

Health and Homelessness among Veterans: Experiences of HCH Grantees

*Phase 1 Findings from Key Expert
Interviews and Focus Groups*

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INTRODUCTION

According to 2011 UDS data, 22,486 unstably housed veterans were served by HCH grantees, which amounts to about 3% of all HCH consumers. This number has fluctuated in recent years, decreasing 11% from 2008 (26,098) to 2010 (23,119), although numbers increased by 10% from 2009 (20,852) to 2010 (23,119) (U.S. Department of Health and Human Services, 2009 & 2010). Since 2008, veteran consumers have utilized HCH projects more frequently than other types of health centers, representing 2.7% of all HCH patients as opposed to 1.2% of total health center patients in 2011 (U.S. Department of Health and Human Services, 2011). This population's propensity for HCH services could have a disproportionate impact on these projects. Given these rates of utilization, this study seeks more information about this unique consumer population, including demographics, health status, service utilization, and unmet health needs. Additionally, it investigates the identification process for veteran status and existing collaborations with local VA medical centers.

METHODS

As preliminary steps in the larger veterans' initiative, key expert interviews and focus groups were conducted to gain an initial understanding of the topic. In February 2012, interviews were held with clinicians, administrators, and consumers with ties to the HCH and VA fields. In March 2012, the three focus groups were conducted with HCH clinicians and administrators. Findings from the interviews and focus groups will inform the development of the needs assessment, which will be administered in September 2012.

The key experts were identified based upon NHCHC staff recommendations for those with veteran expertise and experience. Focus group participants were selected based upon analysis of UDS data. All HCH grantees that served over 200 veterans in 2010 were invited to participate in the focus groups. Participants in the interviews and focus groups represented a geographically diverse sample of HCH grantees, including providers in rural and urban areas throughout a variety of regions.

The interview and focus group guides were developed based upon a thorough literature review and the research objectives of this study. They covered a uniform list of topics, including the HCH identification process for veterans, general demographics, health status, common services, greatest unmet needs, VA collaboration, and training/technical assistance needs.

All data collection and analysis was performed by one person to ensure continuity. Interviews and focus groups were audio recorded, supplemented by the moderator's notes. Qualitative data was uploaded into ATLAS.ti software and manually coded for thematic patterns.

PRELIMINARY FINDINGS

Identification Process

The majority of HCH grantees had some sort of process in place to identify those consumers with veteran status. A few noted that they do not systematically ask or do not require that the question is asked. However, a question about veteran status was typically part of the HCH intake process, often as a prompt in the Electronic Health Record's (EHR) demographics page. Some grantees went on to ask if veteran consumers were eligible or receiving medical services and benefits from the VA.

Certain issues with self-identification were identified. The majority of grantees expressed that the number of veteran consumers was under-reported. According to participant experiences, some consumers thought that identifying as veterans would make them ineligible for HCH services, while others didn't identify due to negative experiences in the military or a less than honorable discharge status. Finally, some consumers were

confused about the definition of veteran status, particularly women, who sometimes don't self-identify despite having served. These factors impacting the accuracy of the veteran count are supported by similar findings from a review of rural community health centers serving veterans, which also reported issues associated with self-identification of veteran status (National Association of Community Health Centers & Atlas Research, 2011).

Veteran Demographics

Grantees estimated that homeless veterans composed about 3-5% of their total patient populations, although this number was likely underestimated due to the self-identification issues listed above. In regard to demographics, grantees reported that homeless veteran consumers matched the general homeless consumer population very closely. The majority were males age 35-65, although some suspect this age group will change over the next few years with more young veterans returning from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF). A small number of women veterans were served, with estimates around 6-10% of homeless veteran consumers. Some noted a recent increase of women veterans, mostly with children. Veteran consumers had no distinct race. Other defining characteristics were the prevalence of chronic homelessness, substance abuse issues, mental health issues, education beyond high school/GED, and prevalence of employable skills from military experience. Veteran consumers typically served from Vietnam to the pre-Desert Storm era and came from all branches of the military. Many entered the military due to a lack of employment options.

Health Status

Like consumer demographics, grantees reported that the health status of veteran consumers was similar to that of general consumers. Veteran consumers were "medically fragile" due to years of disengagement in medical care and were often high-users of emergency rooms. Prevalent serious/chronic medical conditions included hypertension, diabetes, heart disease, lung disease, hepatitis c, and asthma. Many veteran consumers would qualify for disability if they were able to navigate the process due to prevalent back pain and chronic pain. Tobacco use was common among veteran consumers, and substance and alcohol use often co-occurred with mental illness. Prevailing mental health issues included depression, anxiety, and Post-Traumatic Stress Disorder (PTSD), with a few grantees reporting that women veterans had a higher incidence of depression and trauma than male veterans.

Issues of trauma were extremely prevalent before, during, and after military service, but providers had trouble distinguishing whether trauma related to military service or life experiences in general. Participants believed that Traumatic Brain Injury was common, but hard to diagnose. Veteran consumers often had higher incidence of PTSD than the general population, although it was common throughout. Participants reported little experience with Military Sexual Trauma, although one clinician described this example: *"One of our female vets was a younger black woman. She had been sexually harassed while in the service and didn't feel like her superiors supported or protected her. She got in trouble reporting the abuse/unwanted advances."* Participants emphasized the significant effects of trauma on health status in terms of substance abuse, mental illness, decreased capacity to access treatment, and withdrawal from mainstream society.

Common Services

Homeless veteran consumers utilized similar services as general consumers, including primary care (especially for management of chronic conditions), dental/oral health care, mental health, counseling, housing/social services, aging and disability services, substance abuse treatment, enabling services, legal services, and women's health services (pap tests, mammograms). The only service specific to veterans was the linkage case managers facilitated with the VA.

Greatest Unmet Needs

Participants identified the greatest unmet needs among veteran consumers. The most commonly identified unmet need was dental/oral health, with some participants reporting that demand is so great they can't meet enough of it. Other unmet needs included mental health services, access to complementary health care and alternative treatments such as acupuncture and massage therapy, housing (especially for those still using), health literacy, and affordable medications. Many of these unmet needs are supported by the findings of the 2010 Project CHALENG survey of homeless veterans, especially dental care, which ranked in the top five unmet needs (Kuhn & Nakashima, 2011).

Factors Influencing Choice of Provider

Participants discussed the many factors that influenced veteran consumers in their choice of health care provider, namely when choosing between VA and HCH services. The most commonly addressed factor was access and transportation barriers. Many VA medical centers were too far away for consumers – either located outside the city center or in urban areas that were hard for rural consumers to access. Consumers often lacked bus fare and public transit options to travel a significant distance for services. However, participants noted that HCH grantees were located in close proximity to homeless shelters and offered multiple sites, including mobile units, which provided greater access.

Perceptions of VA and HCH providers also influenced utilization patterns. Participants shared varied perceptions of the VA, as communicated to them by consumers. Some consumers expressed an aversion to the VA, citing the long wait time to get an appointment in comparison to the HCH model; perceptions of disrespect from the VA; and anger toward the VA due to its “red tape” and confusing benefits application process. Other consumers noted positive views of the VA, including satisfaction with care; appreciation of the VA's homeless programs, including the HUD-VA Supportive Housing program (HUD-VASH) and Health Care for Homeless Veterans Program (HCHV); and eagerness to use their benefits earned through military service. On the other hand, some consumers expressed greater satisfaction with their HCH providers due to extensive outreach efforts and expanded access; willingness to provide care regardless of income/payment; positive community reputation among other consumers; and strong relationships with HCH primary care providers.

Privacy concerns were noted as another factor which dissuaded veteran consumers from utilizing the VA. Particularly those with mental health and substance/alcohol use issues favored HCH utilization because they didn't want this medical history on their military records due to the perceived stigma. As one veteran consumer explained: *“Men don't want to admit that we have health problems to begin with. Certainly don't want people knowing that we have a mental issue. But anybody who's been to war has a mental health issue. It never goes away. I've been out of the service for over 30 years, and loud noises still make me jump.”*

It was also suggested that the VA's HCHV program model was off-putting to consumers due to its recovery focus. HCHV treatment is contingent upon having mental health and substance use issues and the willingness to treat them. Meanwhile, the HCH model has more of an integrated, primary care focus.

A final factor influencing provider choice was the lack of VA medical benefits. Those with dishonorable discharge status are ineligible for benefits, limiting provider options. Even without dishonorable discharge, providers and consumers expressed confusion with benefits eligibility and navigating the application process. Proper identification is required for the application, including the DD 214 Report of Separation form, which consumers expressed difficulty acquiring. One veteran consumer shared that his inability to acquire his DD 214 prevented him from receiving VA treatment for three years, which resulted in a major deterioration of his health.

Key Women's Issues

Throughout the interviews and focus groups, key issues pertaining to women veterans emerged. The most resounding theme was a question asked by several: "Where are the women?" Few grantees reported serving women veterans, despite the fact that women are being deployed at greater numbers than ever and, upon return, are at four times greater risk for homelessness than non-veterans (Women in Military Service for America Memorial Foundation, Inc., 2009; Foster, 2010). This shortfall in women veteran consumers could be attributed to different factors. Perhaps women veterans are foregoing services altogether – a possibility supported by literature on under-utilization due to perceptions of male-dominated services (Washington et al., 2011; U.S. Department of Labor Women's Demonstration Project, 2010). Another explanation could be self-identification errors – either deliberate or inadvertent. As discussed in the "Identification Process" section, participants described instances of confusion over veteran status with regard to gender, as well as deliberate choices to avoid identification due to the bad feelings it elicited.

Participants also noted instances of poor quality of care or lack of resources for women's health services, particularly with regard to the VA. Some HCH services funded through the VA Grant and Per Diem Program only served male veterans. Additionally, one clinician with experience at both HCH projects and the VA described the VA's women's services as "*patched together from partial resources.*" The clinician shared a particular instance supporting this assertion: "*Like the women's clinic at our VA, we have a women's clinic, but it has a different staff person every day who ... it might be one person who's got limited capacity and leaves. I remember last week, we had a woman in a regular primary care clinic who came in with vaginitis and vaginal discharge. In the regular primary care clinic, we had no microscope. So apparently, there is quote, 'one kit to do a vaginal exam.' One kit for the whole clinic, which is in a red box that only one person knew where it was, and of course no microscope. So we took this woman to the women's clinic where there was no staff to see the patient. The intern from the medical clinic happened to do one year of gynecology and did the exam there. But I suddenly realized, wow, this is like a rinky dink organization with minimal readiness to serve women and their gynecological needs.*"

Local VA Collaboration

Given the breadth of resources the VA offers in terms of medical care and homeless services, there is great potential for collaboration between local VA offices and HCH grantees. However, participants reported mixed results in their efforts to establish such relations. Generally, collaborations were informal, meaning grantees knew a few VA contacts, but rarely had a formal agreement in place. The strength of the relationship varied, with some describing it as "strained" or "non-existent," while others noted significant, mutually beneficial collaboration.

Relations were initiated with the VA in many ways, including physician-to-physician communication; partnership on a grant initiative involving the VA; VA administrative outreach to community organizations such as HCH grantees; and connecting with one person at the VA and building a relationship around that ally.

Many mitigating factors served to facilitate and hinder this relationship-building. Several participants noted the integral role of outreach workers and case managers, both from the VA and HCH grantees, in establishing a relationship with little administrative intervention. For some grantees, VA outreach workers and case managers served as a lifeline for valuable VA information and interpretation. Other facilitators included dynamic leadership at grantees and the VA to build connections; close proximity to each other; gaining cell phone contact information from key VA allies to bridge communication barriers; getting involved in VA trainings and events; getting VA contact referrals from consumers, if available; establishing a cooperative agreement for an exchange of services; and looking out for patients' best interests through a commitment to collaboration over competition.

A number of barriers were said to hinder collaboration with the VA. The most commonly cited barrier was difficulty communicating with the VA. Participants said it was hard to communicate with VA providers in real time, get timely information about an individual's eligibility for benefits, receive consistent information from the VA, and reach an actual person as opposed to voicemail. Some participants said that the VA's "insular culture" was hard to penetrate, as it didn't appear to be an organization to look externally for partnerships often, other than for homeless outreach. Some HCHs were hesitant to refer patients to the VA because they didn't want to lose patient numbers. Finally, some participants said their HCH projects lacked the time and resources needed for collaboration.

Participants that successfully established collaborations with their local VA did so in different ways. The most common form was a referral system, in which HCH case managers linked veteran consumers with the local VA, including assisting them with the benefits application process. Another prevalent method was joint outreach. In some instances, VA outreach workers regularly came to HCH clinics to identify veteran consumers and help connect them with the VA. Outreach workers from HCH grantees and the VA also did joint outreach in the community. A promising type of collaboration was the VA Grant and Per Diem Program, which allowed HCH grantees to receive reimbursement for providing certain services to homeless veteran consumers. In the two instances cited, VA reimbursement was for dental care or reserving a set number of beds for veterans in a substance abuse treatment program. Formalized cooperative agreements weren't commonplace, but one participant had success. Per the agreement, the grantee hosted VA medical interns at their clinic, providing the VA interns with community experience in exchange for being able to offer more specialty care. Other collaborations included hosting joint support groups for veterans and participating in Stand Down events.

Identified Training and Technical Assistance Needs

Participants identified certain topics of interest for trainings and technical assistance to be provided by NHCHC. Several suggested training on trauma issues related to military service, including PTSD, TBI, and MST. Others, including a veteran consumer, suggested training on culturally appropriate methods for communicating with and treating homeless veterans. Another topic of interest was how to successfully establish a relationship with the local VA.

DISCUSSION

The key expert interviews and focus groups provided a breadth of rich information, which will help inform the development of the needs assessment. From these dialogues, certain issues emerged, which defied current literature, supported current literature, and highlighted emerging issues in the field.

A key finding was that veteran consumers receiving services from HCH grantees shared many similarities with the general consumer population, including demographics and health status. Perhaps the health conditions of veteran consumers were similar to the general population, but their contributing factors and appropriate means for culturally competent treatment varied.

A finding supported by current literature was the under-utilization of services by women veterans. Participants reported little contact with this population, perhaps due to perceptions of "male-oriented" homeless services or self-identification errors regarding veteran status. This finding necessitates further research into the utilization patterns of homeless women veterans so that they can be better targeted and served by HCH grantees.

More exploration should also be done regarding HCH and VA collaborations. Participant experiences with local VAs varied widely, but those with successful collaborations benefited immensely from reimbursement, smooth referral processes, joint outreach, and the work of VA medical interns. Future identification of the best practices will help guide other grantees in this complex but rewarding collaborative process.

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