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Serving homeless Veterans in the VA Desert Pacific Healthcare Network: A needs assessment to inform quality improvement endeavors

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Abstract

This report describes a needs assessment of VA programs for homeless Veterans in Southern California and Nevada, the geographic region with the most homeless Veterans in the nation. The assessment was formulated through key informant interviews. Current service provisions are discussed, along with salient unmet needs for this vulnerable population.

Keywords

Homeless people; Veterans; quality improvement; needs assessment

President Obama pledged to end homelessness among Veterans by 2015 and the Department of Veterans Affairs (VA) prioritized quality improvement (QI) endeavors to improve care for homeless people.[1–3] To achieve this goal, the VA must develop QI programs for homeless Veterans that build on current resources and address this population's unmet needs for health care, housing, and social services. To develop regional QI initiatives to improve care for this population, we performed a needs assessment in the VA's Southern California and Nevada region (Veterans Integrated Service Network, or V22), which serves more homeless Veterans than any other region in the nation.

Unfortunately, Veterans are overrepresented among the homeless[3–6] and have unique experiences that increase their risk for homelessness, including combat exposure and military sexual trauma.[1] In a study of women Veterans, Hamilton and colleagues discuss a “web of vulnerability” that leads to homelessness, through childhood adversity, medical/mental/addictive disorders, incarceration, and unemployment.[3]

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Overall, homeless Veterans have fewer primary care visits and more emergency departments (ED) visits than housed persons,[7–8] with an age-adjusted mortality that is nearly three times that of their housed counterparts.[9] Questions abound surrounding optimal systems of care to address these disparities. Numerous researchers focused on interventions in acute care settings,[10] while fewer have focused on outpatient care. Among these, O'Toole and colleagues developed a population-tailored primary care clinic for the homeless that decreased ED visits and improved care management.[10] In particular, inclusion of outpatient outreach and case management services are associated with improved outcomes.[11–12]

This needs assessment was performed as part of the VA Assessment and Improvement Laboratory for Patient-Centered Care, which aims to improve VA primary care through QI initiatives. This report presents current services and unmet needs for homeless Veterans, as described by key informants and supplemented by program reports.

Current Service Provisions and Unmet Needs in V22

Three authors (SG, AY, LG) conducted semi-structured key informant interviews with seven coordinators and administrators of the VA Health Care for Homeless Veterans (HCHV) program—an integrated system of clinical, housing, and supportive services—at each of the five V22 healthcare systems (Greater Los Angeles, Las Vegas, Loma Linda, Long Beach and San Diego). These informants were master's level nurses and social workers with clinical experience and supervisory roles in VA homeless programs, with professional backgrounds that parallel those of HCHV administrators nationwide. Informants described current services for homeless Veterans, unmet needs, and barriers and facilitators to primary care. Initial questions were open-ended, though interviewers subsequently prompted for specific anecdotes of interactions with homeless Veterans. Informants were also asked to provide copies of educational materials that are distributed to homeless patients.

All but one interview was conducted by phone. The three authors present for the interviews each took detailed interview notes, which were compared for consistency. No major discrepancies emerged between the interview notes. Minor discrepancies were resolved with discussion and notes were compiled into a single file within one week of each interview.

Two authors (SG, AY) reviewed the compiled notes. Notably, the interview was designed to cover the six service domains of the VA Greater Los Angeles strategic plan to end homelessness, as presented at the 2012 Los Angeles Homeless Veterans Summit. These domains included: 1) outreach; 2) primary care; 3) income, vocational, and benefits assistance; 4) homelessness prevention; 5) housing; and 6) community partnerships. To develop this needs assessment, the authors collaboratively decided to code interviews and educational materials along these six domains.

Key informants identified areas of need for homeless Veterans, a range of services to meet those needs, and components of these needs that were unmet by available services. Homeless services and unmet needs are presented in six domains and summarized in Box 1.

Outreach

Staff from each facility described community outreach efforts to engage and serve homeless Veterans. Outreach differed greatly among facilities, ranging from partnered outreach with community agencies in shelters to specialized outreach for women Veterans. Often, social workers and peer support specialists joined efforts to engage homeless Veterans. Particularly in communities that lack a VA hospital, out-reach staff struggled to identify and engage Veterans who received care at community hospitals and coordinate VA outpatient follow-up.

However, no V22 facility used a standardized tool to identify Veterans who were homeless or at risk for homelessness. Though staff in clinics that were closely affiliated with housing programs were often adept in referring Veterans to homeless outreach services, it was challenging to cross-train staff in other clinics. Without routine algorithms to identify Veterans who were homeless or at-risk for homelessness, many Veterans who received VA care did not benefit from homeless outreach.

Primary care

Throughout V22, customized medical care was available for homeless Veterans. Three facilities had specific primary care providers whose patients were nearly all homeless. At some sites, these clinicians were co-located with social services for the homeless. One site had primary care for homeless veterans co-located with mental health services.

Interviewees noted that homeless Veterans suffered from high burdens of medical illness and complex psychosocial circumstances. These multidimensional needs interfered with efforts to provide comprehensive primary care. Housing case managers had large caseloads of medically ill Veterans who were non-adherent with care and had limited supports. Though V22 housing programs had nurses as consultants for case managers, it was challenging to meet simultaneous needs for primary care and social services. As a result, each facility struggled to optimize nursing resources and foster collaboration between clinical and social services staff.

Moreover, all informants emphasized the need for open-access primary care appointments for homeless Veterans and specialized training for providers who are passionate about working with the homeless. Providers often needed longer appointment times and smaller patient loads that reflected the complexity of this population. Though same-day primary care could often be facilitated, long wait times for walk-in care in a medical system that emphasized scheduled appointments often resulted in homeless Veterans leaving before seeing providers to address competing priorities (e.g., showers and meals).[9,13] Several informants recounted anecdotes of homeless Veterans who were embarrassed about their hygiene and refused care because shower facilities were not available. Almost universally, limited availability of showers and clothing resources on VA grounds was an identified barrier to primary care.

Income, vocational, and benefits assistance

Homeless Veterans who were eligible for VA/public benefits could receive assistance with application processes. Moreover, vocational rehabilitation efforts were described throughout V22. Some facilities had specialized job training and employment resources for homeless Veterans. However, active substance use, psychiatric symptoms, and competing priorities (e.g., food and shelter) posed obstacles for many homeless Veterans who sought vocational assistance.

Homelessness prevention

Prevention of homelessness was an area of interest for several informants. All facilities took advantage of a national VA call center that provided housing resources for Veterans who were at risk for homelessness. However, informants struggled to identify this at-risk group without standardized tools that screen Veterans for housing problems.

Despite these challenges, high-risk populations were targeted for preventive services. Due to the close interplay of homelessness and incarceration,[14] some counties had Veterans Courts to divert Veterans from incarceration to VA mental health and social services. However, staff several facilities described stringent treatment requirements for its diversion programs and incarcerated Veterans who might benefit from these programs often declined to participate.

Housing

All informants stressed the critical role of VA housing programs and integrated case management in fostering exits from homelessness. The main program of this type cited by interviewees was the Department of Housing and Urban Development's (HUD's) partnership with VA through the HUD-VA Supported Housing program (HUD-VASH), which provides independent housing, intensive case management and supportive services for homeless Veterans. Eligibility requirements for HUD-VASH include: 1) homeless or on the verge of homelessness; 2) identified need and willingness to participate in case management; 3) VA health care eligibility; and 4) HUD-specified income requirements for a Section 8 voucher.[15] In addition, participants must not be registered sex offenders and must agree to pay 30–40% of their monthly income (often disability benefits) towards rent.[15] The Public Housing Authority pays the remainder of rent due with vouchers, and Veterans use vouchers for rental units in the community. Following a “housing first” model, HUD-VASH participants are not mandated to treatment or engagement with services beyond case management,[16] though efforts are made to connect them with VA medical care. Throughout V22, nearly 4,000 Veterans are enrolled in HUD-VASH.

The VA also supports housing programs along a “continuum of care,” or series of step-wise housing interventions, including emergency shelter, transitional housing, residential rehabilitation, and supported housing.[17–18] The Grant and Per Diem transitional housing program, a partnership between community agencies and the VA, was deemed an important housing resource by informants from all facilities. Community agencies receive VA awards to provide supportive housing, case management, substance abuse treatment, and other services for homeless Veterans, complemented by VA medical care. Throughout V22, these

programs serve over 2,000 Veterans. However, several informants reported difficulties finding homes for Veterans who complete these programs, as they are no longer considered homeless and are thus ineligible for HUD-VASH.

Informants from two facilities described funding for Domiciliary Care for Homeless Veterans programs, which provide time-limited residential rehabilitation and ambulatory primary and mental health care. However, there was great geographic variability in transitional and emergency-shelter bed availability. At some facilities, the nearest shelter placement was a several-hour bus ride away from clinics where Veterans seek housing services. With the influx of younger Veterans returning from Afghanistan and Iraq, informants were particularly sensitive to the needs of homeless Veteran families. In particular, since few VA transitional housing referrals are co-educational, single parents with teenage children of the opposite gender or newly homeless couples were often separated. Elderly Veterans and their adult caregiver children of the opposite gender were often separated as well.

Informants emphasized the scarcity of permanent housing options. In particular, Southern California had a dearth of affordable housing. Though homeless Veterans throughout the region often expressed strong preferences for HUD-VASH, voucher supply was inadequate to meet demand.

Community partnerships

Invaluable community partnerships were described across service domains. Throughout V22, interviewees described collaborations with local nonprofits that provided homeless services, public housing authorities, county/community health service providers, and federal agencies that provided social services for vulnerable populations. Each informant described efforts to expand community partnerships to increase services for homeless Veterans.

Conclusions

Throughout V22, the VA and its community partners offer diverse services for homeless Veterans. Though there is geographic variability in programming, the resources described by these key informants reflect nationwide efforts to improve medical care and housing for homeless Veterans. In particular, the VA offers innovative programs to outreach and provide health care for the homeless, intertwining case management, supportive services, and medical care with housing efforts.

However, despite these resources, there are opportunities to improve care for homeless Veterans. First, the lack of standardized tools to identify Veterans who are homeless or at risk for homelessness may result in under-identification of these Veterans and limit the effectiveness of outreach/prevention efforts. Second, lack of availability of on-campus hygiene and nutrition support resources, i.e., showers, meals, and clothing, limits utilization of primary care and vocational services for homeless Veterans. Third, additional emergency shelter and permanent housing options are needed.

At a national level, current QI efforts are aligned with these unmet needs. In September 2012, the National Center on Homelessness Among Veterans released an instrument to screen Veterans for homelessness in primary care and mental health clinics nationwide. To strengthen independent housing options, $75 million was allocated to the HUD-VASH program in 2012 to house 10,450 homeless Veterans.[19] In addition, funding for Homeless Patient-Aligned Care Teams was awarded to 32 VA sites, to provide patient-centered "medical homes" for homeless Veterans that decrease ED utilization, increase care management, and enhance housing options.

Continuous quality improvement is critical to optimize services for homeless Veterans. This report provides an overview of current VA homelessness resources and unmet needs in a region with a high prevalence of homelessness. As such, these interviews provide a foundation for planning directed towards improving the quality of care for homeless Veterans.

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Notes

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Box 1. AVAILABLE SERVICES AND UNMET NEEDS FOR HOMELESS VETERANS IN V22

Domain	Available Services	Unmet Needs
Outreach	Outreach staff identify and engage homeless Veterans in the community to facilitate VA medical care and social services.	Coordination of VA outpatient follow-up for homeless Veterans who receive care at community hospitals. Screening algorithms to identify Veterans who are homeless or at-risk for homelessness for referrals to outreach services.
Primary Care	Several facilities have primary care providers with panels that are largely comprised of homeless Veterans. Primary care is co-located with social services and/or mental health services in some facilities. Nurses serve as consultants to case managers in VA housing programs.	Walk-in, open access appointments for homeless Veterans. Specialized training for providers who serve homeless Veterans. Smaller panel-size to respond to the medical complexity of homeless Veterans. Increased access to showers, laundry facilities, clothing, and meals on VA grounds, to address “competing priorities” that can interfere with primary care receipt.
Income, Vocational, and Benefits Assistance	Assistance with applications for VA and/or public benefits. Supported employment, compensated work-therapy (CWT), and vocational rehabilitation programs.	Substance misuse, psychiatric symptoms, and competing needs for food, clothing, and shelter can interfere with vocational rehabilitation.
Homelessness Prevention	National VA call center provides housing resources for Veterans at-risk for homelessness. Outreach staff connects justice-involved Veterans to VA services, given the close association between incarceration and homelessness. Veterans Courts in some Counties can divert Veterans from incarceration to VA care.	Difficult to identify Veterans who are at-risk for homelessness. Stringent requirements for Veterans Court diversion programs can limit involvement of justice-involved Veterans who may benefit from VA care.
Housing	HUD and the VA partner in the VA Supported Housing (VASH) program, which provides housing vouchers and case management in a Housing First model. Grant and Per Diem (GPD) transitional housing programs provide housing and support along a continuum of care. Domiciliary Care for Homeless Veterans is funded at two facilities to provide time-limited residential rehabilitation. Transitional housing and emergency shelter.	Limited affordable permanent housing options throughout V22. Demand for VASH vouchers far exceeds supply. Limited co-educational transitional housing options poses problems for Veterans with families or elderly Veterans with adult caregivers of the opposite gender (or caregivers who are not Veterans). Inadequate transitional housing and emergency shelter availability in some geographic areas.
Community Partnerships	Collaborations with local nonprofits, public housing authorities, county and community health service providers, and federal agencies.	Increased collaborations with community-based agencies will expand available services for homeless Veterans.