



REACHING OUT: QUALITY HOSPICE AND PALLIATIVE CARE FOR RURAL AND HOMELESS VETERANS



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Reaching Out: Quality Hospice and Palliative Care For Rural and Homeless Veterans

In November of 2008, NHPCO released the request for proposals for the “Reaching Out” grant to improve access to quality hospice and palliative care for rural and homeless veterans; in February of 2009, eighteen grants were awarded. Today, each grantee has begun work on a nine-month long, groundbreaking project and has forged community partnerships that will undoubtedly lay the foundation for a commitment to providing quality care to veterans at the end of life. This report will provide an overview of all projects awarded monies by NHPCO as part of the “Reaching Out” grant.

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SUMMARY OF “REACHING OUT” GRANTEE PROJECTS

Grants have been awarded to eighteen providers that represent a range of community-based organizations. Eleven of the projects constitute Group 1, with a project start date of February 18, 2009. The remaining seven projects constitute Group 2, and have adjusted their timelines to begin project work in March, 2009, under the guidance of Kandyce Powell, project manager.

Reaching Out

The organizations awarded “Reaching Out” grant monies are based in fifteen states that span the country. Including partnership involvement, the “Reaching Out” projects will involve twenty states directly.

Arkansas
 California
 Colorado
 Connecticut
 Delaware
 Florida
 Georgia (Partnership)
 Idaho
 Kentucky
 Maine
 Massachusetts
 Michigan
 Montana (Partnership)
 Nevada (Partnership)
 New Jersey
 North Carolina
 Tennessee
 Utah (Partnership)
 Virginia
 Wyoming (Partnership)



Target Populations

Each grantee project will focus on a specific population: homeless veterans, veterans living in rural areas, or both homeless veterans and those living in rural areas. The distribution of targeted veteran populations does not indicate that there will necessarily be a large variance between the focus on veterans in rural areas and the focus on homeless veterans.

- Five projects will target homeless veterans.
- Seven projects will target veterans living in rural areas.
- Six projects will target both rural and homeless veterans.



ARKANSAS HOSPICE, INC.

Project Title: VET TO VET

Primary Contact: Janice Morrison, MSN, Community Liaison

Email: jmorrison@arkansashospice.org

State: AR

VISN: 16

Target Population: Rural veterans

Abstract:

The purpose of “Vet to Vet” is to develop an educational program conducted by veterans for veterans in the Hot Springs Village community, in anticipation of the increasing number of veterans returning from conflict to rural areas. The project will utilize surveys pre-program and post-program to ascertain the knowledge level and likelihood of seeking hospice care for each veteran and spouse. Outcomes will lead to changes in educational materials and identify best channels for dissemination.

Partnerships:

The following partners were chosen for their established network among Hot Springs Village veterans. Each organization meets monthly in Hot Springs Village.

1. The local chapter of Military Officers Association of America, Hot Springs Village Veteran Memorial Foundation (MOAA)
2. The local chapter of Volunteers of Foreign Wars, Hot Springs Village VFW
3. The local chapter of American Legion, Village Americans Legion

The following partners were chosen for the healthcare services that they provide in the home. A representative from each will attend monthly status meetings and communicate the opportunity to learn about end-of-life care benefits for veterans.

4. Gentiva, a Home Health Agency that provides Hot Springs Village with acute care.
5. Home Care Professionals, a Home Health Agency that provides 'activities of daily living' assistance in the home to residents of Hot Springs Village.

The following partner was chosen for her expertise and will serve as a consultant in the field of veterans’ affairs.

6. Diane Morgan, RMP, APM, Palliative Care Coordinator through the Little Rock VA Hospital, works with veterans each day.
-



Anticipated Outcomes:

1. Data collection in regards to awareness of end-of-life care services and the likelihood that veterans and/or their spouses will access these services in Hot Springs Village.

Measures of data collection include:

- A Pre Presentation Questionnaire completed by each veteran and spouse prior to the educational session/presentation they are attending.
- One General Nonverbal Worksheet is completed for each presentation.

2. The creation of a “Vet to Vet” teaching program, including the screening and selection of eight “teacher vets” to educate veterans and their spouses about end-of-life care.

Measures of the success of the “Vet to Vet” teaching program include:

- “Teacher vets” will share positive and negative experiences, providing specific examples of each.
- “Teacher vets” will provide actionable suggestions for process change.

3. Evaluation of the changes in awareness among veterans and/or their spouses, including their knowledge of end-of-life care services and their likelihood to use them following the “Vet to Vet” program.

Measures of the change in awareness among veterans and/or their spouses include:

- A Post Presentation Questionnaire completed by each veteran and spouse immediately following the presentation they attended.
- One “General Impressions” Mini Focus Group conducted for each presentation.
- Actionable suggestions for change in the “Vet to Vet” program offered by veterans and/or their spouses.



CALIFORNIA HOSPICE FOUNDATION

Project Title: CALIFORNIA/NEVADA HOMELESS AND RURAL VETERAN
PROJECT

Primary Contact: Martha (Marcie) Larkey, Director, New Program & Fund
Development
Email: mlarkey@calhospice.org
State: CA
VISN: 21
Target Population: Both homeless and rural veterans

Abstract:

The goal of this project is to identify and eliminate barriers between community-based providers and the Veterans Administration. The California Hospice Foundation (CHF) and partners will work to determine what services are currently available to veterans living in rural areas as well as homeless veterans, what challenges arise in serving these populations and who has worked to resolve these challenges. CHF will also determine who is interested in developing a collaborative program to better serve these veterans. A replicable education/planning event and a “Best Practice Toolkit” will be developed and tested. Participants in the project will take away a plan to either improve or begin a local collaborative project.

Partnerships:

Veterans Administration

Expertise from the Department of Veterans Affairs will be critical in the design and implementation of the survey and analysis portion of this project.

1. Vyieyanthi (V.J.) Periyakoil, M.D., VA Staff Physician, Department of Veterans Affairs, Palo Alto Health Care System, Palo Alto CA

The following partners were chosen specifically to address service to homeless veterans. San Diego is an urban community with a 2009 projected veteran population of 240, 136; the San Diego homeless program has been following homeless and marginally housed cases since 2003.

2. Jan Cetti, BSN, MS, President, CEO, San Diego Hospice & Institute for Palliative Medicine, San Diego, CA
3. Madeleine S. Toland, RN, BSN, PHN, Manager South Central Home Care Team Coordinator Homeless Programs, San Diego Hospice



The following partner was chosen specifically to address service to veterans living in rural areas.

4. Audrey Flower, Executive Director, Madrone Hospice, Yreka, CA

All partners will contribute their expertise to create successful rural programs, will have input for survey and survey analysis and will participate in developing the toolkit, the education program and the final report.

Anticipated Outcomes:

1. **Identification of existing programs, successful programs, barriers to successful collaboration, as well as individual veterans and programs interested in future collaboration.**

2. **Assurance of accuracy of information regarding end-of-life care programs for veterans.**

Measures of accuracy assurance include:

- Identification and development of relationships with hospice leaders of programs that serve rural and homeless veterans.
- Identification and development of relationships with VA leaders, including those with responsibilities for rural and homeless veterans as well as authorizing community based hospice utilization.

3. **Determination of methods to eliminate critical barriers between community-based providers and the VA.**

Measures of determination of methods include:

- Development of contact lists of hospice and VA leaders.
- Identification of potential mentors or mentoring programs.
- Identification of any additional information that may be necessary.

4. **The development of a toolkit of ‘Best Practice’ opportunities for new and existing collaborations utilizing survey data, and input from all partners.**

Measures to determine success of final ‘Tool Kit’ include:

- Assurance that the content of the toolkit has been evaluated as necessary and helpful to existing and beginning programs.



5. Development of a compelling pilot ‘Education and Project Planning Event.’

Measures to determine success of pilot event include:

- Assurance that the pilot is based on the identified critical barriers and best practice models.
- Assurance that the pilot is mailed to appropriate prospective attendees.
- Evaluation of the pilot event by key individuals.

6. The compilation of a resource directory.

Measures to determine the value of the resource directory include:

- Utilization of data from survey and program planning events.

7. Distribution of the Tool Kit, Education and Project Planning Event Model and the Resource Directory to a wide audience.



COLORADO CENTER FOR HOSPICE & PALLIATIVE CARE

Project Title: COLORADO HVP EXPANDED ACROSS VISN

Primary Contact: Cordt T. Kassner, CEO

Email: CKassner@cochpc.org

State: Colorado

VISN: 19

Target Population: Rural veterans

Abstract:

This project seeks to create a new collaboration between Colorado, Montana, Utah and Wyoming state hospice organizations to share best practices and further develop rural Hospice/Veteran Partnerships (HVPs) in these four states. These four states were selected for collaboration because veterans Integrated Services Network (VISN) 19 includes most of Colorado, Montana, Utah and Wyoming.

Partnerships:

Collaborative leadership from the following state hospice organizations is critical to the success of this project.

1. MHA... An Association of Montana Health Care Providers
2. Utah Hospice & Palliative Care Organization
3. Wyoming Hospice Organization

Veterans Administration

These state hospice organizations will partner with VA leadership within each state and across the VISN to further develop each HVP.

4. Denver, Colorado VA Medical Center
5. Grand Junction, Colorado VA Medical Center
6. Salt lake City, Utah VA Medical Center
7. Cheyenne, Wyoming VA Medical Center
8. Sheridan, Wyoming VA Medical Center
9. Helena, Montana VA Medical Center



Anticipated Outcomes:

1. Establishment of a VISN 19 HVP Leadership Team that includes all relevant stakeholders and has a regular meeting schedule and communications system.

Measures to determine that the Leadership Team remains an active group include:

- Assurance that the team includes hospice representatives as well as VA representation from each of the four states.
- Documentation of the number of member organizations actively involved in the Leadership Team.

2. Successful implementation of the HVP Toolkit – Chapter 1.

Measures of the success of the HVP Toolkit – Chapter 1 include:

- Identification of potential partners, including community hospice agencies, state veterans homes, VISNs, VA AACT Teams, VA Medical Centers, VA community-based clinics, Veteran Service Organizations.
- Documentation of the number of member organizations actively involved in the state HVPs.

3. Successful implementation of the HVP Toolkit – Chapter 2.

Measures of the success of the HVP Toolkit – Chapter 2 include:

- Establishment of an HVP Steering Committee of 10-20 members representing as many stakeholders as possible, including both hospice and VA participants in each state.
- Establishment of the purpose, structure, and responsibilities of committee members.
- Communication between state leadership in regards to implementation of the toolkit.

4. Successful implementation of the HVP Toolkit – Chapter 3.

Measures of the success of the HVP Toolkit – Chapter 3 include:

- Establishment of a process for centralized communication among HVPs in each state.

5. Successful implementation of the HVP Toolkit – Chapter 4 (Needs Assessment).

Measures of the success of the HVP Toolkit – Chapter 4 include:

- Completion of a needs assessment in each state in both hospice and VA organizations.
- Evaluation of survey results, to be used to create individual strategic plans.

6. Successful implementation of the HVP Toolkit – Chapter 4 (Strategic Plan).

Measures of the success of the HVP Toolkit – Chapter 4 include:

- Creation of state-specific strategic plans.



- Inclusion of at least one HVP education event in the next 12 months for each strategic plan.

7. Successful implementation of the HVP Toolkit – Chapters 5 and 6.

Measures of the success of the HVP Toolkit – Chapters 5 and 6 include:

- Dissemination of hospice tools to VA populations in each state via handouts, email, and Web site posting.
- Development of a minimum of one tool by each state HVP.

8. The development of multi-year strategic plans by each state to sustain the VISN 19 HVP Leadership Team and the state HVPs, which will include a focus on caring for veterans living in rural areas.

Measures of the sustainability of the VISN 19 HVP Leadership Team include:

- Development of strategic plans that include tracking and reporting the number of veterans being served by community hospices.
- Development of strategic plans that include a focus on caring for veterans living in rural areas in all four states.
- Documentation of the strategic plans posted on the VISN 19 HVP website.
- Categorization of Montana and Wyoming as “active” HVPs on the national HVP map
- Continued categorization of Colorado and Utah as “active” HVPs on the national HVP map.

9. Development of a VA education event focused on caring for veterans living in rural areas.



COMMUNITY HEALTH AND COUNSELING SERVICES (CHCS)

Project Title: HOSPICE ACCESS TO RURAL WASHINGTON COUNTY MAINE
VETERANS

Primary Contact: Pamela Page, Regional Manager, Home Health & Hospice Services
Email: ppage@chcs-me.org
State: ME
VISN: 1
Target Population: Both homeless and rural veterans

Abstract:

A network of hospice, VA and community professionals will work to improve access to hospice care for veterans residing in rural Washington County, Maine. During the grant period, partners will meet with identified veteran stakeholders to develop a focus group format. Three focus groups will convene to discuss availability and access to end-of-life care for veterans, as well as barriers that veterans encounter in rural areas. Based on the results of these meetings, partners will develop an action plan to overcome barriers and improve access.

Partnerships:

Collaborating partner organizations represent a cross section of State and Federal organizations that work closely with veterans within Washington County.

Partners will serve as the core work group and share the following responsibilities:

- Identify focus group participants and leaders.
- Develop focus group format/questions.
- Review results and assist in assembling findings.
- Draft action plan designed to address perceived barriers to care.
- Disseminate findings to their various population bases.

Veterans Administration

Maine Veterans Home

The following partners will seek out homeless and isolated veterans for one-on-one interviews.

1. Washington County: One Community(WC:OC)
2. Maine Rural Partners (MRP)



The following partners will provide space to host the focus groups in order to cut costs.

3. Downeast Community Hospital (DECH)
4. Maine Veterans Home

The following organizations are additional partners in the Hospice Access to Rural Washington County Maine Veterans project.

5. Eastern Area Agency on Aging (EAAA)
6. Togus VA Hospital
7. Vets Center

Anticipated Outcomes:

1. **Determination of barriers to hospice care among rural Washington County veterans.**

Measures of the determination of barriers to hospice care for veterans include:

- Development of lists of barriers by focus groups, partners and veterans and their families.
- Documentation of Satisfaction Surveys results from group participants and leaders who have discussed barriers to hospice care.

2. **Development of a coordinated action plan to address identified barriers to hospice care for veterans living in rural areas.**

Measures of an effective action plan to address identified barriers include:

- Documentation identifying strategic barriers to hospice care common to all veterans, as well as barriers by specific veteran populations.

3. **Development of a plan for the dissemination of the action plan to address barriers to hospice care for veterans living in rural areas.**

Measures of a successful dissemination plan include:

- A record of press release/s.
- Documentation of feedback from stakeholders.



CONNECTICUT ASSOCIATION FOR HOME CARE & HOSPICE

Project Title: VETS CARING FOR VETS: THE CT RURAL VETERANS
PARTNERSHIP

Primary Contact: Kimberly Skehan, VP, Clinical & Regulatory Services

Email: skehan@cahch.org

State: CT

VISN: 1

Target Population: Rural veterans

Abstract:

This project will focus on improving access to hospice volunteer services for veterans in rural Northwestern CT; increase awareness of hospice and home care-based palliative care services, as well as VA services; and improving coordination of services between these settings. Through partner collaboration, CAHCH would like to expand the "Vets to Vets" program to recruit and train veterans to assist with other veterans at end of life in Litchfield County rural areas.

Partnerships:

Veterans Administration

The following partners will assist in the coordination of volunteer recruitment and training efforts; they will also each provide valuable expertise throughout the project.

1. Linda Accordino MSN, APRN, Manager of Geriatrics and Extended Care, VA Connecticut Healthcare System
2. Laurie Harkness PhD, CPRP, Director, Errera Community Care Center, VA Connecticut Healthcare System, Associate Professor in Psychiatry, Yale School of Medicine
3. Lucile Burgo, M.D., Assistant Clinical Professor of Medicine, Yale University CBOC Firm Chief, VA Connecticut Healthcare System
4. Deborah Grassman APRN, Veterans Administration PTSD Trainer
5. Mary Winar RN, BSN, Connecticut Office of Rural Health, Projects Coordinator
6. Lea Alberghini RN, BSN, CHPN, Hospice Director, VNA Northwest, Inc.
7. Donna DiMartino, RN, MSN, Hospice Director, Foothills Visiting Nurse & Home Care, Inc.
8. Margaret Manz RN BS, COS-C, QA/QI Supervisor, VNA Northwest, Inc.



The following partners are community hospice providers who will assist in the identification of veterans in need of hospice services, participate in marketing and recruitment and will provide hospice volunteer training.

9. Foothills Visiting Nurse & Home Care, Inc.
 10. Salisbury Visiting Nurse Association, Inc.
 11. VNA Northwest, Inc.
-

Anticipated Outcomes:

1. Collection of baseline data on veterans receiving homecare or hospice services.

Measures of data collection include:

- Completion of a pilot study.
- Documentation of baseline data.

2. An increase in veterans' awareness of available Hospice and VA (CBOC) services.

Measures of an increase in veterans' awareness of available services include:

- Development of outreach materials.
- Distribution of information to fifteen Veteran Service Groups.

3. Identification and recruitment of fifteen veterans to provide enhanced hospice volunteer services to other veterans by 5/1/09.

4. Development of coordinated educational programming materials to be sustained for the next 5 years.

Measures of coordinated educational materials include:

- The training of fifteen veterans trained using hospice volunteer curriculum.
- Modification of Vet-Vet training completed for fifteen volunteers.
- Completion of PTSD training.
- Evaluation of materials.

5. Strengthened collaboration between three rural homecare and hospice partners and the CBOC system.

Measures of the strengthened collaboration include:

- Coordinating and tracking the utilization of fifteen veteran hospice volunteers.
- Documentation of veteran involvement, including hours.
- Identification of sustainability strategies.



COVENANT HOSPICE

Project Title: COVENANT HOSPICE “VETERANS’ OUTREACH PROJECT”

Primary Contact: Tristessa Osborne, Vice President of Business Services

Email: tristessa.osborne@covenanthospice.org

State: FL

VISN: 16

Target Population: Both homeless and rural veterans

Abstract:

Covenant will create a “Veterans’ Outreach Program,” with Community Education, Volunteer, and Clinical components to improve access and care for both homeless and rural vets. The organization will utilize Military Ambassador Volunteers for regular “rounds” of homeless shelters, homeless coalitions, and veterans’ service organizations to identify dying vets. The Military Ambassador Volunteers will also continue rounding and education efforts to military/VA hospitals and clinics, and educate Covenant staff on veterans’ end-of-life needs.

Partnerships:

The following partners will provide expertise in dealing with homeless veterans.

1. The EscaRosa Homeless Coalition will assist veterans in obtaining the identification that they need, providing escorts to appointments if necessary, and working with Covenant to get them set up with the VA.
2. Heavenly Blessings Shelter will provide room and board for those who need it. Rules at this shelter are flexible enough to accommodate someone who is ill and unable to spend daytime hours outside the shelter.

The following partner is a “supporting” partner, and has not yet submitted a letter announcing a formal partnership with Covenant.

3. Okaloosa/Walton Continuum of Care in the Niceville/Destin area have sufficient volunteers to provide 24-hour vigil and caregiver services as well.

Covenant also has an established alliance with American Legion Post 78 in Milton, and will receive their assistance with identifying homeless and dying vets in Santa Rosa County, bringing them to our attention, and helping them qualify for official VA benefits.



Anticipated Outcomes:

1. Identification of twelve homeless veterans with life-limiting illnesses in Covenant's service area, and provision of end-of-life services by 11/18/2009.

Measures of identification of, and provision of services to, twelve veterans include:

- Documentation of services provided.
- Identification of barriers to achieving this goal.

2. Increased outreach to rural veterans with the goal of increasing the number of rural veterans in Marianna patient population to 56 by 11/18/2009.

3. Decreased percentage of patients whose veteran status is unknown to 30%.

Measure of decreased percentage of patients with unknown veteran status include:

- Identification of barriers to identifying veteran patients.

4. Increased ability to identify homeless patients in our census to 70% accuracy.

5. Qualification of 75% of homeless veteran patients for VA benefits, by improving ability of social workers and Finance Department to understand and navigate VA system and street economy and successfully apply for compensation.

Measures of qualification of 75% of veteran patients for VA benefits include:

- Documentation of payment received for total patient days delivered to veterans.
- Identification of barriers to reimbursement for care.

6. Education of Covenant staff about end-of-life needs of veterans to enhance understanding of reasons for homelessness, as indicated by aggregate improvement score of 1 full point (Likert Scale) on pre- and post-test of attitudes towards homeless veterans.

Measures of education of Covenant staff include:

- Documentation of staff training.
- Demonstrated increase in ability to identify homeless patients.
- Evaluation score by participants of 4.7 or above.
- Documentation of average score on re-administered survey is 1 point higher than average initial score.



DELAWARE HOSPICE, INC.

Project Title: HOSPICE INITIATIVE FOR HOMELESS AND RURAL VETERANS

Primary Contact: Rebecca Nelson, Service Development Specialist

Email: rnelson@delawarehospice.org

State: DE

VISN: 4

Target Population: Both homeless and rural veterans

Abstract:

The Hospice Initiative for Homeless & Rural Veterans is a state-wide program to improve end-of-life care for rural and homeless veterans. The project will focus its efforts on identifying veteran needs, assessing client awareness of available resources, educating veterans on available community resources, assisting community organizations in identifying veterans in need of hospice and palliative care, and serving as a resource for veteran agencies with clients in need of hospice & care support.

Partnerships:

The following individuals have established partnerships with Delaware Hospice.

From the Delaware End-of-Life Coalition:

1. Madeline Lambrecht, Past President, will advise on production issues relating to development of the CD on special needs of veterans at the end of life.
2. Moonyeen Klopfenstein, President, will attend partner meetings and provide assistance with projects.

Veterans Administration

From the Wilmington VA Medical Center:

3. Maria Ash will oversee the development and training of the program for first responders.
4. The Homeless Coordinator will serve as a technical expert to the group and help with education of the homeless shelters' staff.

From the Delaware Veterans Home:

5. Dean Reid will attend partner meetings and assist in the development and execution of education programs. One of his staff members will assist with conducting the survey.



6. Christopher Portante will assist with all communications issues.

From the Commission of Veterans Affairs:

7. Paul Lardizzone will attend partner meetings and assist in contacting veterans' service groups and serve as an expert on veterans' issues for the group.
-

Anticipated Outcomes:

- 1. Data collection evaluating the effectiveness of hospice-veteran partnerships in collaborating to meet the needs of rural and/or homeless veterans in Delaware.**

Measures for data collection include:

- Documentation of baseline data collection from surveys.
 - Development of an action plan to identify opportunities for the VA and hospice to work better together to meet the needs of rural and/or homes veterans in Delaware.
 - Identification and implementation of joint activities during this grant cycle.
- 2. By June 2009, fifty percent of the hospices in Delaware will be educated on the importance of collecting military status upon admission and the use of the military checklist.**
- Measures for education include:
- Documentation of the number of hospice providers receiving education about collecting military status and the use of the military checklist.
 - Identification of the number of hospices collecting military status upon admission.

- 3. By October 2009, first responders at five locations will have adequate knowledge to identify at-risk veterans needing hospice and palliative care and will be able to connect them with the VA.**

Measures for identification of veterans and appropriate referral to the VA by first responders include:

- Completion of a training program for first responders to ensure all appropriate veterans receive information about hospice and palliative care.
- Documentation of the number of first responders trained and their locations.
- Documentation of the number of veterans appropriately referred to the VA by first responders.



4. Employees of five homeless shelters will be able to identify veterans who are in need of hospice and palliative care and describe the process for referring them to the VA by October 2009.

Measures of identification of veterans and appropriate referral to the VA by homeless shelter employees include:

- Completion of “Talking Points” and pocket guide training post test by 80% of homeless shelter employees.
- Documentation of the number of veterans from homeless shelters referred to the VA.

5. By October 2009, approximately 1,500 veterans and 25 healthcare organizations will have access to information and/or education on the Medicare hospice benefit.

Measures of access to information on the Medicare hospice benefit include:

- Distribution of hospice brochures.
- Record of the number of articles about hospice in veterans publications, the number of education sessions for veterans and their families, the number of education sessions for healthcare organization, and the number of websites with appropriate information, including the number of visits to each website.
- Record of the number of referrals from hospice to VA for assistance with care, benefits or services.

6. By October 2009, 25 healthcare organizations’ awareness and knowledge about the special needs of veterans at the end of life will be documented via an on-line assessment.

Measures of awareness of the special needs of veterans by healthcare organizations include:

- Record of the number of healthcare organizations that complete the assessment.



HINDS HOSPICE

Project Title: PARTNERS SERVING RURAL VETERANS

Primary Contact: Katherine Caldwell, Project Manager

Email: katherine@hindshospice.org

State: CA

VISN: 21

Target Population: Rural veterans

Abstract:

Partners Serving Rural Veterans is a collaborative project responding to the critical need for increased access to end-of-life care for Eastern Madera County veterans. Partnership provides community education; patients and families receive an individualized Plan of Care encompassing their physical, psychosocial, and spiritual and bereavement needs, as well as information on veteran benefits for the patient and surviving spouse. The rural community will benefit by coming together to provide care.

Partnerships:

Veterans Administration

1. VA Central California Health Care System (VCCHCS)
VCCHCS is a 114-bed, Level 2 medical center with two community based out-patient clinics supporting veterans' health care needs in the Central Valley of California. Service connected veterans, veterans with no insurance who need medical attention, and veterans with insurance who want to be treated at VMAC are all welcome at the hospital.
2. Disabled American Veterans, Homer Blevins/Fresno Chapter One (DAV)
DAV is a nonprofit association of veterans who have suffered some degree of disability while serving in time of war or armed conflict. Today, the DAV has more than 1.25 million members, with more than 116,000 residing in California.

As a partner, DAV will offer in-kind training to Hinds Hospice and VCCHCS in veteran and dependent benefits. The hospice and palliative care partners will evaluate the impact of the veteran's military experience and determine if there are benefits to which the veteran and surviving dependents may be entitled.



DAV will provide in-kind assistance to the patient in completing any benefits forms and in certain circumstances provide transportation to the DAV office or come to the veteran.

The following individual will serve as key partnership personnel.

3. George Steese, Jr. served in the United States Air Force from 1968 through 1979, where he received a service related disability. In 1983, he joined the DAV. He served as Commander of DAV Chapter 1 in 1995, and was elected National Commander in 2001. He holds a Bachelor of Science in Business from California State University, Fresno.

Anticipated Outcomes:

1. **Data collection to establish baseline data on interest in participating in a pilot project by rural veteran patients and caregivers.**

Measures of data collection include:

- Evaluation to determine the number of rural veteran patients served by zip code and whether there is interest in the program on a 1-10 scale.
- Evaluation to determine whether the questions asked during patient intake and assessment allow determination of a patient's suitability for the project.

2. **Utilization of technology to increase access to end-of-life care for up to eleven terminally-ill rural veteran patients in eastern Madera County and the unincorporated area of Auberry in Fresno County.**

Measures of the utilization of technology include:

- Schedule of meetings to train Hinds Hospice staff and partner staff to use telephone and internet technology, including webcams, to meet the needs of patients.
- Discussion of the purchase of laptops with built-in webcams.
- Evaluation of the utilization of technology to increase patients' end-of-life access to a hospice nurse.
- Collection of data to determine the amount of VA patient referrals to Hinds Hospice, and the amount of referrals to DAV during the grant period. Hospice for grant period

3. **Collection of baseline data on veteran patients who are aware of veteran's benefits and make referrals where appropriate.**

Measures of data collection on awareness of veteran patients include:



- Evaluation to determine whether the project increased knowledge of VA benefits and access to those benefits.
- Determination of the number of rural veterans and surviving dependants who made use of the information and to what extent the information was helpful.
- Evaluation to determine the number of rural patients who are currently receiving benefits and the number who apply for benefits as a result of referrals.

4. **Collection of baseline data on the number of veteran patients who are living without caregiver support.**

Measures of data collection on the number of veteran patients living without caregiver support include:

- Evaluation to determine the number of rural veterans who are without caregiver support upon entering hospice care and the number of rural veterans who later accept a caregiver.
- Evaluation to determine of those who accept support, whether care was provided by a friend or family member, or a rural hospice volunteer.



HOSPICE & PALLIATIVE CARECENTER (HPCC)

Project Title: HOSPICE VETERANS PROJECT OF HPCC

Primary Contact: Lisa H. Holleman, VP, Community Affairs

Email: lisa.holleman@hospicecarecenter.org

State: NC

VISN: 6

Target Population: Homeless veterans

Abstract:

Hospice and Palliative CareCenter's "Hospice Veterans Project" began over a year ago, to honor, serve and support the veterans in HPCC's care. Now, HPCC is seeking to improve access and quality of care to homeless veterans. Facts demonstrate that homeless veterans in the area need hospice and palliative services, but lack appropriate care related to the needs of the patients and the places in which they receive service. This project lays a foundation for that care to begin.

Partnerships:

Veterans Administration

1. VA Regional Office in Winston-Salem, NC, VISN 6

The VA homeless coordinator will provide contacts with the local homeless services staff, will assist in identification of potential homeless veterans who may be appropriate for hospice and/or palliative services, will help locate space for a hospice exam and meeting room and will assist with coordination of activities between HPCC and homeless shelter staff.

2. Veteran's Home in Salisbury, NC, VISN 6

The project enhances the relationships of the partners without duplicating services by laying a foundation for homeless veterans to receive hospice services. Currently, there is a gap in service for homeless veterans. Homeless veterans do not have a "place" for care to occur, do not have an adequate identification system for appropriate referral to hospice care and are not receiving end-of-life care that is appropriate for a veteran.

The partnership between the VA and HPCC will serve to encourage new relationships between the homeless providers in the area.



Anticipated Outcomes:

1. Development of a method to track the number of homeless veterans in HPCC's care in HPCC's thirteen-county service area.

Measures of the development of a tracking method include:

- Investigation of the current method of identifying homeless veterans.
- Presentation to educate pertinent groups within HPCC, including social workers, chaplains, leadership, mid-management and nurses, regarding the need to capture this information.

2. Education of homeless shelter staff at three homeless shelters in Forsyth County, NC.

Measures of the education of shelter staff include:

- Pre-test of shelter staff knowledge.
- Development of educational materials used to educate shelter staff, including PowerPoint presentations and handouts.
- Post-test of shelter staff knowledge.
- Development of assessment tool for shelter staff to utilize regarding veterans who may be appropriate for either palliative or hospice services.
- Evaluation of satisfaction survey results.
- Record of the number of attendees at educational sessions.

3. Establishment of a convenient, private and safe venue for homeless veterans to meet with HPCC staff in order to be assessed and receive care through intermittent visits.

Measures of the establishment of such a venue include:

- Collection of data from a site search, including consideration of the items needed in the space.
- Establishment of any necessary agreement between HPCC and the property owner.
- Collection of data concerning how many homeless veterans can be served in the space and the number of visits that can be made in the space.
- Evaluation of a satisfaction survey to shelter employees concerning the ease of use and referral.
- Evaluation of a satisfaction survey to homeless veterans served at the venue.



HOSPICE LIFE CARE, A PROGRAM OF THE HOLYOKE VISITING NURSES ASSOCIATION, INC.

Project Title: THE HOSPICE LIFE CARE-SOLDIERS HOME HOLYOKE VETERAN PARTNERSHIP

Primary Contact: Marie Deitz, Director of Hospice & Palliative Care

Email: mdeitz@holyokevna.org

State: MA

VISN: 1

Target Population: Both homeless and rural veterans

Abstract:

Hospice Life Care and the Soldiers Home in Holyoke have built a successful partnership on behalf of terminally ill veterans in Western Massachusetts. This project aims to further this collaboration and service by outreach to rural and homeless veterans in the defined Hospice Life Care service area. Through coordination with veterans and veterans' service providers, this project will improve access and streamline entry for veterans into quality hospice and palliative care programs.

Partnerships:

1. Soldiers Home in Holyoke

Veterans Administration

2. North Hampton VA Medical Center
3. Springfield VA Outpatient Clinic
4. Chris Lecca, Veterans Service Agent

The overarching goal of this grant is to integrate the services of our two agencies into the continuum of health care services currently offered to veterans in our area. These services are presently offered through the Veterans Administration Medical Center, their Outpatient Clinics, veteran drop-in programs, neighborhood clinics, and hospitals. There are no formal links, however, between these settings and hospice services. Hospice Life Care and the Soldiers Home in Holyoke anticipate bridging this gap through this grant.

Veterans who require institutionalization will be referred first to the Comfort Care Unit at the Soldiers Home. If they are unable to take in the veteran due to lack of availability of beds, the veteran will be referred to one of three local nursing homes until the Soldiers



Home can accept them. For 2007, the average length of stay on the Comfort Care Unit was 51 days, so we do not anticipate difficulty getting veterans onto this Unit.

Anticipated Outcomes:

1. Collection of baseline data regarding end-of-life care issues in order to provide outreach to homeless and rural veterans and their support networks within the twenty-town Hospice Life Care service area.

Measures of baseline data collection include:

- Completion of a contact tool to track key contacts, services provided by each contact and access and frequency of these services to veterans.
- Completion of a directory of communication sources for veterans.
- Analysis of literature building on existing sources of information and a list of best practice guidelines.
- Establish meeting dates and agendas for three meetings with project partners to compile data and incorporate strategies into work with veterans.

2. Increased awareness of end-of-life care resources for veterans and their support networks by providing six educational programs within the twenty-town service area.

Measures of increased awareness of end-of-life care services for veterans include:

- Production of a brochure for veterans and their caregivers, printed and disseminated within the community.
- Completion of six community educational programs for veterans, families and providers regarding services for end-of-life care.
- Compilation of program evaluations and documentation of feedback from participants.

3. Provide homeless and rural veterans in the service area with improved access and streamlined entry into end-of-life care programs by creating and implementing a referral algorithm for veteran service providers.

Measures of improved access and streamlined entry into end-of-life care programs include:

- Documentation of all veteran community contacts in the Resource Directory.
- Contracts developed and in place.
- Completion of an informational packet with algorithm and referral process.
- Education to four hospital ERs.



- Development and implementation of orientation materials.
- Record of tracked referrals and admissions into palliative and hospice services that demonstrate an increase in the number of veterans serviced by 25%.



HOSPICE OF CHATTANOOGA, INC.

Project Title: REACHING OUT IN SOUTHEAST TENNESSEE

Primary Contact: Meg C. Beene, Director of Development

Email: meg_beene@hospiceofchattanooga.org

State: TN

VISN: 9

Target Population: Both homeless and rural veterans

Abstract:

“Reaching Out in Southeast Tennessee” will consist of two components, the first of which is access to hospice and palliative care for homeless veterans in Metropolitan Chattanooga through partnerships. Established partnerships between Hospice of Chattanooga and organizations providing daily care and services for the homeless will lend themselves to improved access to hospice and palliative care for homeless veterans. The second project component is a region-wide awareness campaign. The region-wide awareness campaign will involve state partners and a call center to link rural veterans to high quality hospice and palliative care in up to sixteen rural counties in Southeast Tennessee and North Georgia.

Partnerships:

The following partners have been chosen for the contribution they will make to both the access to hospice and palliative care for homeless veterans objective, and the rural outreach objective.

1. Palliative Care Services, Inc., Chattanooga

PCS will provide assessment of care needs of homeless vets referred for care or counseling, establish plans of care and case management for palliative patients.

Admissions intake coordinators at PCS will staff the Reaching Out dedicated telephone call line and refer clients to appropriate services in their rural communities.

Veterans Administration

2. The VA Chattanooga Outpatient Clinic

The clinic will provide benefits education for homeless veterans and referral to other services.



The clinic will also contribute staff, existing clients and offices in all the counties covered under the grant for the rural outreach objective.

3. The Southeast Regional Office of the Tennessee Department of Health
The Department of Health will provide state and federal data to the partners and report on activity and clients served to the State of Tennessee.

The Department of Health will also contribute staff, existing clients and offices in all the counties covered under the grant for the rural outreach objective.

The following partners have been chosen for the contributions that they will make to the access to hospice and palliative care for homeless veterans objective.

4. The Homeless Healthcare Center, Chattanooga
The Center will screen clients to determine veteran status and refer veterans to the Southeast Tennessee Reaching Out Project Director or Intake Coordinator and assist with case management as appropriate.
5. The Chattanooga Community Kitchen
Providing far more services than the name indicates, Chattanooga Community Kitchen will assist with client screening to determine veteran status, counseling needs, housing for direct services and counseling and case management including clients staying in the new post hospital residential respite rooms.

The following partner has been chosen for the contributions that they will make to the rural outreach objective.

6. The Southeast Tennessee Development District Area Agency on Aging and Disability
The Agency will be the chief collaborating partner in the Rural Outreach Awareness Campaign through field staff, existing clients, referring agencies and county offices.

Anticipated Outcomes:

1. **Identification of challenges and elimination of barriers that exist in working with the Veterans Administration to provide end-of-life care for veterans in Southeast Tennessee by December 31, 2009.**

Measures of the identification of challenges and the elimination of barriers in working with the VA include:



- Reduction of time for VA enrollment for end-of-life treatment.
- Utilization of established process by both parties by July 31, 2009.

2. Establishment of baseline data on Veteran Status of hospice and palliative patients served by December 31, 2009.

Measures of the establishment of baseline data on veteran status of patients include:

- Copy of updated intake form available upon request.
- Utilization of established process by all healthcare partners by July 31, 2009.
- Accurate data will be available on request.

3. Creation of a coalition of partners to inform and refer homeless veterans to multidisciplinary hospice and palliative care services for end-of-life care needs by December 31, 2009.

Measures of the creation of a coalition to inform and refer homeless veterans to multidisciplinary hospice services include:

- Creation of a document identifying providers, contact staff and resources by July 31, 2009.
- Inclusion of a new Reaching Out partner named for the project.
- Completion of an educational packet distributed to fifty churches in the metro Chattanooga Area.

4. Creation of a coalition of partners to inform and link rural veterans to multidisciplinary hospice and palliative care services for end-of-life care needs by December 31, 2009.

Measures of the creation of a coalition to inform and link rural veterans to multidisciplinary hospice services include:

- Development and utilization of an Intake and Response Protocol developed and in use.
- Establishment of a functional phone line and maintenance of phone line log.
- Established schedule for media releases and follow-up tracking in place.
- Maintenance of a tracking log for calls received from veterans in rural counties.



HOSPICE OF THE BLUEGRASS AND PALLIATIVE CARE CENTER OF THE BLUEGRASS

Project Title: PARTNERSHIP TO IMPROVE ACCESS TO QUALITY HOSPICE CARE FOR HOMELESS VETERANS IN SOUTHEASTERN KENTUCKY

Primary Contact: Kay Mueggenburg, VP, Education, Research & Community Integration

Email: kmueggenburg@hospicebg.org

State: KY

VISN: 9

Target Population: Homeless veterans

Abstract:

This project will improve end-of-life care for veterans and their families by providing targeted educational messages in person and through media in partnership with local service organizations. Sharing of knowledge and expertise of available resources as well as referral processes among all program partners will decrease fragmentation and facilitate access to needed care for homeless veterans in the community.

Partnerships:

Hospice of the Bluegrass (HOB) is in partnership with some of the VA providers and service organizations in the 12-county target community. Currently, HOB assists in caring for nineteen terminally ill patients at the VA nursing home in Hazard.

HOB has relationships with the churches throughout the targeted area and staff will visit the churches to recruit veterans as volunteers and to distribute the new brochure.

Collaboration with the public library in the community will be expanded to include a Hospice link on public computers used by the local community, including homeless veterans and their families. An email link for users to ask a specific question will be added to the veteran service link.

Anticipated Outcomes:

- 1. By September 30, 2009 define and create links between eligible veterans/families with available hospice and palliative care services in the southeastern region of Kentucky through educational meetings.**

Measures of links between eligible veterans and hospice and palliative care services include:



- Collection of baseline data of the number of veterans and families admitted from the project start date.
- Development and dissemination of a brochure for all partner organizations and designated locations.
- Record of meeting attendance and meeting evaluations.

2. Development of a partnership coalition of service organizations who have relationships with the homeless veterans in the targeted region by May 1, 2009.

Measures of a partnership coalition include:

- Development of a plan for educating hospice organizations across Kentucky.
- Recruitment of national and local VA staff to present at KAHPC.

3. By August 1, 2009 offer at least one state-wide program for state hospice organizations and at least three education programs for VA service centers that are evidence based about end-of-life care needs of homeless veterans.

Measures of development of educational programs include:

- Record the number of rural veterans, the number of homeless veterans, the number of family members and the number of service providers who attend.
- Secure and review session evaluation from KAHPC.
- Determination of interest in additional sessions for 2010.



HOSPICE OF THE FOOTHILLS

Project Title: PALLIATIVE CARE FOR VETERANS STRATEGIC PLAN

Primary Contact: Vanessa Bengston, Executive Director

Email: vanessa@hofo.org

State: CA

VISN: 21

Target Population: Rural veterans

Abstract:

The Palliative Care for Veterans Strategic Plan is the framework for a long-term outreach and service delivery program for hospice and pre-hospice services to veterans living in rural Nevada, Placer and Sierra Counties. The plan identifies who will be served, what services are available, which services are needed, how the program will be evaluated, and how it will be sustained. Once implemented, the plan will yield a 50% increase in service delivery capacity to the veteran population in the area.

Partnerships:

The following partners include medical service providers, institutional partners, and community-based organizations.

1. Nevada County Veterans Services Office, a division of the County of Nevada's Department of Social Services, within the Health & Human Services Agency. Evelyn White, Veterans Service Representative, will provide substantial information, data and insight to the planning process, with a particular role in identifying resources. Ms. White will also be responsible for identifying specific veterans and families who might contribute directly to the planning process. The outcome of this collaboration will be the development of a referral/screening tool to identify veterans who may benefit from community based palliative care.

Veterans Administration

2. VA Sierra Nevada Health Care System
Located in Reno, NV, the VA Sierra Nevada Health Care System provides primary and secondary care to an area that includes Nevada, Placer and Sierra Counties. The Reno campus is the site of the Ioannis A. Lougaris VA Medical Center, which operates 56 hospital beds and 60 Transitional Care Unit beds. A primary relationship and source of referrals in this project is the VA Sierra Foothills Outpatient Clinic in Auburn, Placer County, CA.



3. Patty Johnson, RN

Patty Johnson is a registered nurse with a Masters degree in anthropology. Her primary role will be the development and completion of the needs assessment, which is the central component of our planning process.

In collaboration with these partners, we anticipate participation from the following organizations.

- Sierra Nevada Memorial Hospital staff in Grass Valley
- Chapa De Medical Clinic in Grass Valley
- Sutter Auburn Faith Hospital in Auburn
- Sierra County Health Department
- Placer County Veterans Services in Auburn

Anticipated Outcomes:

1. **Creation of a needs-based service delivery matrix for long-term outreach and service delivery to veterans.**

Measures of the creation of a needs-based service delivery matrix for veterans include:

- Integration of applicable best practice components from model palliative care and case management models into HoF service delivery program.
- Identification of three primary needs of veterans.
- Assessment of opportunities for improvement to sustainability to service delivery program at quarterly meetings attended by stakeholders.
- Integration of case management component is into service delivery program.

2. **Establishment of baseline identification of current population of veterans served within Western Nevada County in order to assess potential service by Hospice of the Foothills.**

Measures of the establishment of baseline data to assess the number of veterans that HoF could potentially serve include:

- Increase in the capacity of HoF to serve rural veterans within the area more than 20%.
- Assessment of patients for veterans status to establish 2009 baseline 80% of pre-hospice and hospice patients.



3. **Creation of a qualitatively-informed needs assessment tool to investigate how Nevada County veterans view palliative and hospice care services.**

Measures of the creation of a needs-assessment tool to investigate the viewpoint of veterans toward palliative and hospice services include:

- Distribution of qualitatively-informed needs assessment data and analysis to grant team and additional stakeholders, including veteran representatives, in July, 2009.

Measures of the distribution of the needs-assessment data and analysis by July, 2009 include:

- Completion of Ethnographic (i.e., population of veterans) and multi-disciplinary research by May, 2009.
- Development of interest topics to provide structure to the data.
- Provision of qualitative and quantitative needs assessment data.



INTERFAITH SANCTUARY HOUSING SERVICES

Project Title: PROJECT LINK

Primary Contact: Fawn Pettet, Development & Social Services Director

Email: fawnpettet@gmail.com

State: ID

VISN: 20

Target Population: Homeless veterans

Abstract:

Project LINK will create a new partnership between existing agencies to initiate and increase hospice services to homeless veterans in Boise, Idaho. The project includes two distinct, but overlapping activities, the first of which is the creation of a needs assessment to determine the number of homeless veterans eligible for hospice services and their barriers to receiving these services. The second project activity involves assistance to identified veterans in enrolling and receiving hospice care in the homeless shelter setting.

Partnerships:

Interfaith Sanctuary is a homeless shelter; it will act as the grantee, administer the grant and provide oversight to program staff throughout the process.

1. Legacy Home Health & Hospice

Legacy will assist in directing and planning the project, as well as provide skilled and trained nursing and social work staff for education, enrollment assistance, and provision of hospice services. Legacy will also contribute to production of informational materials.

Veterans Administration

2. Boise VA

The VA will assist in directing and planning the project, providing outreach services to identify more appropriate living opportunities for veterans while in the process of enrolling in and receiving hospice services. The VA will also provide medical evaluation and treatment of homeless veterans.



Anticipated Outcomes:

1. Identification of the number of current homeless veterans in the Boise area who qualify for palliative and /or hospice care.

Measures of identification of the number of current homeless veterans who qualify for palliative and/or hospice care include:

- Creation of baseline data through information from the VA, scientific journals, and literature review.
- Selection of a research method and development of research tools to be compared to those shown to be most effective in gathering data from this population in previous studies.
- Consultation with local experts and service providers for homeless individuals and veterans to determine best locations and methods to access the population.
- Completion of a post-test survey by veterans addressing the effectiveness of assistance.

2. Identification of real and perceived barriers to accessing palliative and/or hospice care by otherwise eligible homeless veterans, focusing both locally and nationally.

Measures of the identification of barriers to accessing palliative and/or hospice care for eligible veterans include:

- Production of a completed literature review addressing the topic. This information will be used to create the baseline.
- Evaluation of post-test survey results from veterans to determine barriers to accessing medical assessment and hospice care.
- Consultation with local experts and service providers for homeless individuals and veterans to determine best locations and methods to access the population.

3. Identification of real and perceived barriers to accessing VA care, focusing both locally and nationally.

Measures of the identification of barriers to accessing VA care include:

- Production of a completed literature review addressing the topic. This information will be used to create the baseline.
- Evaluation of post-test survey results from veterans to determine barriers to accessing medical assessment and hospice care.



- Consultation with local experts and service providers for homeless individuals and veterans to determine best locations and methods to access the population.
- Completion of a post-test survey by veterans addressing the effectiveness of assistance.

4. Production of a report about end-of-life services needed by homeless veterans in the Boise area and utilization of the report to inform local community members.

Measures of the production and utilization of a report about end-of-life services needed by homeless veterans include:

- Production of a full report created and reviewed by all partners.
- Distribution of the report to Homeless Coalition, the VA, Legacy Home Health and Hospice, the Boise Rescue Mission, Corpus Christie house and other hospice agencies.
- Inclusion of the report in press releases.
- Development and review of presentation materials for accuracy, completeness of information, ease of comprehension and access.
- Provision of feedback by social service and veteran agencies on how equipped they feel to make accurate referrals to veterans eligible for hospice and/or palliative care.

5. Provision of information to homeless veterans accessing Interfaith Sanctuary Housing Services, The Boise Rescue Mission, City Lights, Corpus Christi House and the Salvation Army about making informed decisions about end-of-life care.

Measures of the provision of information to homeless veterans include:

- Determination of the information gathered and used by veterans in making decisions by comparison of the pretest survey with the posttest survey.
- Evaluation of the usefulness of materials and assistance through the post-test survey.
- Documentation of the success of this program through a record of the number of veterans attending social service meetings regarding end-of-life care.
- Provision of feedback by social service and veteran agencies on how equipped they feel to make accurate referrals to veterans eligible for hospice and/or palliative care.



6. Development of a one-year plan with partners with the intent of bringing Hospice and Palliative Care into homeless shelters in Boise area.

Measures of the development of a one-year plan include:

- Scheduled meetings between staff from hospice agencies and from the shelter(s) to discuss sustained relationships, continued distribution of informational materials, quality of referrals, and improvements to be made.

7. Development of guidelines between Interfaith Sanctuary Housing Services, project partners and other local hospice agencies for delivering hospice care to veterans in homeless shelters.

Measures of the development of guidelines for delivering hospice care to veterans in homeless shelters include:

- Administration of a post-test survey during a follow-up case management appointment that addresses the following issues:
 - Whether hospice care was received within the shelter.
 - Whether the hospice agency offered to make shelter-based hospice care available to you.
 - Whether the veterans felt that they were treated with respect and appropriate care.



LINK OF HAMPTON ROADS, INC.

Project Title: PALLIATIVE AND END OF LIFE CARE FOR RURAL AND HOMELESS

Primary Contact: Lynne Finding, Executive Director

Email: linkhospice@gmail.com

State: VA

VISN: 6

Target Population: Both homeless and rural veterans

Abstract:

This project will provide rural and homeless veterans with palliative and/or end-of-life care in a home environment utilizing private homes. The modality will provide veterans with palliative and holistic care by a team of professionals, volunteers and friends and family with the focus on choice, dignity and comfort in the six months or less of each veteran's end-of-life transition.

Partnerships:

The following agencies will partner with LINK during the project.

1. Sentara Home Health Care and Hospice

This agency will help recruit private homes, conduct background checks and drug screening, train homeowners and volunteer relief/respice workers, refer veterans and provide hospice medical services at the choice of the veteran.

Veterans Administration

2. Newport News VA Medical Center

Their social worker will meet with veterans to advise and activate benefits, refer veterans, provide chaplain services at the request of the veteran.

The following list details collaborating agencies.

- Interfaith volunteers

Volunteers will assist homeowners by making adaptations to the home (i.e., handicapped ramps, wheelchair ramps, handicap rails in bathrooms, etc. within the home,) visit veterans and provide emotional support. Many volunteers are veterans and look forward to visiting and providing support to veteran patients. Church pastors will provide chaplain services at the option of the veteran.



- Center For Child and Family Services
The Center will provide “power of attorney” services when appropriate in conjunction with local attorneys who specialize in services to terminally ill patients.
- Peninsula Agency on Aging
The Peninsula Agency will coordinate with the VA Medical Center to assist elderly veterans in determining civilian benefits.
- Virginia Cooperative Extension
The agency dietitian will meet with homeowners to assist with meal planning and special diets, and teach meal preparation as appropriate and requested.
- St. Jerome Catholic Church
Parish nurses will provide caregiver relief, visit with and read to veterans.

Each of the partners and collaborating agencies provide specialized services that are necessary and distinct from the other agencies. Where there are similarities such as chaplain services and other volunteer experiences, the veteran will be given the opportunity to make the choice based on personal preference.

The veterans will have the choice of hospice services, the three largest being hospital-based Sentara Hospital, Riverside Hospital and Bon Secours Hospital. The choice may be dependent upon personal choice and benefits.

Anticipated Outcomes:

1. Identification of six home-like settings to accommodate ten rural and homeless veterans by December 31, 2009.

Measures of the identification of six setting to accommodate rural and homeless veterans include:

- Evaluation of assessment of meeting with each prospective host and recommendation following each meeting.
- Maintenance of records of prospective hosts and individual records of veterans.
- Completion of UAI in veterans’ records.



2. **Qualification of ten rural and homeless veterans for military and civilian benefits by December 31, 2009.**
3. **Provision of physical care and emotional support for ten rural and homeless veterans by December 31, 2009.**

Measures of the provision of physical care and emotional support include:

 - Maintenance of files, including copies of MOUs and care plans.
4. **Establishment of a five-member Hospice Advisory Committee that will meet monthly for the purpose of providing program support and monitoring and evaluating program outcomes.**

Measures of the establishment of a Hospice Advisory Committee include:

 - Identification and invitation of potential committee members.



MICHIGAN HOSPICE & PALLIATIVE CARE ORGANIZATION

Project Title: HOSPICE FOR HOMELESS VETERANS

Primary Contact: Jeff Towns, President/CEO

Email: jtowns@mihospice.org

State: MI

VISN: 11

Target Population: Homeless veterans

Abstract:

This project aims to develop enhancements to the Michigan State Homeless Management Information System (MSHMIS) that assists Continuum of Care (CoC) organizations in identifying and referring homeless veterans to hospice and palliative care providers, and increase understanding and awareness of end-of-life support services available to homeless veterans among Homeless Continuum of Care (CoC) providers statewide.

Partnerships:

Collaborative partners for this project are members of the Michigan Hospice-Veterans Partnership (MHVP).

The following partners currently serve veterans in their home care and hospice residence programs and will be actively engaged in the design of the assessment tool and the educational programs at the CoC Regional meetings and the MHPCO conferences.

1. Hospice of Lansing
2. Harbor Hospice

Veterans Administration

This project allows the MHVP to work with homeless advocates through the following partners.

3. VISN 11

VISN 11 is one of 21 Veterans Integrated Service Networks (VISN) of the VA. It is a large and geographically diverse network that includes the VA Medical Centers and Community Based Outpatient Clinics (CBOC) which provide comprehensive inpatient and outpatient health care to veterans in Michigan.

4. The Michigan Coalition Against Homelessness (MCAH)



MCAH is an advocacy organization working to improve the lives of the homeless and support the agencies that serve them by working on policy level changes through education and outreach. MCAH administers the statewide data base that offers case management and online resource tools to community providers caring for the homeless.

Anticipated Outcomes:

- 1. Development of pilot enhancements to the Michigan Statewide Homeless Management Information System (MSHMIS) that will assist pilot-effort Michigan Continuum of Care (CoC) providers to identify homeless veterans in need of end-of-life services and refer them to appropriate care.**

Measures of the development of pilot enhancements to MSHMIS include:

- Population of hospice and palliative care resources in the “ResourcePoint” module will be completed by June 1, 2009.
- Implementation of the use of hospice and palliative care need and service referral codes by pilot agencies will begin in June 2009.

- 2. Collection of baseline data to identify the number of homeless veterans being served in pilot-effort communities, using a reporting tool in the Michigan Statewide Homeless Management Information System (MSHMIS) and data indicators adopted by the project.**

Measures of the collection of baseline data include:

- Analysis of the July 2009 baseline report.
- Periodic tracking of data indicators, including the number of homeless veterans, the number flagged with EOL needs and the number with EOL needs & referred to hospice or palliative care.
- Documentation of the process and frequency of monitoring data indicators.

- 3. Reduction of barriers to identifying and referring homeless veterans that need EOL services among participating HMIS providers in the two pilot communities.**

Measures of the reduction of barriers to identifying and referring homeless veterans in need of EOL services include:

- Completion of the HMIS agency educational objective.
- Recommendations for expanded training for HMIS providers statewide.



NEW JERSEY HOSPICE AND PALLIATIVE CARE ORGANIZATION

Project Title: NOT ALONE: CARING FOR NEW JERSEY'S HOMELESS VETERANS
AT END-OF-LIFE

Primary Contact: Donald L. Pendley, President

Email: don@njhospice.org

State: NJ

VISN: 3

Target Population: Homeless veterans

Abstract:

“Not Alone” seeks to educate groups serving the homeless and veterans about hospice and build a lasting network with these groups. This includes training hospices to provide care to homeless veterans and supplying hospices with the tools they will need. Project partners will lead hospice agencies to participate in Stand Downs in their service areas and provide meaningful support to establish a Stand Down in Central New Jersey. “Not Alone” also seeks to make hospice a permanent presence in the Stand Downs held annually in New Jersey.

Partnerships:

Veterans Administration

1. Department of Veterans Affairs - New Jersey Health Care System

The VA New Jersey office has committed itself to working with NJHPCO on the project. VANJ's role is to marshal support of the veteran service community and apply its expertise to the project's various initiatives.

Supportive Organizations:

- Veterans Haven

The Veterans Transitional Housing Program (Veterans Haven) is a New Jersey State operated facility for homeless veterans. They will offer leadership and technical assistance.

- Community Hope

Community Hope provides a continuum of residential recovery programs for over 270 individuals with mental illness. In 2004, it launched its "Hope for Veterans" program in 2004, an intensive discharge planning program as veterans prepare to leave the transitional housing program, where they can reside for up to two years.



Other supportive organizations include: the Affordable Housing Network of NJ, Community Quest, Inc., Family Promise, Habitats for Veterans, Homeless Veterans Outreach Center, New Jersey Alliance for the Homeless, and the Veterans Transitional Housing Program.

Anticipated Outcomes:

1. Collection of baseline data on provision of end-of-life services to homeless veterans in 2008.

Measures of baseline data collection include:

- Baseline data collection from NJHPCO member hospice agencies.
- Baseline data collection from other caregiver provider associations.

2. Initiation of collaborative efforts with homeless and veteran service organizations.

Measures of initiation of collaborative efforts include:

- A minimum of six meetings held with potential collaborators.
- Expression of desire for further collaboration between all parties and understanding of all parties' care-giving services.

3. Promotion and support of hospice participation in Stand Downs.

Measures of the promotion of hospice participation in Stand Downs include:

- Identification of the level/volume of contact made with homeless veterans.
- Identification of the types of services made available at the Stand Downs by hospice participants, e.g., offering informational resources.

4. Promotion and support of a Stand Down in central New Jersey.

Measures of the promotion of a Stand Down in central NJ include:

- Establishment of ground work with New Jersey National Guard.

5. Education of hospice providers about clinical issues and available resources related to caring for homeless veterans in NJ.

Measures of education of hospice providers about caring for homeless vets include:

- Creation of curriculum content and supportive resources by the task force.
- Presentation of materials at the NJHPCO Conference and posted on the HVP page of the NJHPCO website.



- Evaluation of available information to determine if the level of knowledge of hospice providers increased.



TENNESSEE HOSPICE ORGANIZATION

Project Title: REACHING OUT AND EDUCATING THE VETERANS IN TENNESSEE
REGARDING HOSPICE AND PALLIATIVE CARE BENEFITS

Primary Contact: Mike Dietrich, Executive Director

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Target Population: Rural veterans

Abstract:

The Tennessee Hospice Organization proposes to produce a video of hospice care – what it is and what it is not. The video will follow veteran families who receive hospice care during the course of the patient’s transition and the care of the family after the loved one has died. Educational materials including a brochure and catalog will be developed for easy reference. The brochure and catalog will be distributed to veterans via the Veterans’ Service Groups, community hospice programs and the Tennessee Hospice Organization. A speaker’s bureau will include hospice volunteers sharing their experiences, technical assistance provided by the Veterans Administration program directors and hospice providers sharing the most appropriate time and location for hospice care.

Partnerships:

The following four hospice agencies serve much of the rural population in middle Tennessee, and have military bases either located in their community or very close by with an identifiable military retiree population. Each organization will assist in the development of the information materials and participate in the Speaker’s Bureau to educate their communities regarding the benefits of hospice care. In addition they will share best practices with other THO members so the project can be replicated to cover the rest of Tennessee.

1. Alive Hospice
2. Gateway Hospice
3. Sumner Hospice
4. Hospice of the Highland Rim

The following partners will offer valuable expertise in working with veterans.



Veterans Administration

5. Georgia Carruth, Palliative Care Coordinator, Tennessee Veterans Health System (TVHS)
6. Sumathi Misra, MD, Chief Palliative and Hospice Program, TVHS
TVHS will assist in coordinating training sessions and viewings for the video once it is developed, as well as providing speakers for the Speaker's Bureau.

Veterans Service Groups will also distribute the brochure and catalog, and gather veterans together to view the video regarding hospice benefits for veterans.

Anticipated Outcomes:

The overarching goal is to improve awareness of hospice and end of life services and resources available to veterans and their families living in Middle Tennessee.

1. **Improvement of awareness of hospice and EOL services and resources through the creation and distribution of a video and other outreach material.**

Measures of improvement of awareness of hospice and EOL services and resources include:

- Assessment of veterans' awareness of and familiarity with EOL services before and after watching the video.
- Record of the number of outreach activities carried out and the number of people reached through the project.

2. **Improvement of hospice agency use of veterans' assessment tool in care delivery.**

Measures of the improvements of the use of the veterans assessment tool in care delivery by hospice agencies includes:

- Determination of whether the tool is regularly used.
- Identification of any barriers to use of the tool, and work to eliminate barriers.
- Collection of baseline data and on-going information from partner agencies.