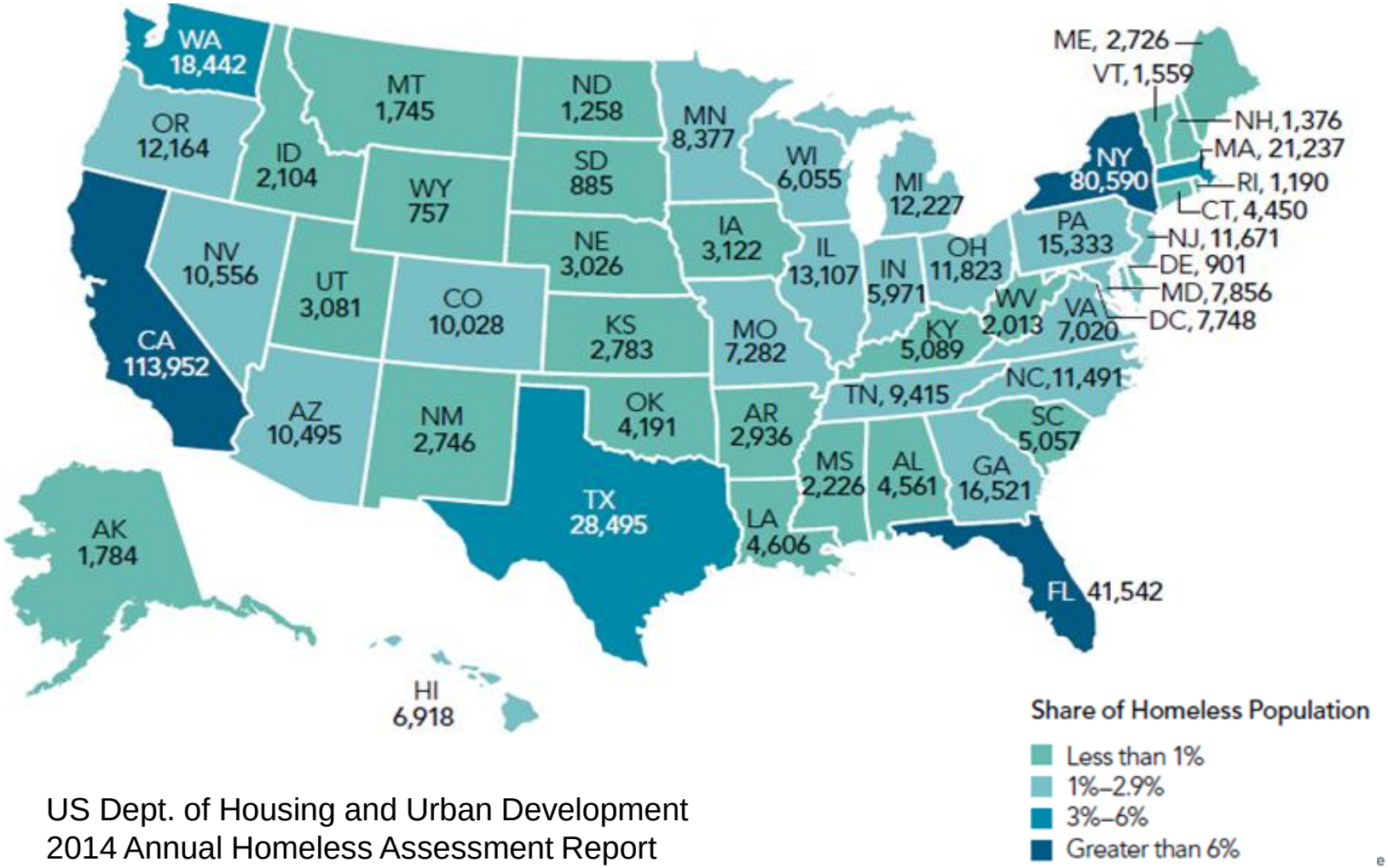
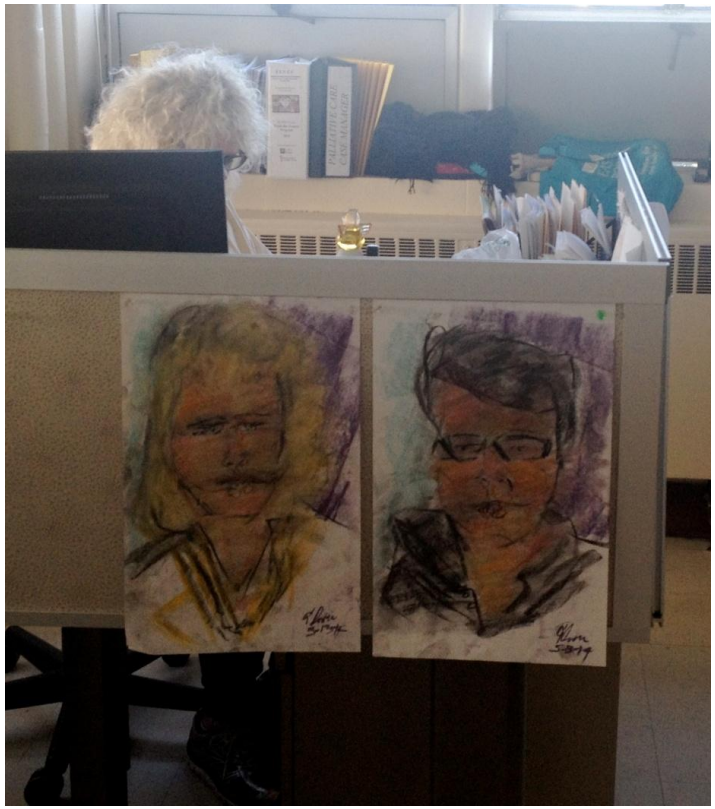
2014 Estimates of Homeless People



US Dept. of Housing and Urban Development
2014 Annual Homeless Assessment Report

Homeless and Dying



Audience Polling

- **About what % of the homeless population have ≥ 1 major chronic health condition?**
  - More than 30%
  - More than 40%
  - More than 50%

Serious Illness & Homelessness: Risk Factors

- >50% of homeless have ≥ 1 major chronic health condition
- 40-60% use illicit substance(s) during lifetime
- Often present late for care

Average age of death is early-mid 40s

Hewitt 2011. Hwang 2001. McNeill 2012.

Common Concerns and Preferences for seriously ill Homeless Individuals

- Concerns shared with housed patients
- Very personal experiences of death and dying
- Imposed, unwanted care
- Loneliness
- Fear of anonymity and a lack of memorialization
- Uncertainty over care of body after death

Kushel 2006. Ko 2014. Norris 2005.
Daiski 2007. Song 2007.

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Challenges

Identify challenges for providers who care for seriously ill homeless patients

Common barriers to accessing palliative care

- Housing/Shelter
- Access to food
- Transportation
- Money
- Access to phone etc.
- Substance use and abuse
- Legal issues
- Mental health
- High symptom burden

Kushel 2006.

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Challenges for Healthcare Professionals

Gaps in knowledge of population	Gaps in attitudes of population	Complex social needs
Complex medical needs	Limited knowledge of community resources	Limited contact with community resources
Inappropriate withholding of pain medicine	Unconventional advance care planning needs	Unconventional hospice needs

McNeil 2012. Daiski 2007. Kushel 2006. Hwangt 2001.

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Example 1: Unconventional Advance Care Planning

- 80% would want a physician making EOL decisions rather than court appointed surrogate
- More likely to want CPR than matched cohort
- Non-traditional surrogates
- Lack of trust of institutions and providers
- Extreme poverty prevents funeral planning

Ko 2014. Norris 2005.

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Example 2: Unconventional Hospice Needs

- ➔Prognostication is difficult
- ➔Hospice rarely available
- ➔Existing models emphasize dying-in-place
- ➔Often excludes homeless/marginally housed
- ➔Limited social support for caregiving
- ➔Staff and medication safety concerns

Daiski 2007. Kushel 2006
Hwang 2001. McNeil 2012.

Novel approaches

Describe different models for addressing these needs

Seattle Pilot: “Care Conference” Model Guiding Principles

- Interdisciplinary care team coordination
- Person centered respectful, safe, and realistic care
- Harm reduction
- Coordinate communication across all care settings

Seattle Pilot: "Care Conference" Model

➔Combination of medical, community, and public health providers

➔Blend of clinical care conferences and IDT meetings

➔Financial support in the form of donated staff time, clinical space, and political support

Seattle Pilot: “Care Conference” Model

- Two models:
  - “Care Conferences” with community partners
  - Traditional bricks-and-mortar clinic

- Target Patients
  - Homeless or chronically homeless adult
  - Clear palliative care need
  - Identified by team member

- Recruitment goal 20-30 patients

Seattle Pilot: “Care Conference” Model

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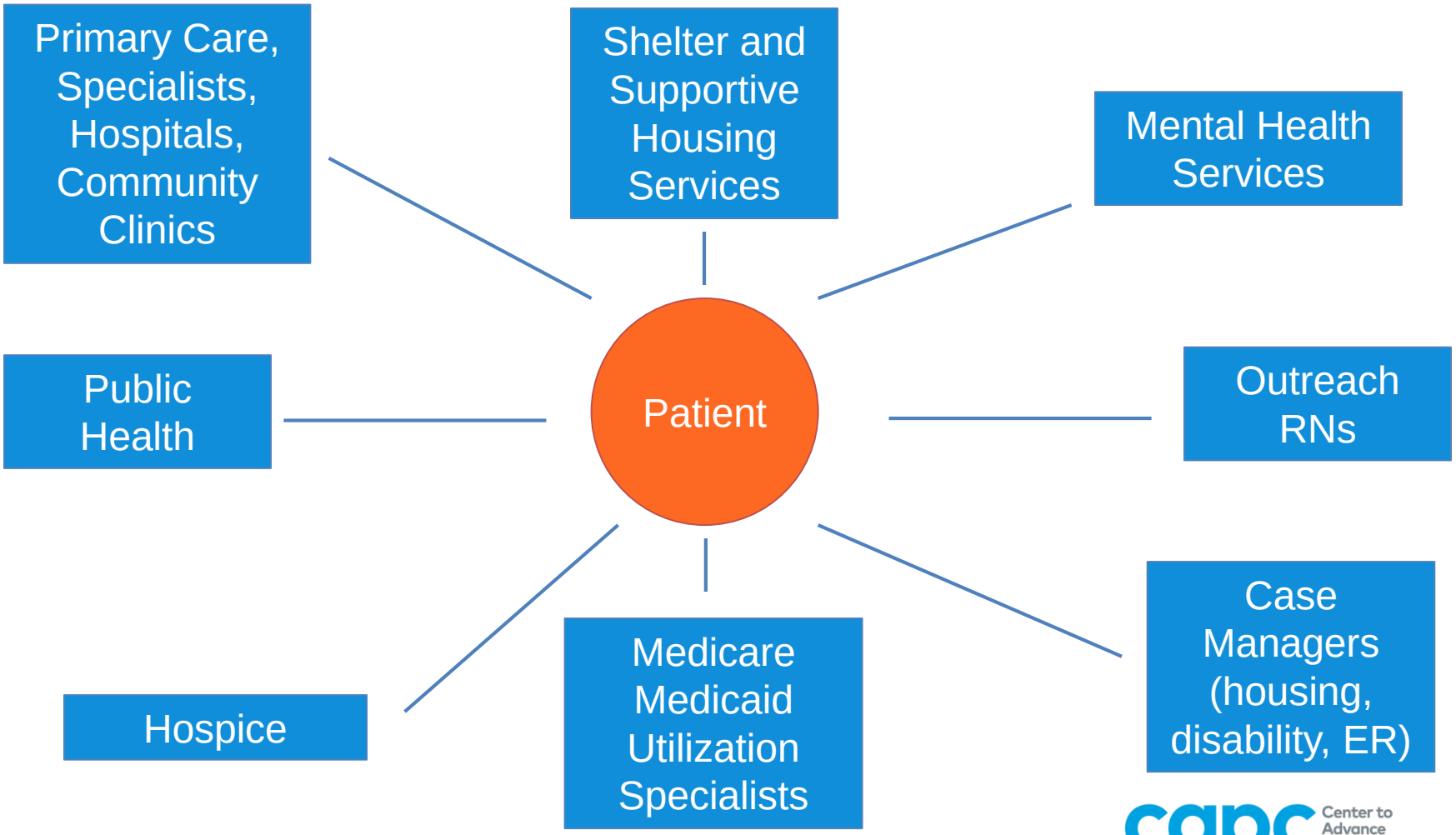
Seattle Pilot: "Care Conference" Model: Community Partners



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Results

Variable	Results
Dates	Jan 2014 - June 2014
Patients enrolled	36 in first 12 weeks *
Total patient visits	138
No-show rate bricks-and-mortar	80%
No-show rate Care Conferences	<10%

Case Outcomes: Randy Hays

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Case Outcomes: Randy Hays

Barrier to palliative care	Team Solution
Opioid concerns	Planned transition to Methadone for pain Alarmed lock box Frequent scripts with small number of tablets
Lack of social support	Housing for fiancé Hospice support

Case Outcomes: Randy Hays

Barrier to palliative care	Team Solution
Financial Concerns	Team worked with payee Medical Marijuana donated by local Green dispensary
Life review and Quality of Life	Guitar out of pawn Used iPad to record life story
Fragmented care	Utilized palliative care clinic for call coverage and backup Email / virtual conferences

Case Outcomes: Stanley Glover

Case Outcomes: Stanley Glover

Barrier to palliative care	Team Solution
Mistrust of providers	Established good rapport by capitalizing on trusting relationship with nurse
Goals of care	Discussed over several visits at shelter Actively involved him in care-planning

Case Outcomes: Stanley Glover

Barrier to palliative care	Team Solution
Lack of social support	“Professional family”
Lack of secure housing	Collaboration between shelter, medical respite, hospice, and hospital for coordinated escalation of care
Life review/legacy	Used social media to contact family for reconciliation

Seattle Pilot of a “Care Conference” Model

- UWMC obtained a grant to continue this model in Seattle
  - HRSA "Expanded Primary Care and Palliative Care Services" through Public Health - 2015
- Grant awarded to community health clinic and public health partnership
- Provides funding for a dedicated RN case manager and half-time NP/PA provider

Palliative Care Models

- Respite model
  - McInnis House (Boston, MA)
- Shelter hospice model
  - Ottawa Inner City Health Project 2006
  - San Francisco DPH Medical Respite Program
  - PEACH: Palliative Education and Care for the Homeless (Toronto)
- Volunteer/Hospice integrated model
  - Balm of Gilead (Birmingham, AL)

http://www.thestar.com/news/gta/2014/08/03/palliative_care_program_helps_homeless_in_their_final_days.html

Podymow 2006 Kvale 2004.

System Improvement Outcomes

- ➔ Less no-shows for clinic appointments
- ➔ Less Emergency Department visits
- ➔ Less days in the hospital at end-of-life
- ➔ Less burnout and moral distress among staff

Starks 2013. Podymow 2006. Raven 2011

Systems-Level Interventions

- Education for other health care providers
  - Invite community partners to take the lead
- Develop strategies to improve transitions across different care-settings
- Advocacy for access to care to reduce disparities
- Research
  - Needs
  - Utilization patterns
  - Care models
- Partner with payers

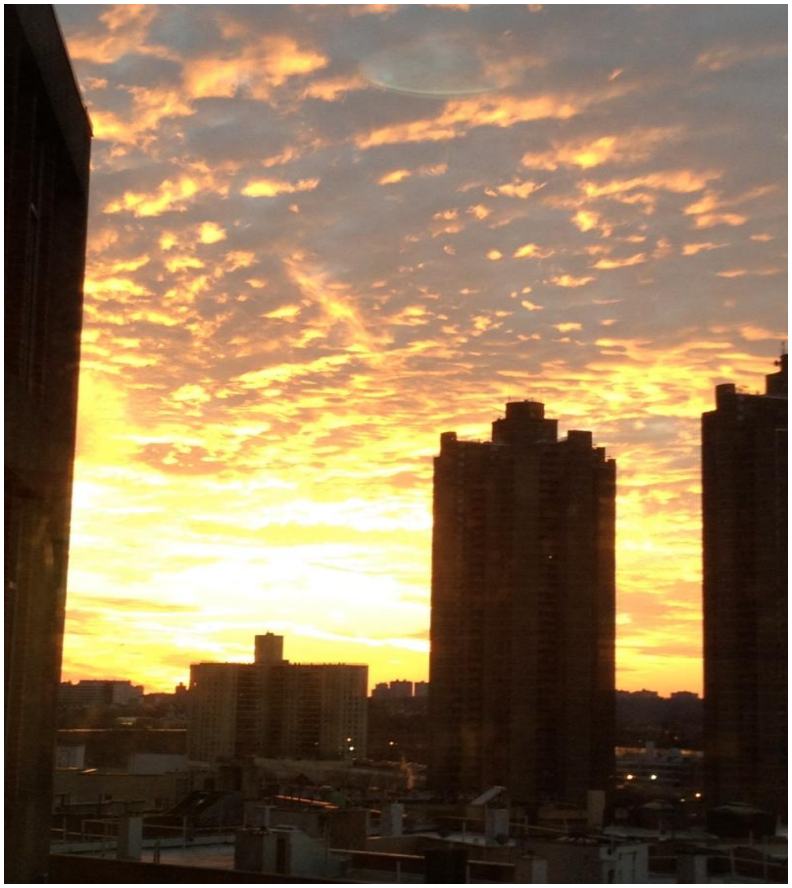
Systems-Level Interventions

- Housing first
  - Growing recognition of the cost of homelessness on healthcare systems
  - 100,000 homeless persons in Santa Clara county (San Jose, CA)
    - Costs **$520M** / year (all services)
  - Housing saves **$40 - 50,000/year**
- Many units have on-site support staff

Systems-Level Interventions

- Medicaid 1115 Waiver Programs - Innovation grant for state Medicaid programs
  - California's program includes "whole-person care"
    - Targets "high users"
    - Integrates physical and mental health, social services providers
    - Goal/patient-centered

Take Home Points



Describe strategies you can implement in your own setting.

Strategies to implement: Education

Patient level interventions	Clinic and Community Interventions	Health Systems interventions
Educate yourself about common concerns, community resources	Educate community partners, case managers Educate other HPM providers	Education for frontline health care providers (Primary Palliative Care)

Take Home Points: Patient-Level Interventions

➔Be aware of special considerations in homeless medicine and plan accommodations

➔Leverage relationships in the community (hospice, etc) to facilitate palliative care services

➔Meet patients where they are

Take Home Points: Community-Level Interventions

- Provide teaching and support for community homeless services
- Get to know your community providers
- Coordinate ‘care’ conferences with community providers and stakeholders

Take Home Points: Systems-Level Interventions

- Research cost savings
- Partner with payers
- Increase coordination with community partners for smoother transitions
- Less burnout and distress among providers

Thank you

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➔All the providers and patients shown for permission to use their image.

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- Today's webinar recording and list of references can be found in CAPC Central under **'Webinars: Community-Based Palliative Care'**
  - https://central.capc.org/eco_player.php?id=186