Barriers and Facilitators to End of Life (EOL) care for Homeless Veterans

Mary Weber, PhD, PMHNP-BC, FAANP
Jacqueline Jones, RN, PhD
Karen Albright, PhD
Evelyn Hutt, MD
Hannah Dischinger, BS

Objectives

- Identify and discuss barriers to providing high quality EOL care to homeless veterans.
- Formulate potential system changes and collaborations to facilitate high quality EOL care for homeless veteran

Disclosures

- Funding for this work from Federal Health Services Research and Development Grant
- No Conflict of Interests
- No off-label use

Background

- 76,000 veterans homeless on any night
- 150,000 veterans homeless during a year
- 633,782 people on any night
- Annual mortality homeless vets 2004 – 8%
- Homeless people die young
  - Mean age 34-47
  - Most common dx age >45 = cancer and heart disease
- Being a veteran increases the odds of dying among homeless cohorts by 1.7

Project Goals

- Characterize existing approaches to the care of homeless veterans at EOL
- Understand the barriers and facilitators to providing excellent EOL care for homeless veterans
- Develop a program framework for meeting their needs that can be tested and replicated across the nation

Objectives for the grant

1. Survey existing VA homeless and palliative care programs .
2. Visit 4 VAMCs across the country to develop a deep and broad understanding of the issues, barriers and facilitators to excellent EOL care for homeless veterans.
3. Conduct a National Program Development Forum with representation from each focus group, national stakeholders and policy makers to define the key structural, clinical and policy elements required and generate a framework that can be tested and replicated.

Objective 1: Survey to Understand Existing Services

- Surveyed Homelessness and EOL programs at VA Medical Centers (VAMCs) by email
- Programs and care challenge ratings were described statistically. Bivariate analysis and multivariate models compared homelessness and EOL program responses.

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Survey Results

- 50 of 152 (33%) VAMCs completed the survey
- VAMCs treated an average of 6.4 homeless veterans at EOL annually.
- Lack of appropriate housing was the most critical challenge.
- EOL programs expressed somewhat more concern about lack of appropriate care site and care coordination than did homelessness programs.

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Structural and clinical barriers identified

- **Lack of appropriate care sites for homeless veterans nearing the end of life**
- **Poor coordination between existing homeless and EOL programs**

Objective 2: Site Visits to Collect Qualitative Data

- Purpose: develop a deep and broad understanding of the issues, barriers and facilitators to EOL care for homeless veterans
- Four VAMC sites visited nationally chosen to explore possible geographic variation
- At each site, key informant interviews with high-level decision-makers, Homeless Veterans, and focus groups with multidisciplinary providers, and community and VA program leadership

Data Collected at Site Visits: Number of Interview Sessions

	Seattle	Boston	Houston	Orlando
Key Informant Interview (KII) with stakeholder	5	5	3	4
Homeless Veteran Interview (HVI)	6	7	10	3
Focus Group	3	2	2	2

Structural Elements Assessed

- Model of care
  - Medical foster home, modified medical respite
- Size
  - Number of beds in area
- Physical requirements of facility
  - VA fire and safety regulations, medication storage
- Functional requirements for residence
  - Degree of ADL dependence
- Veteran status
  - Level of service connection
- Key relationships with other entities
  - HPACT
  - Safety net hospitals
  - Pharmacy available 24/7
  - VA electronic medical record
- Staffing
  - Ratio and type/specialty
- Transport to VAMC
  - Facilitated, difficult/lengthy

Qualitative Results

Current housing options are too often limited to places that insist on functional independence and a “clean and sober” lifestyle

Problems with clean and sober housing in homeless palliative care

“There are many rehab programs don’t allow you to take pain medicine at all. …So they’re not allowed to get to certain recovery beds, 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)

Qualitative Results

Pain management within the context of addiction, unstable housing and behavioral health problems is challenging

Pain Management and EOL

“ It’s gonna get worse…And 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)

Qualitative Results

Discontinuity of care between and within VA systems restricts EOL care delivery

Silos of homeless and palliative care for homeless Veterans

"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 I know for myself 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)

Qualitative Results

VA regulations pose significant challenges to collaboration with community providers, to the detriment of frail, vulnerable homeless Veterans

Differences in codes/requirements

"Even though it meets the City and the State...fire and safety codes, it does not meet the federal government's fire and safety codes...it's an older building. They don't have a sprinkler system and fire doors. 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, 'Thanks, but no thanks.' So, because we couldn't contract with them, we cannot place our veterans there". (FGP)

Qualitative Results

So how does care occur?

Dedicated homeless and EOL program staff collaborate informally

- *Site visit FGs both encouraged and tapped into existing collaborations*
- *Allowed further networking and sharing of ideas*

Implications

- Personal, clinical and structural challenges face care providers for Veterans who are homeless at EOL
- Among the most pressing challenges:
  - Lack of housing suited to homeless Veterans with rapidly declining health
  - Isolation of homeless and EOL providers from each other
- Promising care models include maximization of VA-community partnerships and use of peer support by formerly homeless Veterans

Objective 3: National Program Development Forum

During the study's final year, the grant team is now working at the National level with a select focus group participants with national VA palliative and homelessness care leadership to develop policies, collaborations and programs to facilitate high quality EOL care for homeless Veterans

Potential areas for national/local work

- More flexible housing criteria for palliative care
- Establish policy that gives HV at EOL priority on accessing housing (needs to include clear definitions and criteria)
- Since Doms are already required to take EOL Veterans, find unused capacity in Dom system to use for EOL care
- Education needed regarding homelessness to EOL providers and about EOL to homeless providers

Potential area for national/local work

- Pilot program of a group home or housing for palliative care with a harm reduction model
- Expand core palliative care training in VA to incorporate training on homelessness and harm reduction (quarterly webinars, SCAN-ECHO)
- Examine existing barriers to care access at policy level

Questions?

THANK YOU!