Caring for Older Adults Experiencing Homelessness

Northwest Geriatrics Workforce Enhancement Center
Geriatric Healthcare Series
March 7, 2024

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University of Texas San Antonio
School of Social Work

1

Holding & Welcoming Space

This is shared work

All work is built on collaboration and people who came before us

Culture of feedback and lifelong learning

Honor experience & wisdom in the space

Humble to experience & wisdom not present

Hold our humanity in this work

Recognize how the systems we work in harm others and us

2

Acknowledging Positionality

- Our identities shape our experiences, worldview, beliefs and access to resources
- We have “outsider status” to many of the identities and experiences of our patients
- People with oppressed and marginalized identities disproportionately experience harm and lack access to equitable care
- We come from social positions that have experienced and caused harm

3

Learning Focus

1. **Identify trends and issues at the intersections of aging, serious illness, and homelessness**
2. **Describe four trajectories of care for people with serious illness who are unhoused and implications for care planning**
3. **Plan practice change and policy advocacy strategies to improve patient care**

4

Bring It In

Your learning interest: ________________

5

Bring It In

Think of a patient you cared for who was experiencing homelessness as well as a serious illness and/or advanced chronic illness(es)

Your learning interest: ________________

Write 2-4 sentences about their health situation and course of care.

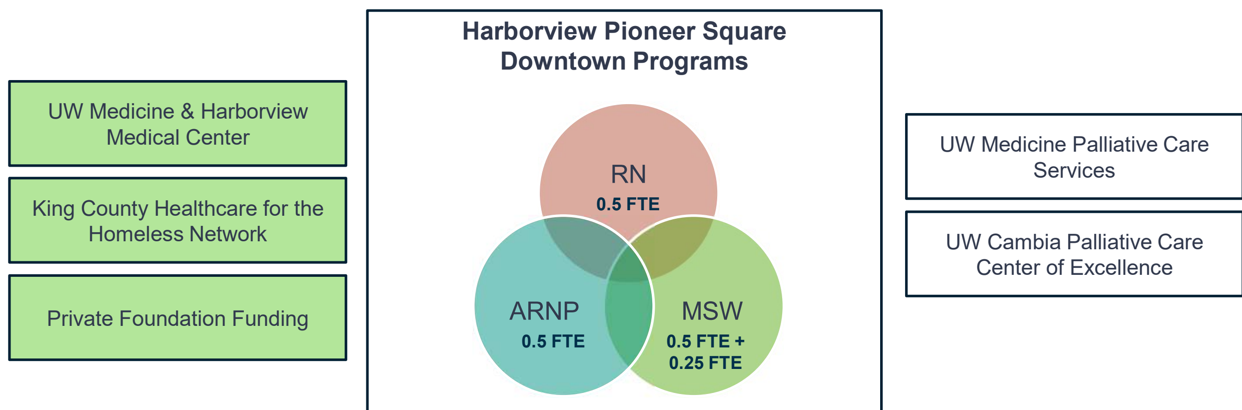
What is/was most challenging or complicating about their care?

6

Mobile Homeless Palliative Care

Harborview Medical Center
Seattle, WA

Program Model



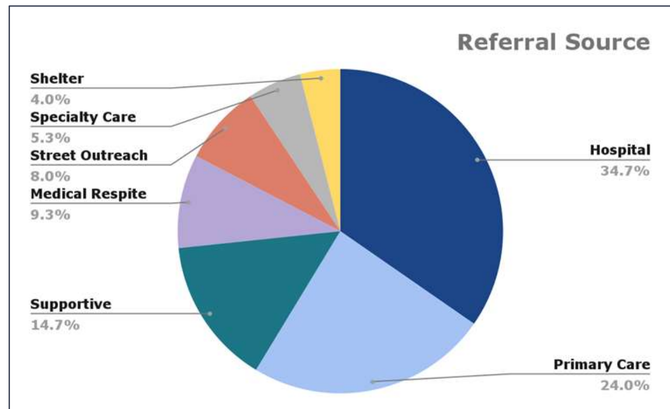
Patients & Referrals

HRSA definition of homeless
(doubled-up, institutions, motel/hotel, supportive housing)

Living in **Seattle** with **serious illness** or **advanced chronic disease** & significant decline

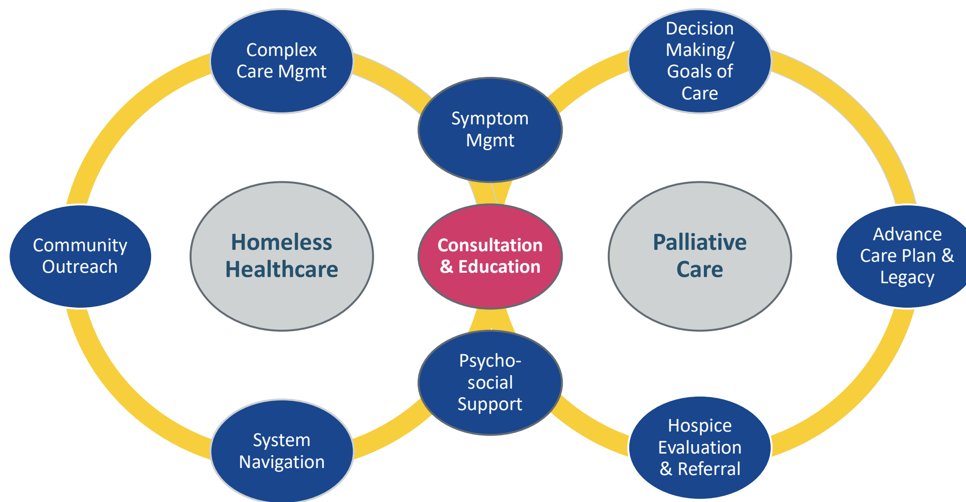
Avg. census 35-40; 100 Pt's/year; 900 visits/year

Referrals accepted from **any team member** with **any organization.**



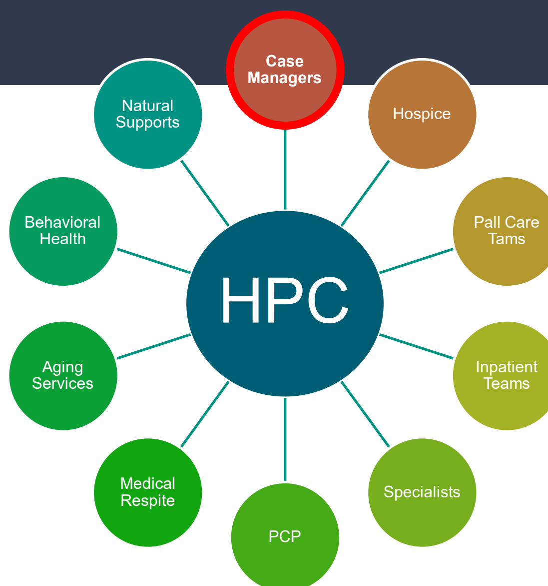
Census data from March 2019, 2020, and 2021 (n=75)

Program Model



Partnerships In Care

- Augment existing team
- Focus on communication & collaboration
- Co-visits with PCP, specialists, social service professional
- Hospital outreach, consultation, and care planning



PATIENT OUTCOMES

We measure success in

- Access to appropriate & goal-concordant care
- Autonomy & dignity throughout the course of care
- Support & engagement of complete care team
- Reduced medical trauma & systemic barriers
- Attendance to legacy & personal goals

Visit us Online

- Program Info
- Referrals
- Donation
- Press
- Publications

Photo credit: Erika Schultz, Seattle Times

13

RASCAL-UP

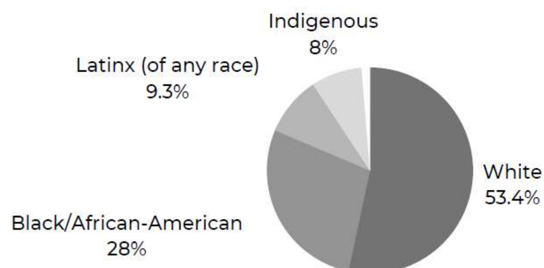
- Retrospective chart review
- Mixed-method, longitudinal data from March 2019, 2020, & 2021
- Criterion-based purposive sampling (n=75)
- Interviews with health & social service professionals (n=30)
- Team observations

14

RASCAL-UP

63 years
median age

69.3%
Baby Boomers
(b. 1946-1964)



4.9	average comorbidities at enrollment
1/3	Patients with co-occurring medical health, mental health, and substance use diagnoses
52%	Reported active mental health concern, such as depression, anxiety, grief/ bereavement, & PTSD
65.2%	Actively using substances, most commonly heroin, alcohol, & methamphetamine

15

Contextualizing Homelessness

16

What images come to mind with the word “homeless?”

slido

17

18

Defining People

John is 43yo homeless man presenting with…

CIRCUMSTANCE	CONTEXT	EUPHEMISM
people living in shelter, transitional or supportive housing, or places not meant for human habitation	people with multiple psychosocial barriers to resources and services including healthcare	people with mental illness, substance use, or behaviors and lived experiences we find uncomfortable, or morally undesirable
BE CLEAR & SPECIFIC	USE PERSON-FIRST LANGUAGE	ADDRESS BIASES

19

Defining Place

HOMELESSNESS IS ABOUT POWER, NOT HOME, COMMUNITY, OR PLACE

20

Social Policies of Intollerance

Criminalization of homelessness

- Sleeping
- Begging
- Storing stuff
- Riding the bus
- Peeing
- Parking

Hostile Architecture

21

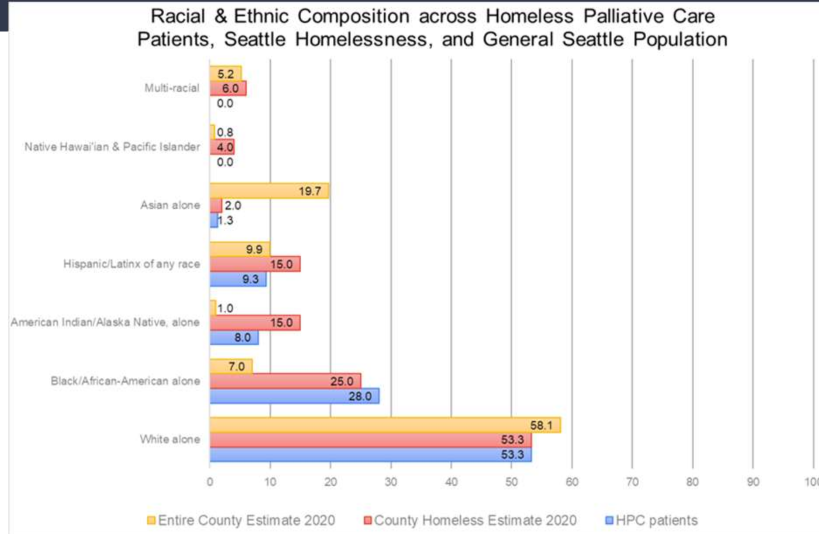
Defining Issues

Homelessness is the result of moral decisions expressed in policies which allow resource insecure people to live without secure housing.

Person first language is not enough. It's critical to continually address biases and undo white supremacist culture which upholds health and housing disparities.

22

Disparities in Housing



Disparities in Housing

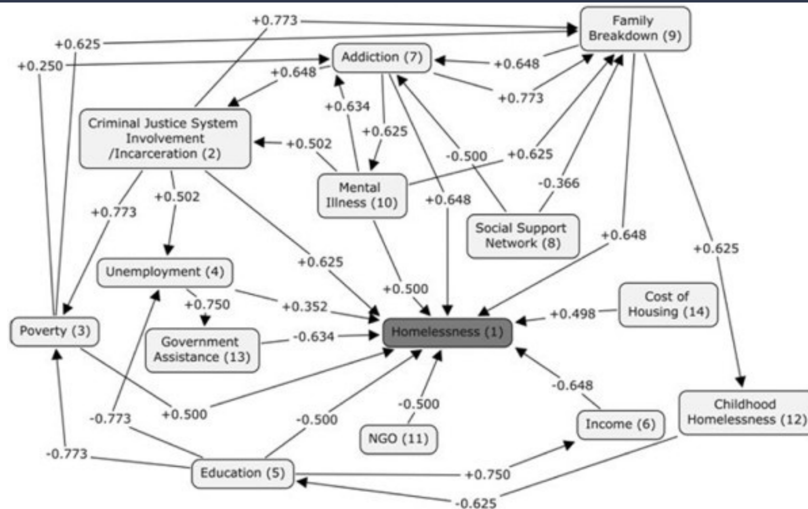
Hispanic or Latino	10% of the general population	15% of people experiencing homelessness
Black	7% of the general population	50% of families with children experiencing homelessness
American Indian / Alaska Native	1% of the general population	32% of people experiencing chronic homelessness
LGBTQ	5% of the general population	18% of people experiencing chronic homelessness

Oppressed groups also experience disparities in employment, incarceration, healthcare access & outcomes, and other crucial areas of life, wellness, and safety.

www.seattletimes.com/seattle-news/data/data-show-seattle-metros-lgbt-population-at-173000

All Home (2020). Seattle/King County Point in Time Report; U.S. Census Bureau (2021). Quick Facts: King County, WA.

Structural Violence & Cumulative Disadvantage



Mago VK, Morden HK, Fritz C, et al. Analyzing the impact of social factors on homelessness: a fuzzy cognitive map approach. BMC Med Inform Decis Mak. 2013;13:94.

25

Most of us are a few paychecks or a serious medical event away from experiencing homelessness

NW GWEC Winter 2024 Experiencing Homelessness (Light & Johnson)

26

27

Variability

- Place
- Population
- Policy

28

HOMELESSNESS & HEALTH

29

Health Risks

SUBSTANCE USE

EXPOSURE

COMMUNICABLE DISEASE

HYGIENE

MENTAL ILLNESS & COGNITIVE D/O

NUTRITION

HEALTH ACCESS

VIOLENCE

Facts about Death - National Health Care for the Homeless Council

30

Health Risks

SUBSTANCE USE

- SUD may precipitate homelessness
- Rigors of living homeless may cause & perpetuate SUD (McVicar, 2015)
- Many PEH use substances to self-medicate mental health symptoms (Henwood, 2014)
- Few PEH start SUD treatment & fewer complete treatment (Collins, 2015) though this is also true for the general population

Risk of death only moderately affected by substance use or mental illness

Morbidity & Mortality

Increased ↑	RISK/COMPLICATION PREVENTABLE & TREATABLE DISEASE
3-6x	RATE OF ILLNESS
4x	RATE OF HOSPITALIZATION
8-16x	MORTALITY RATE
48-52	AVG AGE OF DEATH
1900-1920	YEARS U.S. WHITE MALE LIFE EXPECTANCY WAS 46-54yo

National Coalition for the Homeless. Health care and homelessness. July 2009; Kushel, Vittinghoff , Haas JS. Factors associated with the health care utilization of homeless persons. *JAMA*. 2001;285(2):200–206; O'Connell. Premature mortality in homeless populations: a review of the literature. Nashville, Tenn.: National Health Care for the Homeless Council; 2005; Baggett, T et al. Mortality Among Homeless Adults in Boston. Shifts in Causes of Death Over a 15-Year Period. JAMA Int Med. Vol 173, 3. February 11, 2013; Facts about Death - National Health Care for the Homeless Council; Funk et al (2022). The impact of homelessness on mortality of individuals living in the United States. Journal of Health Care for the Poor and Underserved, 33(1), 457-477. https://doi.org/10.1353/hpu.2022.0035

The experience of homelessness IS a life-limiting condition

Homelessness & Aging

“Older adult” adjusted to 50 and older

50% over 50yo

Est. increase x3 by 2030 (pre Covid)

Bi-Directional Relationship

Barriers to Palliative Care & Hospice

Sicker / Advanced Disease

Comorbidities & Co-occurring Disorders

Living Situation

Care Models, Settings & Transitions

Caregiver Access

Understanding & Comfort with Issues & Services

Crisis-Focused Care

PATIENTS | **PROVIDERS** | **SYSTEMS**

West, Wrobel, Pallotta, Coatsworth. Bearing Witness: Exploring the End-of-Life Needs of Homeless Persons and Barriers to Appropriate Care. Journal of Death and Dying. 2020;82.

Experiences of Loss

- Body Function
- Body Image
- Control
- Freedom
- Health
- Home/Property
- Identity
- Independence
- Job
- Life
- Plans, Hopes, Future
- Relationships
- Religious Belief / Faith
- Social / Family Roles
- Safety
- Sexual Function
- Significant Person
- Special Objects

Experience of Homelessness

HISTORY OF LOSS

Experience of Serious Illness

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How does/did the experience of proving care feel for you?

How does/did the experience of proving care feel?

slido

The Geriatrics 5M's

Mind / Mentation

Medication

Mobility

What Matters Most

Multicomplexity

Tinetti M, Huang A, Molnar F. The Geriatrics 5M's: A New Way of Communicating What We Do. J Am Geriatr Soc. 2017 Sep;65(9):2115. doi: 10.1111/jgs.14979. Epub 2017 Jun 6. PMID: 28586122.

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Take notes on what might apply specifically to your patient.

41

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42

Cognitive Complexity

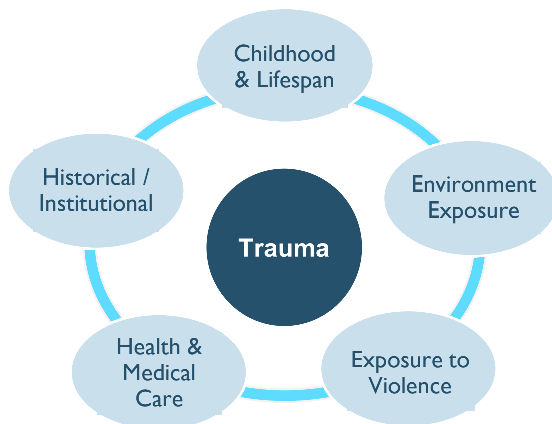
Cognitive impairment prevalent; increased risk with aging; frequently unrecgonized[1,2,3]

>50% suffered a traumatic brain injury (TBI); 2-4x the rate of general population[4,5]

Higher rates of mental illness & worse outcomes; higher prevalence of serious mental illness[6]

>50% suffered a traumatic brain injury (TBI); 2-4x the rate of general population[4,5]

Trauma



"Homelessness is more than the absence of physical shelter, it is a stress-filled, dehumanizing, dangerous circumstance in which individuals are at high risk of being witness to or victims of a wide range of violent events."

Fitzpatrick KM, LaGory ME, Ritchey FJ. Dangerous places: Exposure to violence and its mental health consequences for the homeless. 1999.

Trauma-Centered PPE (Patient Protective Engagement)

		Signs	Approach
	Physical	• Headaches Sleep disturbances Gastrointestinal issues	• Don't dismiss frequent or unexplained physical complaints as psychosomatic.
	Emotional	• Angry, irritable Anxiety Shocked or numb	• Explicitly attend to emotions; provide breaks during visits; practice de-escalation
	Cognitive	• Memory changes Trouble focusing Tracking information	• Break down tasks into concrete steps; use teach-back often to check comprehension
	Behavioral	• Self-harm Drug and alcohol use Relationship challenges	• Consider referrals for behavioral health and consult with team
	Worldview	• Lack of trust Shame and hopelessness Withdrawing from supports	• Check biases; don't expect trust; engender a sense of safety in care and clinical spaces; ask permission before touch, procedures, and discussing sensitive topics

45

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46

Consider Barriers for Each Intervention

Example: Medication

- Comorbidities
- **Adherence**
- Concurrent substance use
- **Burden of side effects**
- Burden of frequency / volume
- Medical literacy
- **Cognitive concerns**
- Acceptability / belief models
- Pharmacy access
- Transportation
- Insurance coverage / cost
- Financial assistance documentation
- Supplies (crusher, splitter, syringes)
- Appropriate storage
- **Lost / stolen items**

47

Realistic & Harm Reduction Care Plans

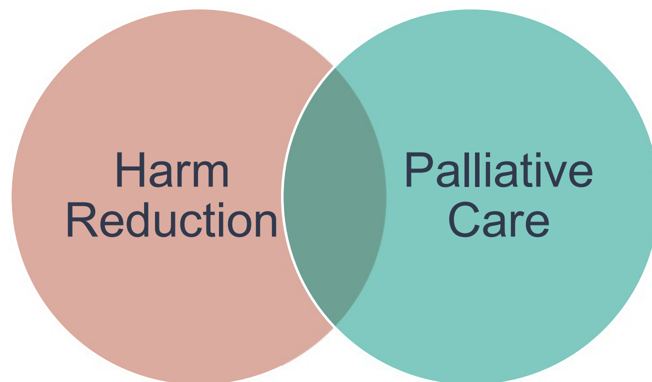
Optimal > Standard/ Maximal Care

Adapt "standard" care to "optimal" care to reduce potential harm while providing the greatest possible benefit in accordance with patient goals & priorities and a realistic assessment of current barriers and opportunities for change

48

Principles for Harm Reduction Care

- Focus on suffering, not the underlying condition
- Focus on quality of life and wellbeing
- Patient voice & autonomy
- Values-aligned, goal-concordant care



National Harm Reduction Coalition, 2020. Principles of Harm Reduction

Specific Recommendations

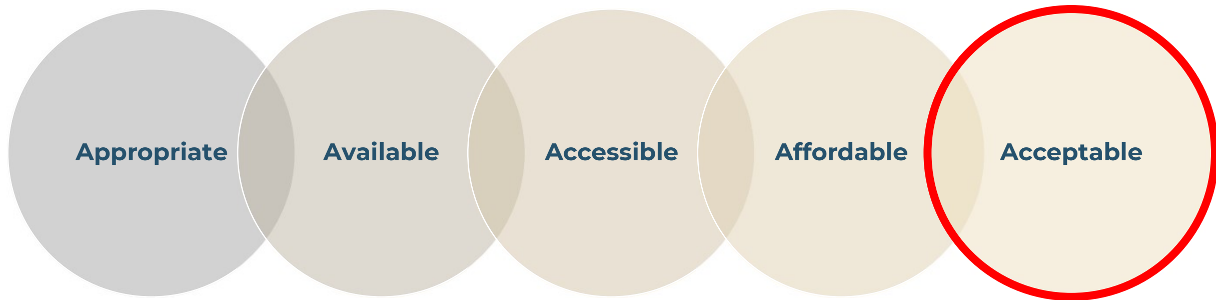
- Simplified medication regimen
- Consider side effects
- Multiday wound dressings
- Consider loose blood sugar control
- Anticipate possibility of poor follow up
- Coordinate with case managers
- Maintain perspective when plans fail
- Prioritize self-care to avoid burnout

Leslie Enzian, MD
Medical Director
Edward Thomas House Medical Respite Program

Capacity management Physician
Harborview Medical Center

Reality Testing: The 5 A's

Is this intervention:



Patient-directed with Expert Patient

51

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52

Understanding Facilitators & Barriers by Setting

STREET (7%)

ENCAMPMENT (10%)

TRANSITIONAL HOUSING (18%)

**SUPPORTIVE HOUSING

SHELTER (35%)

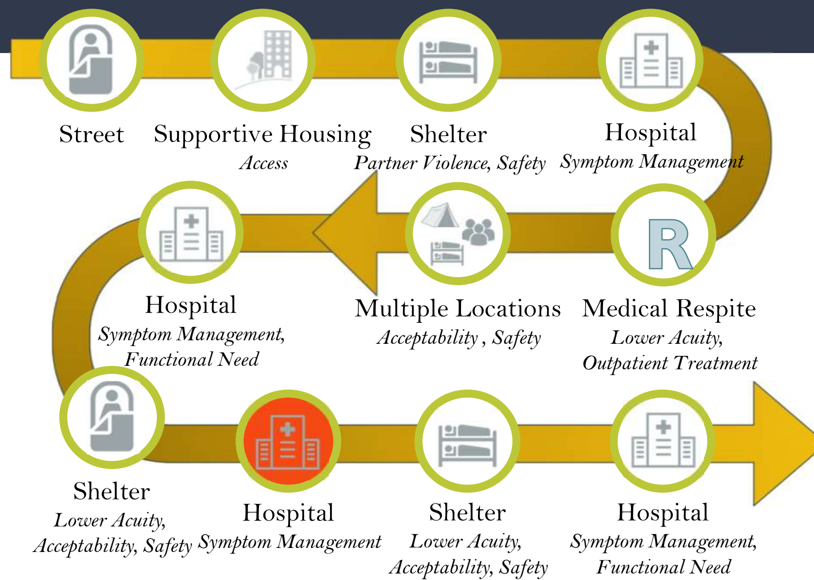
VEHICLE (23%)

**DOUBLED UP

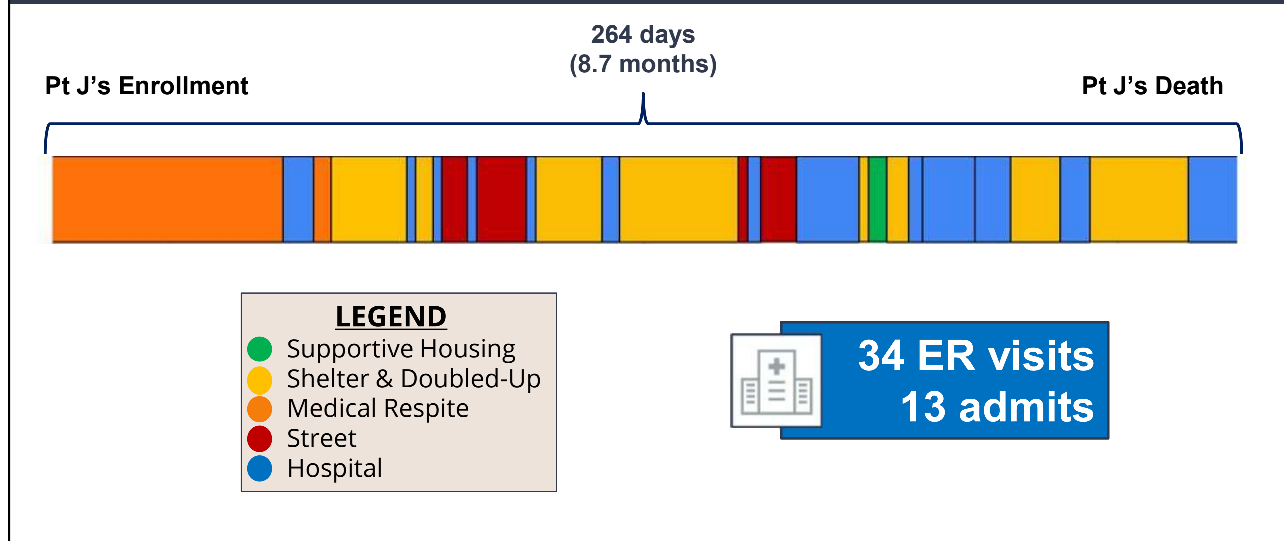
**HOTEL/MOTEL

% People Living Homeless, Seattle 2020.
**Not counted by HUD.

Transitions in Setting



Transitions in Seatting



Pathways of Care

AIM:
Identify patterns in where palliative care patients experiencing homelessness or housing precarity stayed overnight across their time enrolled in care.

FOUR PATHWAYS IN CARE

Among the sampled patients from Harborview's Homeless Palliative Care outreach team, four patterns emerged:

Aging & Dying in Place

Frequent Transitions

Healthcare Institution as Housing

Housing as Palliation

Pathways of Care

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Identify patterns in where palliative care patients experiencing homelessness or housing precarity stayed overnight across their time enrolled in care.

WHAT HAPPENED

26.6% were supportive housing and shelter residents able to receive care where they historically slept

20% never established a desirable place of care during treatment and had low engagement in services

29.3% spent over half their palliative care enrollment in hospitals and skilled nursing, with notable unsuccessful departures that led back to hospital, street, or county jail

24% of patients accessed housing during a time where their serious illness progressed, and stayed there through death or discharge

Communicating Recommendations

What does the hospital need to know?

- Medical, behavioral health, and safety concerns
- Trauma triggers & engagement strategies
- Evaluation and treatment to prioritize
- Care to avoid
- Considerations for hospitalization
- Barriers to discharge
- Care team contacts

… and how will you communicate it?

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59

Primary Palliative Care: Identifying Patients

SURPRISE QUESTION

ORIGINAL
"Would you be surprised if this patient died in the next year?"

MODIFIER
Chronic homelessness is a life-limiting, life-threatening condition

ALTERNATE
"Has something changed that makes me worried my patient is more likely to die soon?"

60

Primary Palliative Care: Share Worris—Document Values

Open the Conversation

"If you were critically sick or injured and couldn't communicate, what would you want us to know to provide you the best care possible?"

Document & Quote

- Perspectives on illness
- Experience with serious illness, critical illness, and end-of-life
- Hopes and fears
- Acceptable quality of life
- Values related to health, hospitalization and advanced medical interventions

Accept & Expect

- Accept that patients are at a higher risk of death
- Expect the need for surrogate decision making
- Not all patients value advance care planning
- Code status difficult to discuss
- ACP documents may be difficulty to store and access

Primary Palliative Care: Focus on Autonomy & Surogates

- Know your state's surrogacy laws & hierarchy
- Help patients understand medical-legal reality
- Support agency in identifying surrogates
- Understand legal documents and save records
- Explore family history and context
- Engage case managers for support

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. **Agent**. In the event that my attending physician or their designee determines that I am not capable of giving informed consent to health care, I ____________, designate and appoint ____________ as my attorney-in-fact (Health Care Agent).

2. **Alternate Agent (optional)**. If the above-named Health Care Agent is unable or unwilling to act or not reasonably available, I designate and appoint ____________ as my alternate attorney-in-fact (alternate Health Care Agent). **(Optional)** If the above-named alternate Health Care Agent is unable or unwilling to act or not reasonably available, I designate and appoint ____________ as my alternate attorney-in-fact (alternate Health Care Agent).

3. **Authority of Health Care Agent**. My Health Care Agent is authorized to make decisions about my health care treatment that I am otherwise not able to make. This includes but is not limited to consent to initiate, continue, discontinue, or refuse medical care and treatment, as well as healthcare coordination. This includes artificial nutrition or hydration, surgical procedures and the withholding or withdrawal of life sustaining treatments. If I have executed an advance directive or living will, I authorize and direct my Health Care Agent to follow these directions. If I have not stated any wishes or desires, my Health Care Agent should act in my best interest.

4. **My Rights**. I keep the right to make health care decisions for myself as long as I am capable. This power of attorney will become effective only when I am unable to make health care decisions for myself as determined by my attending physician or their designee. My designated Health Care Agent's power will cease if and when I regain my capacity to make health care decisions as determined by my attending physician or their designee.

5. **Durable**. I intend to create a durable health care power of attorney. This power of attorney shall not be affected by my disability.

6. **End Date**. This health care power of attorney will terminate if I revoke it or when I die.

7. **Revocation**. I hereby revoke any prior grants of durable power of attorney for health care I have signed in the past. Should such prior durable power of attorney for health care exist in a document containing other grants of powers of attorney, I intend this document to revoke only the health care grants of power.

Signed ____________ Date ____________

FORM CONTINUES ON NEXT PAGE

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington
DURABLE POWER OF ATTORNEY HC
Page 1 of 3
U0289
UH0289 REV NOV 18

Durable Power of Attorney for Healthcare (DPOA-HC)

Primary Palliative Care: Attend to Legacy Work

Help your patient attend to life while coping with illness

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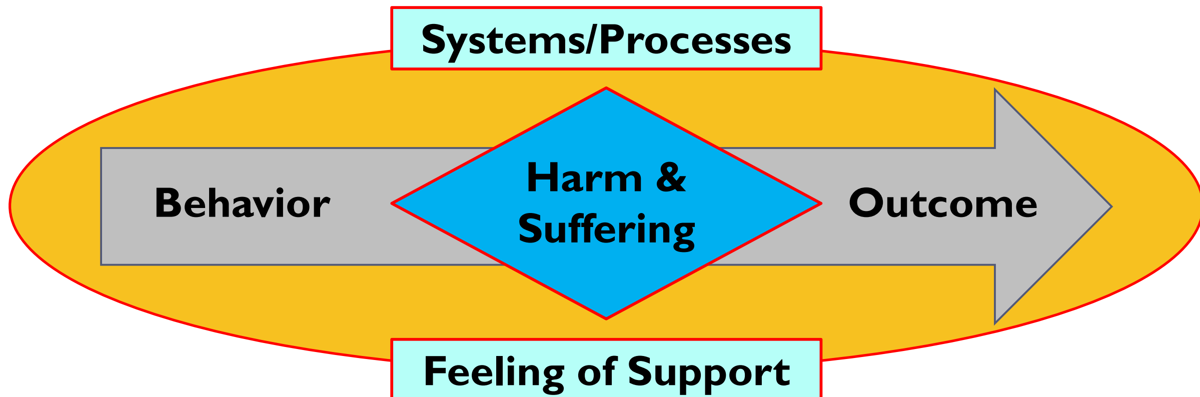
Reorienting Change Strategy



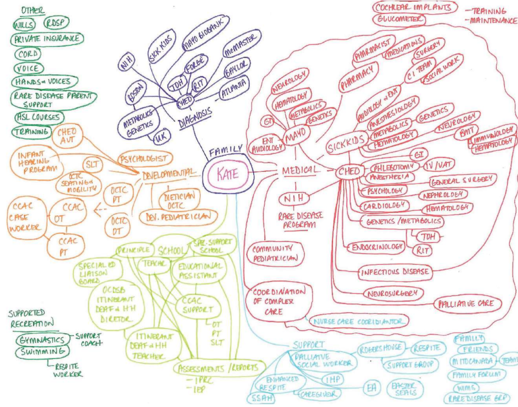
65

Consider Time as a Limited Resource

- Set shared agenda and identify priorities
- Allow time for rapport and trust building
- Accommodate walk-ins
- Be flexible with late arrivals
- Minimize follow-up needs
- Maximize inpatient stays
- Discuss life goals outside of healthcare

66

Build Inclusive Care Teams



- Leverage psychosocial experts
- Ask where patients access support & services
- Document care team members names and contacts
- Engage shelter and housing staff, case managers, and other human service professionals
- Bridge knowledge of personhood and values to acute & critical care teams

67

Lean Into Moral Distress with Relationship-Centered Care

FEELING OVERWHELMED?

SO IS YOUR PATIENT!

68

Underlying Moral Injury

Friction with "deeply held moral beliefs & expectations."

In the chat…

What informs the values, beliefs, and expectations that guide our care?

- **Our identity as care providers, healers, or workers?**
- **Our professional guidelines and code of ethics?**
- **Our feeling of competency in providing care & solving problems?**
- **Our own experiences with substances or serious illness in our lives?**
- **Our positionality?**
- **Our bias?**

69

There are no simple solutions to systemic injustice and structural violence or their sequelae

70

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Take notes on what might apply specifically to your patient.

What do/did you admire, respect, or love about your patient?

71

What do you admire, respect, or love about your patient?

slido

72

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What do/did you admire, respect, or love about your patient?

What is one thing you will take into your practice next week?

73

Resources

74

Current Publications

Johnson, I. & Light, M.A. (2023). Pathways of individuals experiencing serious illness while homelessness: An exploratory 4-point typology from the RASCAL-UP Study. *Journal of Social Work in End of Life & Palliative Care*. http://dx.doi.org/10.1080/15524256.2023.2223772

Ward, C., Johnson, I., Bamwine, P., & Light, M. (2023). The pet paradox: Uncovering the role of animal companions during the serious health events of people experiencing homelessness. *Anthrozoös*, 1-17. https://doi.org/10.1080/08927936.2023.2280376

Johnson, I., Light, M.A., Lewinson, T., Perry, T., & Moore, M. (2022). Understanding the ephemeral moment of COVID avoidance hotels: Lessons learned from acknowledging housing as central to dignified later life. *Journal of Gerontological Social Work*. https://doi.org/10.1080/01634372.2022.2087129

Johnson, I., Traver, A. & Light, M.A. (accepted). Resident care in the 'in-between time': Cross-sector perspectives on enhancing synergy between palliative care and permanent supportive housing. *Journal of Health & Human Services Administration.*

Johnson, I. et al. (under review). The costs of caring: I-poems as illustrations of moral distress among professionals working with seriously-ill homeless individuals. *Medical Humanities.*

Johnson, I. & Light, M.A. (under review). Meaningful healthcare and social service access for homeless populations: Generating alliances through theories of therapeutic landscape. *Journal of Progressive Human Services.*

Other Resources

- **Implicit Bias Assessments**
  - implicit.harvard.edu/implicit/user/pimh/index.jsp
- **Compassion Meditation Training**
  - centerhealthyminds.org/join-the-movement/compassion-at-work
- **Trauma Informed Care**
  - kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/training.aspx
- **De-escalation Tips**
  - crisisprevention.com/Blog/October-2017/CPI-s-Top-10-De-Escalation-Tips-Revisited
- **Harm Reduction**
  - nhchc.org/training-technical-assistance/online-courses/harm-reduction/
- **Brief Resilience Scale**
  - psytoolkit.org/survey-library/resilience-brs.html
- **General**
  - Klein JW. Care of the Homeless Patient. Med Clin North Am. 2015 Sep;99(5):1017-38. doi: 10.1016/j.mcna.2015.05.011

Adapting Your Practice

Recommendations for End-of-Life Care for People Experiencing Homelessness

nhchc.org/wp-content/uploads/2019/08/2018-end-of-life-care-guidelines.pdf

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Recommendations for

End of Life Care for People Experiencing Homelessness

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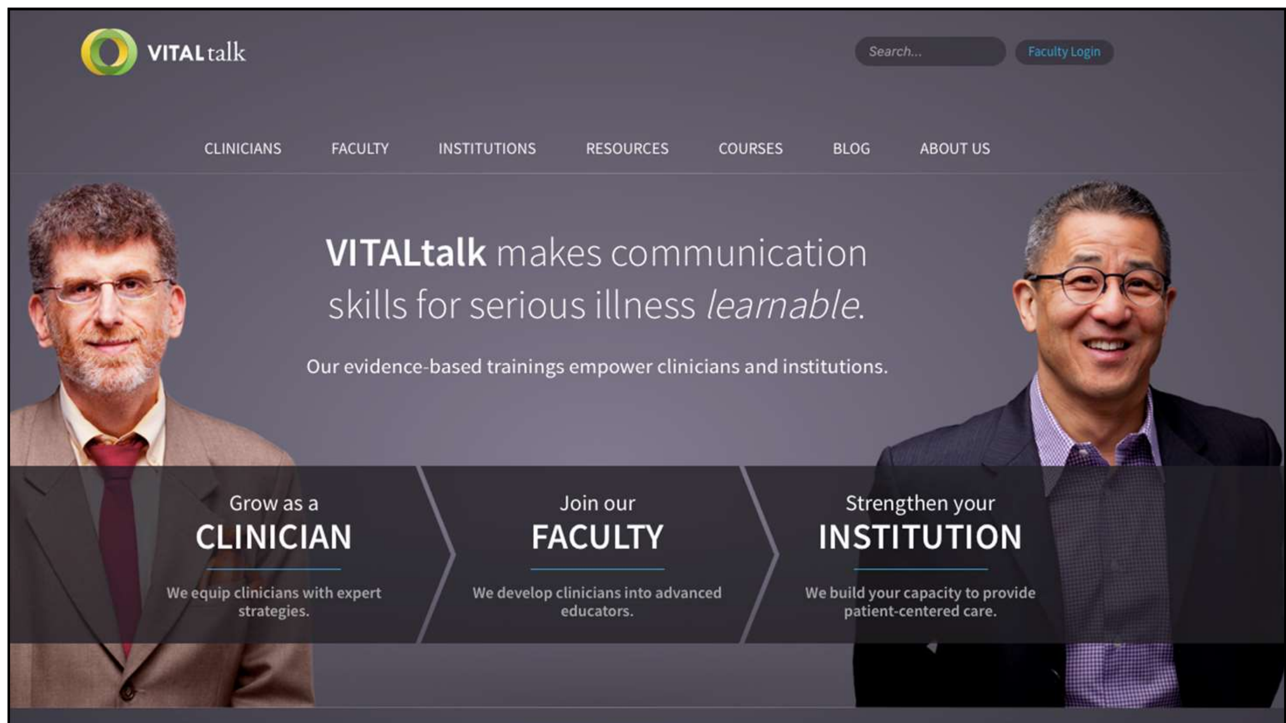
Serious Illness Conversation Guide

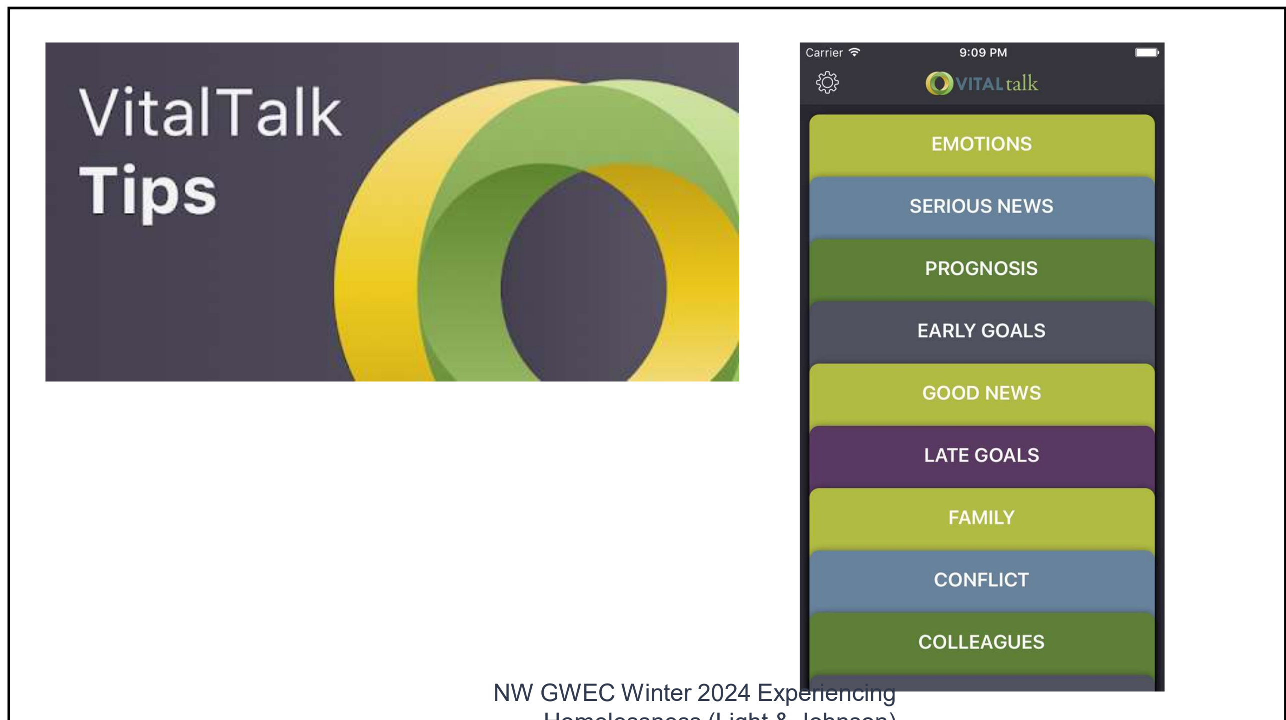
ariadnelabs.org/resources/downloads/serious-illness-conversation-guide/

What Matters to Me

ariadnelabs.org/2021/11/16/what-matters-to-me-workbook/



79



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