Hearing Their Voice:
Advance Care Planning for the Homeless

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Objectives

- At the end of this presentation you will be able to:
  - Identify key characteristics of the people experiencing homelessness population.
  - Discuss barriers that people experiencing homelessness face in accessing healthcare services.
  - Obtain a greater understanding of the need for Advance Care Planning (ACP) for all patient populations, with particular focus on the chronically ill patients experiencing homelessness.
  - Discuss the value of interdisciplinary collaboration in addressing the need for ACP in vulnerable patients experiencing homelessness.

Who are the PEH in the United States?

- The 2020 Annual Homeless Assessment Report (AHAR) to Congress found more than half of all PEH in the United States were primarily in four states: California (28% or 161,548 people); New York (16% or 91,271 people); Florida (5% or 27,487 people); and Texas (5% or 27,229).
- California accounted for more than half of all unsheltered people in the country (51% or 113,660 people), a 10,270 increase between 2019-2020.
- Of the homeless in California, 70% live outdoors.

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Who are the PEH in Los Angeles?

- Greater Los Angeles Homeless Count - 20
- The largest percentage of the homeless population are found in South Los Angeles and Metro Los Angeles[5]
  - Approximately 66,436 people are experiencing homelessness on any given night in Los Angeles County
  - There has been a 12.7% increase in the PEH population since last year's count.
  - The number of seniors 62 and older increased 20%.
  - African-Americans continue to make up a majority of the PEH population

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Who are the Homeless in Santa Monica?

- Santa Monica – "The Home of the Homeless"
- The January 2020 homeless count found 907 People Experiencing Homelessness in Santa Monica.
- About 600 were unsheltered and 300 were living in shelters or institutions.
- The city's PEH population grew by 3% in 2019 and 4% in 2018 after jumping 26% in 2017.

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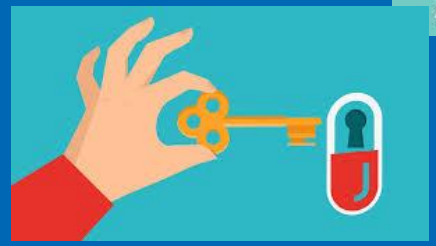
Social Determinants for PEH

- Housing
- Food insecurity
- Inability to afford prescription medications
- Poor sleeping conditions
- Transportation issues
- Inability for healthcare providers to identify causes of pain
- Patient/healthcare professional relationship
- Inability to limit physical activity
- Lack of belonging
- Lack of social safety net
- Access to healthcare







PEH are dying on our streets and in our hospitals

- Causes of death include: Hepatitis C, Pulmonary Disease (COPD/Emphysema), Liver failure, Renal failure, Cardiac Disease (untreated Hypertension).
- Harsh living conditions and secondary sources of suffering increase likelihood of death (uncontrolled pain, skin rashes, dental problems, exposure).
- These patients may come to our hospitals critically ill as “John Does”; even for those we identify, find a next of kin can be a challenge.
- Often any decision makers we locate may be estranged or unsure of the patient’s wishes.

How do we Become Part of the Solution?

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Funding

- Grant was submitted by SM-UCLA Spiritual and Palliative Care Departments in April 2014 to the Coalition for Compassionate Care of California.
  - Travel expenses
  - Trainings
  - Office supplies for printing.

- Train-the-Trainer training for Advance Directive and POLST completion was initially completed in 2014 by team members.
  - Team members have remained extremely active with the Coalition and have taken frequent updates and refresher.
  - Team members have kept the Coalition abreast of our initiatives.

Advance Care Planning with the Homeless

- **Purpose:** to improve our patient care for homeless and at-risk persons, including initiating an advance care planning process with the opportunity to complete an Advance Health Care Directive (AHCD) and/or (if appropriate) a Physician's Order for Life-Sustaining Treatment (POLST) for all homeless patients with a chronic or progressive illness.

Advance Care Planning with PEH

- **<u>Goal</u>:** the primary goal of this project is to develop a communication and intervention process to directly engage patients experiencing homelessness, facilitating a conversation about advance care planning and producing a health care directive to be entered into the medical record. We will do this by establishing working relationships with venues that provide services to individuals experiencing homelessness.

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Advance Care Planning with PEH

- **Scope:** individuals identified as homeless or at risk for homelessness presenting for care at Santa Monica UCLA Hospital and at other selected hospitals and clinics. Homelessness is defined as "lacking a fixed or adequate night time residence."

Advance Care Planning at Santa Monica-UCLA

- **Initial** trainings and outreach were done for our own staff members, case managers and Emergency Room Staff.
  - We learned that our emergency room averages 50-75 visits from individuals experiencing homelessness for a variety of reasons every month.
  - Initially, we hoped to reach these patients during their visits in our own setting

BUT

  - We discovered that doing PEH outreach for Advance Care Planning in our Emergency Room was not effective.
- At that point, we turned to those who know this population the best…
  - Next wave of education was for community homeless outreach programs.

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Community Training

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Community Training

- Three ACP trainings for in-house staff and community members have been held (a total of 50 participants).
- Clinical Nurse Specialist provided two trainings to 30 American Association of Critical-Care Nurses (AACN) members which has produced additional volunteers for our project.
- SM-UCLA Structural Empowerment (12 Participants).
- Area Hospices also chose to partner with us, offering not only Advance Directives but providing care for patients experiencing homelessness through our secondary project, Hospice under the Bridge.
- Trainings continued to multiple venues from 2014 to the present, including the LA Homeless Services Authority (LAHSA); almost 100 participants were reached during this outreach.

Community Training

- AD terms
- Overview of forms
  - AHCD, POLST, Living Will
  - Differences between the forms
- Role of and choosing a healthcare agent
  - Including if the patient/client does not have a person to list
- Scope of health care agent's authority
- Completing the AHCD/how it becomes legal
- Document distribution
- Facilitating the conversation

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Community Outreach: St. Robert's Food Bank

Some Key Components

- Using the Easy-read Directive, to overcome literacy challenges.
- Trust is the key:
  - Since we visit often, the “regulars” know us and bring others to us.
  - We provide healthcare resources in addition to Directives, meeting the needs that our clients have voiced to us.
  - We encourage clients to take a Directives and review it instead of completing it right away, including sharing it with their Case Worker or trusted community volunteer.
    - This is a major reason why the community education is so important!
    - Even as we share completed Directives with our community partners, we ask them to share completed Directives with US in return so we can scan them into our Electronic Medical Record.
    - Commonly used Electronic Medical Record systems such as Epic make Directives visible NATION WIDE. I.e. if they are hospitalized in Sacramento, a hospital there will see that the patient has a Directive.

Advance Health Care Directives

IHA California Advance Health Care Directive (Multiple Languages, Bilingual, States)

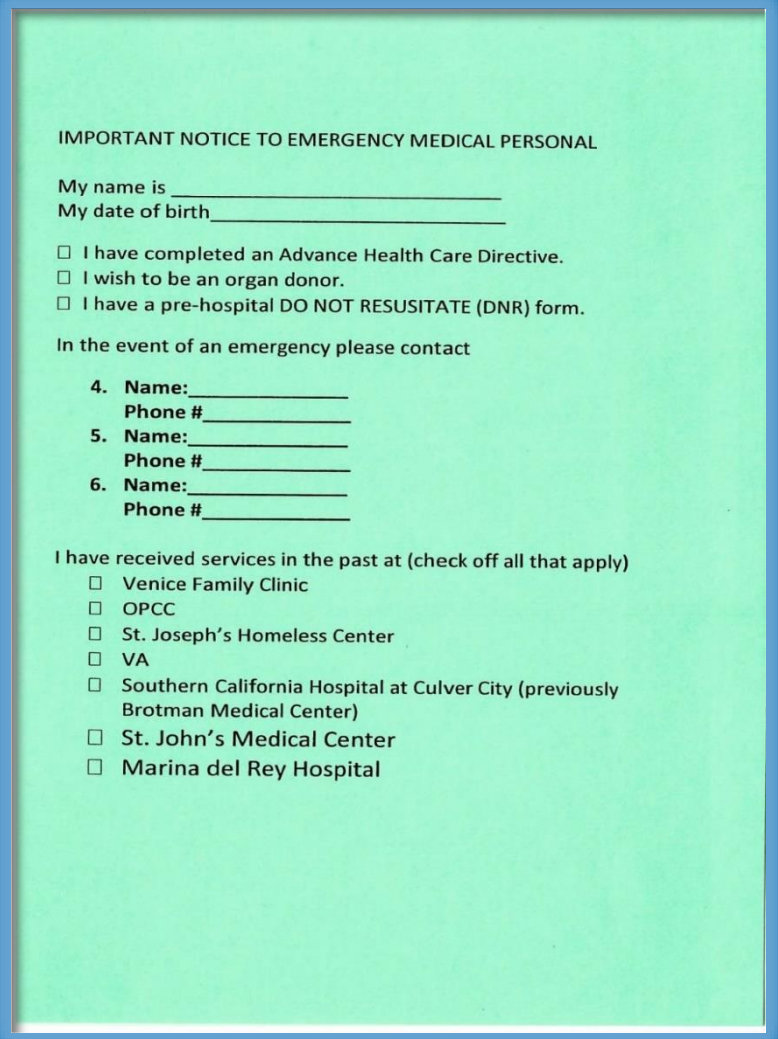
https://www.iha4health.org/our-services/advance-directive/

Additional Key Components

- Having a Directive will likely NOT save the patient from an initial resuscitation

However,

- It WILL allow the hospital to identify and honor their wishes once they are admitted, as well as potentially identifying a decision maker/next of kin.
- The “Green Paper”
  - Suggested and created by our clients themselves.
  - Even if belongings are lost, this can be kept in a pocket or shoe.
  - Will be found by a hospital employee (usually a Social Worker).



IMPORTANT NOTICE TO EMERGENCY MEDICAL PERSONAL

My name is _____
My date of birth_____

☐ I have completed an Advance Health Care Directive.
☐ I wish to be an organ donor.
☐ I have a pre-hospital DO NOT RESUSITATE (DNR) form.

In the event of an emergency please contact

4. **Name:**_____
   Phone #_____
5. **Name:**_____
   Phone #_____
6. **Name:**_____
   Phone #_____

I have received services in the past at (check off all that apply)

☐ Venice Family Clinic
☐ OPCC
☐ St. Joseph's Homeless Center
☐ VA
☐ Southern California Hospital at Culver City (previously Brotman Medical Center)
☐ St. John's Medical Center
☐ Marina del Rey Hospital

- Name
- Date of birth (DOB)
- Completion status of an advance care planning document (s)
- Code status

- List of emergency contacts with contact information (phone, email)

- Check off list of received services/ connection to agencies, including your agency/center

Sharing Completed Directives

- Obtain a consent, with list of places where client receives care or resources
- Scan or photograph a copy of the completed Directive (patient keeps original)
- Share Directive via e-mail with contacts at organizations as requested by patient.
- If the client receives care at a UCLA facility, upload the document into his Electronic Medical Record.

Strategies and next steps

- UCLA is expanding their own homeless outreach programs, including a mobile clinic; our program plans to partner with them to have the clinic available at St. Robert's when we are doing our outreach.
- Continue to provide education and outreach programs to increase the number of volunteers.
- Work with and educate physicians in the hospital to make referrals for ACP conversations for patients experiencing homelessness who are admitted and have capacity.
- Work with and educate community agencies to engage and continue the ACP conversations started in the Food Bank outreach.
- Continue outreach to Hospice and Hospital Administration to discuss End of Life/Hospice needs for PEH.
- Efforts are being made to expand to other areas and partner with other hospital systems, including in the San Fernando Valley.

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Our Successes!

- Over 600 Directives distributed to homeless individuals.
- New volunteers being recruited and trained.
- Clients coming back to us asking for additional Directives to share with their friends.
- At the request of the Director of the Outreach Center, the CNS is doing monthly education on Directives and distributing them to other volunteers.
- The UCLA Medical Outreach Van has joined Hearing their Voice to provide on-site medical care every month.

Hearing their Voice

Advance Care Planning for the Homeless

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KEYWORDS

• Homeless • People experiencing homelessness • Advance directive
• Advance care planning • Dying • End of life

KEY POINTS

- Homeless individuals are at high risk of dying in inpatient settings.
- Homeless individuals are seldom engaged in Advance Care Planning.
- Homeless individuals welcome the opportunity to complete an advance directive.
- Trust with homeless individuals is more easily established in a familiar setting.

INTRODUCTION: HOMELESSNESS AND THE IMPACT ON CRITICAL CARE

An unidentified man is found in cardiac arrest behind a local store. Bystander CPR is initiated and an ambulance is called to transport the man to the hospital. When the ambulance arrives, the Emergency Medical Technicians (EMTs) determine he is in ventricular fibrillation and he is defibrillated with 200 J, and given epinephrine without effect, then intubated. Advance Cardiac Life Support (ACLS) continues as he is transported to an area Academic Medical Center.

Upon arrival, although ACLS continues, a social worker searches through the man's clothing. He has been found to be wearing 2 layers of shirts and pants and has a small amount of money in his inside pocket along with some unidentified medications and a bottle holding an unidentified liquid that smells strongly of alcohol. No identification is found and he had no other belongings with him. His shoes are in tatters.

As the team is preparing to stop the code, return of spontaneous circulations (ROSC) is obtained. The man, now "John Doe 230," is transported to critical care, placed on a hypothermia protocol with amiodarone and levophed infusions, sedated with propofol, and provided with a low-dose fentanyl infusion for pain control. He

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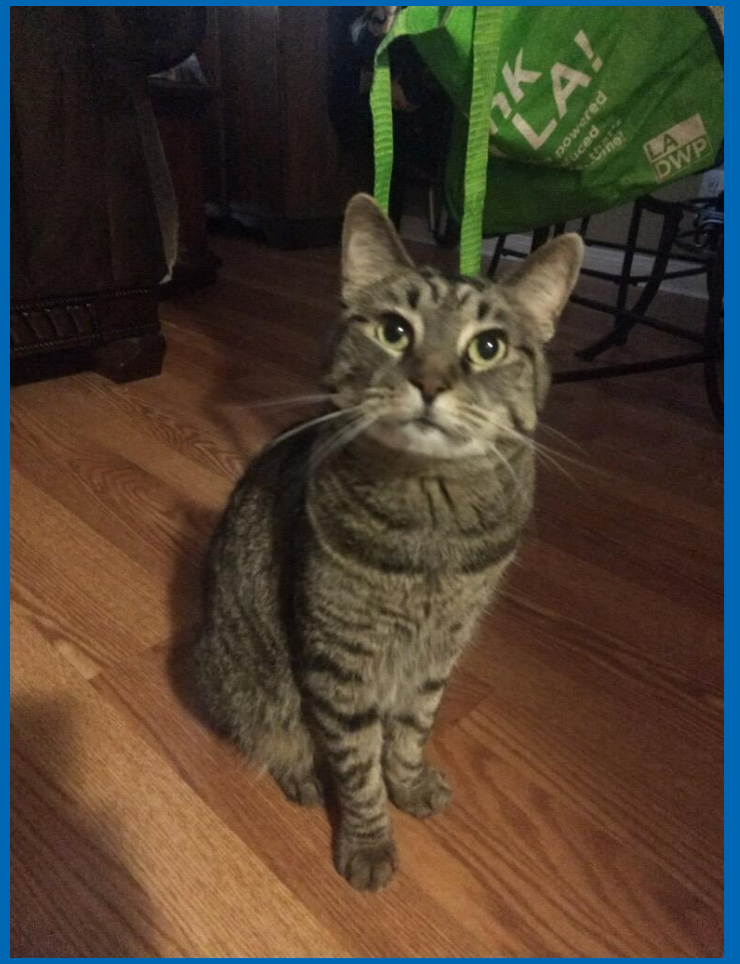
Duplicating the success of Hearing Their Voice

- We need more volunteers!
  - Our small group can only cover a single site once a month (if that; sometimes there are conflicts).
- We need more sites and opportunities to get in front of the homeless population.
- Outreach for additional at risk populations such as LGBTQ+, human trafficking survivors, undocumented individuals, etc.
- We need more opportunities for COMMUNITY EDUCATION!
  - If a homeless client presents with a copy of the Directive we gave them, it's important that your Case Managers, volunteers and team members are able to:
    - Assist them with completion, if desired.
    - Keep it on file.
    - Share it with other organizations, including Healthcare Systems, where the patient gets care.

Hospice Under the Bridge: an Additional Opportunity

- This program has been a low-key collaborative of interested individuals operation since 2015.
- A network of interested and passionate individuals from UCLA, Hospices, Homeless Advocates, LAHSA and other key strategists.
- OUR GOAL: to provide dying homeless individuals relief of suffering and dignity in their setting of choice at the end of life.
- Our networking and brainstorming, and the passion of our members, has led to initiatives such as Brilliant Corners.

QUESTIONS???



THANK YOU!

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