National Health Care for the Homeless Conference, 2019

Equitable Aging in Place

EXPANDING THE "HARM REDUCTION" MODEL TO HIGHER LEVELS OF CARE

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Introductions

- What is your job/role?
- Where are you from?
- What is your main concern about Aging in Place for those with lived experience of homelessness?

Rapidly aging population, growing need for access

- People with lived experience of homelessness are at greater risk of premature aging, while also being at high risk for experiencing substance use disorders (SUD) and mental illness.
- Half of this population is age 50 or older and experiencing gerontological conditions at much younger ages than the general population
- Creates a growing need for access to higher levels of care that are low-barrier, harm-reduction, and trauma-informed.

Definitions

- Equity: the quality of being fair and impartial.
- Aging in place: a person making a conscious decision to stay in the inhabitation of their choice for as long as they can with the comforts that are important to them.
- Harm reduction: an umbrella term for interventions aiming to reduce the problematic effects of behaviors, i.e. safe sex, needle exchange, medication assisted treatment
- Higher level of care: an increase in frequency of treatment, closer monitoring, or a more structured treatment setting
- Permanent supportive housing: "independent living" with housing case management during business hours and front desk support staff on site 24/7. May have other community supports visiting during business hours

Case study: W.M.

- 58 yo Native American man, reluctant to seek care for any reason, medical needs addressed only by visiting outreach RN and doctor
- Severe long-term alcohol use disorder, 10+ years homeless, estranged from family
- Housed in permanent supportive housing SRO building 2015. Independent living apartment building with front desk staff and case management. Happy with his housing and support.
- COPES caregiver visiting a few times a week to help with housework
- Develops worsening Korsakoff's dementia, incontinence, venous stasis dermatitis requiring daily wound care and support as he can't remember to stop scratching his legs. Significant weight loss, forgets to eat, decreased mobility, uses 4WW as a wheelchair
- Increasingly vulnerable to other residents in the building who prey on his forgetfulness and generosity. Unable to find/retain a caregiver due to level of complexity and care needs

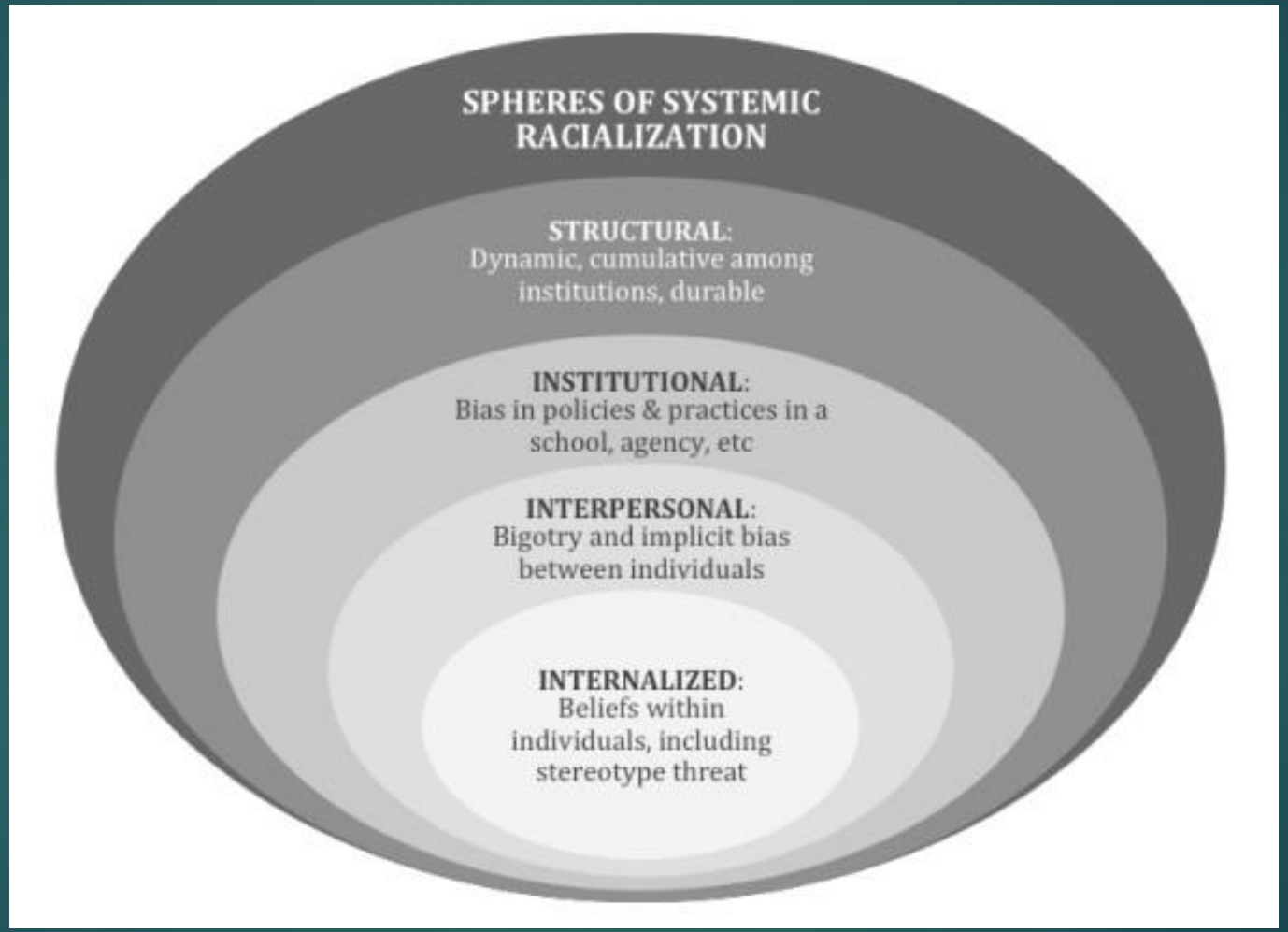
Case study WM (continued)

- Late 2017: Pt develops cellulitis and admitted as inpatient to hospital for treatment
- Altered mental status, no longer independent (not oriented to place/time)
- Discharged to the only skilled nursing facility willing to accept him, 34 miles away from Seattle for assumed long-term care placement
- Spring 2019: his former housing case manager receives notice from SNF that pt "left AMA" from SNF due to issues around drinking alcohol
- Pt is seen in Seattle, now homeless again

Equity

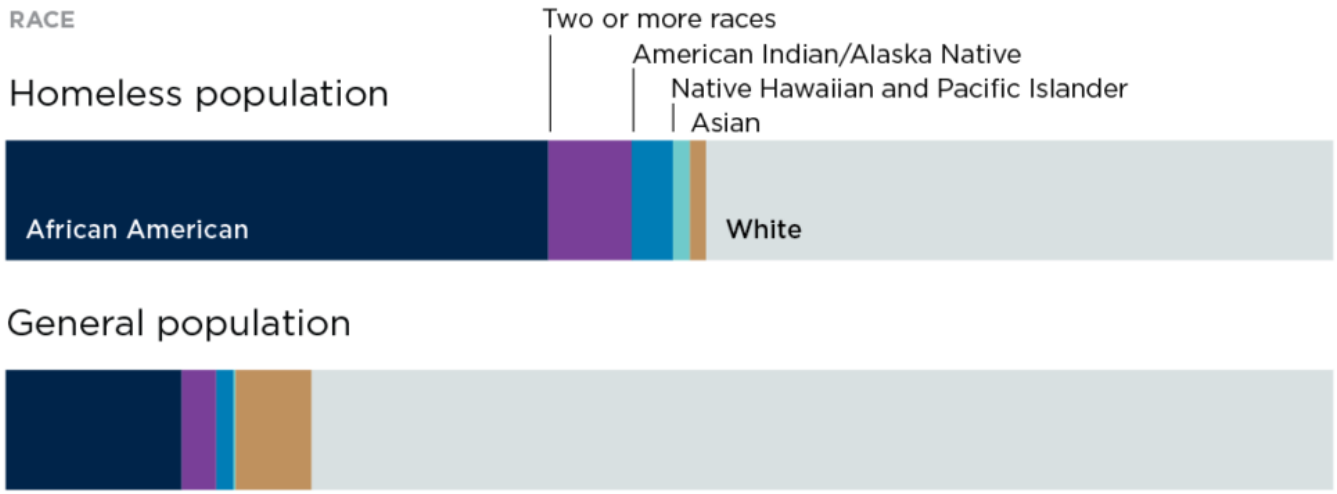
- Who is getting inequitable treatment when it comes to aging and end-of-life care? What strategies do you use to address these inequities?
- Describe the barriers to aging in place for WM. In your setting, what other solutions are possible?

Spheres of Systemic Racialization



Most Minority Groups Make up a Larger Share of the Homeless Population Than They Do of the General Population

Race and ethnicity of those experiencing homelessness compared with the general population



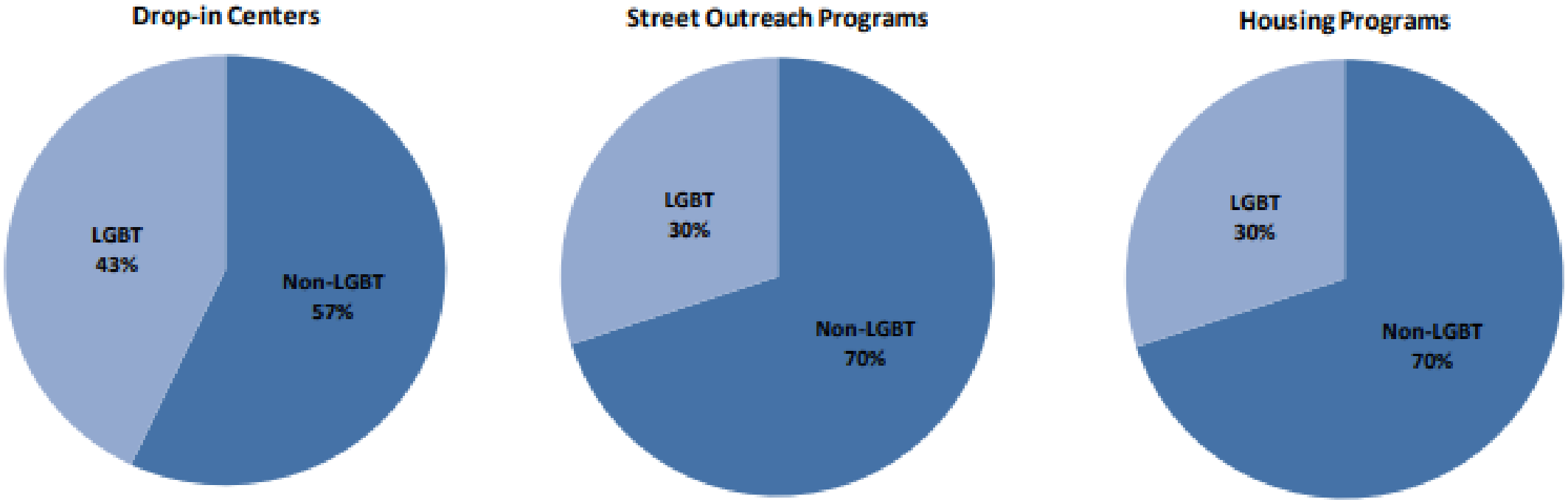
Homeless population data are for a given night in 2017.
Source: 2017 *Annual Homeless Assessment Report to Congress*, Part 1

National Alliance to End Homelessness

According to the National Coalition on Homelessness, up to 40% of homeless youth identify as LGBTQ, while the general youth population is only 10% LGBTQ In Washington D.C. alone, 43% of homeless youth identify as LGBTQ

LGBT youth represent between 30% and 43% of those served by drop-in centers, street outreach programs, and housing programs:

Percent of Clients Served – LGBT and Non-LGBT Youth



Source: *Serving Our Youth: Findings from a national survey of services providers working with LGBT youth who are homeless or at risk of becoming homeless*. The Williams Institute/The Palette Fund/True Colors Fund. July 2012

Risk factors for health disparities

- Race
- Ethnicity
- Gender identity, sexual orientation (LGBTQ+)
- Non-native English speakers, cultural differences
- History of substance use
- History of mental illness
- Criminal conviction
- Sex offender registration
- Socioeconomic/employment status
- Education
- Hearing/visual/Physical/Cognitive impairments or challenges
- Veteran/military discharge status

Access

- What are the barriers to accessing higher levels of care, whether in-home, or long-term care placement?
- How do you address these barriers with clients in your work?

Continuum of care: where are the gaps?

- Hospitals/EDs provide help for acute, billable problems
- Primary care can give advice on how to manage chronic conditions, but can only offer services in clinic
- Skilled nursing facilities can only keep patients who require a certain level of care
- Assisted living facilities and "adult family homes" vary widely, and have many rules about who they will accept (hard to get in, easy to fail out)
- Patients need to agree to accept care
- Delayed discussions about end-of-life care due to cultural barriers, institutional mistrust, disengagement from care

Autonomy

- Why don't aging adults want to go to nursing homes, even when it is obvious to others that they can no longer take care of themselves independently?
- How does harm reduction relate to patient autonomy and end of life decision-making, and how do you integrate harm reduction principles in your work with adults aging in place?

Who is falling through the gaps?

- High utilizers of emergency services, but "too independent" for hospital or SNF
- Lack of assisted living/adult family homes/SNFs that will accept clients with SUD, MH/BH issues, other barriers
- Facilities may feel like institutions/prisons to patients, it may feel like they're being asked to give up their autonomy, chosen community, safe space
- Decisional capacity vs. patient autonomy vs. patient safety
- Patients on medication assisted treatment (MAT) who are no longer physically able to go to methadone clinic
- Having no close friends or family to help with end of life decision-making conversations (DPOA, health care proxy)

Communication

- How can we improve communication with our patients?
- How can we improve communication with other providers?

Solutions from a Seattle perspective

- Embedding outreach RNs, social workers, and MD/ARNP providers in PSH for low barrier access to care
- Improving inter-organizational communication and relationships
- Aging and Disability services now have dedicated case managers to work in designated areas of the county
- "Clustering of care" for multiple clients with in-home caregiver services in supportive housing buildings through DSHS Home and Community Services
- Home health PT/OT/RN visits can be ordered from primary care
- Community health workers to support RN outreach, accompany patients to appointments and other delegable tasks

Where are the “gaps?”

- Varying quality and stability of in-home caregiver services provided by state agencies
- Varied or lack of training for housing staff (front desk, case management) to confront frequent problems like safe transferring after a fall, cleaning up biohazardous waste (putting staff at higher risk for occupational injuries)
- Lack of support and training, low pay, contributes to high turnover rates in staffing and disruption of continuity of care between clients and direct service providers
- Other?

Recommendations & Reflections

- Other questions to pose to the group?
- How are you or can you contribute to making aging in place more equitable?
- What kind of recommendations would you make to your community partners regarding aging in place for people with lived experience of homelessness, and how can we work together better?
  - Local government
  - Housing developers
  - Housers
  - Hospitals, Skilled nursing facilities, Assisted Living, Primary care clinics
  - Hospice
  - In-home caregiver agencies
  - Other community groups…