Homelessness and Access to Palliative and End-of-Life Care

By Hannah Murphy Buc, MSN, RN, CNE

Twenty years ago, still fresh out of college and not exactly sure what was next, I found myself back in Atlanta (where I had grown up) and answering a need at an organization my parents had started some 25 years earlier. The Open Door Community worked to address the needs of the homeless poor in Atlanta by providing a range of services (soup kitchens, shelter, and weekly medical clinic) while also advocating for supportive and just legislation to end homelessness. As I arrived back in Atlanta, they needed a volunteer and on-site coordinator for the weekly medical clinic, and I fit the bill.

For five years, I recruited and trained volunteers, worked with faculty and students from Emory University School of Medicine, and found my own passion for patient care through starting a foot clinic to care for the ragged and injured feet of the patients who came to the clinic for medical management and treatment. Two years into this adventure, I enrolled in nursing school and started bringing my friends along with me to the clinic each week (it was a brilliant recruitment strategy!).

Providing care for patients experiencing homelessness is rife with complexities. Morbidity and mortality rates among this population are appalling; some sources note a decrease of life expectancy by as much as 50%. This staggering statistic, combined with the fact that homelessness disproportionately impacts patients with other marginalized identities (people of color, veterans, low socioeconomic status, lower educational completion, etc.) illuminates the realities of intersectional oppressions combining to systematically disenfranchise this whole population.

As I knelt to care for the feet of many patients over these five years, I heard stories and built relationships that have shaped me as a clinician, teacher, and human — and as I grew to care deeply for many of these patients, I became increasingly horrified by the system of care that created barriers for their access to any sort of medical management or treatment. These challenges grow even more complex for patients experiencing homelessness when they receive a life-limiting diagnosis or have palliative or hospice care needs.

Access to Palliative and End-of-Life Care

The combination of complex chronic care needs and barriers to care can make accessing palliative and end-of-life care nearly impossible for patients experiencing homelessness. Examples from the literature include negative experiences with health care providers leading to deep distrust and therefore an unwillingness to engage with providers; an often complete lack of available resources to manage chronic and life-limiting illness in the absence of stable housing; lack of creative models, like street outreach teams, to help stabilize and/or provide ongoing care to patients with high symptom burden; and the use of traditional approaches rather than harm-reduction approaches and trauma-informed care (BMC Palliat Care 2016;15:96; BMC Palliat Care 2018;17:67; Omega [Westport] 2020;8:63–91). On the organizational side, hospice and palliative care organizations struggle to identify patients experiencing homelessness because the requirement of a place to receive care often disqualifies them for admission unless the patient meets the criteria for inpatient hospice admission.

As my clinical and research interest in palliative and end-of-life-care have grown, I’ve always gone back to my experiences in the foot clinic. These sorts of opportunities to build trusting relationships with clinicians are exactly what is needed to reach patients experiencing homelessness who need care at the end of their lives. But there are few opportunities for this sort of relationship and trust building to happen in traditional health care settings where efficiency and profit are considerations in the patient care and scheduling algorithm. And palliative and hospice care depends on a home, or at least a stable housing setting, where the patient can receive care.

As conversations around health care equity and inclusion are now happening in a much wider context, we must carefully examine our current practice and how our systems are set up to easily exclude certain populations. In this case, the issues are clear: the traditional model of palliative and hospice care excludes people without stable housing when there are no inpatient sites or housing options where patients can receive care.

When sites do exist, they often have restrictive policies that dissuade a patient from enrolling, such as limiting visitors or having curfews or requiring abstinence from drugs and alcohol. Instead, we need inclusive practices to address issues of equity for homeless patients.

Essential inclusive practices include:

• Flexible treatment options;
• Harm-reduction approaches that honor the whole person regardless of their needs and/or practices; and
• Trauma-informed care that anticipates the needs of a population that experiences near-constant crisis marked by violence and loss.

A Successful Model

One very successful model is the Palliative Education and Care for the Homeless (PEACH) program in Toronto, Ontario. In this model, clinicians reach patients who are experiencing homelessness or vulnerable housing by focusing on accessibility, flexibility, and a humanistic approach to human dignity. Leveraging relationships with community organizations, particularly those with harm-reduction programs, PEACH clinicians build long-term relationships with people who are concomitantly dealing with life-limiting disease and experiencing homelessness or housing vulnerability. (For more information on their program, visit their site at Inner City Health Associates, PEACH – Palliative Education and Care for the Homeless, https://bit.ly/34oBgo.) This organization is one of several that have both a street outreach team and an inpatient facility where patients can live while receiving end-of-life care.

Moving Forward

The connection between homelessness and palliative and hospice care is clear: homelessness itself is a life-limiting diagnosis, and palliative and hospice care using a harm reduction and trauma-centered approach helps address the barriers to care. As we work to reduce harm and engage with our patients, we all need to create opportunities to sit at our patients’ feet and listen to their stories, to provide care that addresses their own identified needs, and to help them find comfort in a way that honors their precious lives.

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they are part of something bigger. Consider forming a resident hiring committee so residents can have a say as well. For more ideas, see Leslie Peddie’s book *What Living as a Resident Can Teach Long-Term Care Staff: The Power of Empathy to Transform Care* (Health Professions Press, 2017).

To increase our capacity to understand ageism and to implement some of these strategies, it’s also important to acknowledge the complexity of our current environment — that we are constantly managing risk, liability, and responsibility. It’s difficult to balance regulations at the federal and state levels and hundreds of policies and procedures, not to mention the impact and long-term implications of the last three years living and working in a pandemic.

But regardless of these challenges, what I’ve ultimately learned in my work is this: it’s important to initiate conversations about difficult topics like ageism and really listen to what other people share. Talk to people about their frustrations, disappointments, and successes. Offer support when people get discouraged. And remember that change happens slowly — keep going!

Resources

• For creating community and purpose: A Heart to Serve program, https://www.ahearttoserve.com/

• Ibasho’s Eight Principles, https://ibasho.org/ibasho-principles

Ms. Hector is an author, speaker, and educator specializing in clinical operations for the interdisciplinary team, process improvement and statistical theory, Nonviolent Communication, risk management and palliative care, among other topics. She is a member of the Editorial Advisory Board for Caring for the Ages. She is passionate about nursing homes and supporting staff to care for the most vulnerable people in their communities.