Health and Homelessness among Veterans: A Needs Assessment of HCH Grantees

Final Analysis of Phase 1 and 2 Findings from Key Expert Interviews, Focus Groups, and Needs Assessment Survey

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DISCLAIMER

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EXECUTIVE SUMMARY

In 2011, 22,486 unstably housed veterans accessed services from Health Care for the Homeless (HCH) grantees, accounting for 3% of all HCH consumers.[1] Following separation from the military, veterans may experience a host of service-connected and non-service-connected health issues. However, veterans without stable housing are more likely to receive military sexual trauma (MST)-related treatment, have higher disability ratings, and be diagnosed with a mental disorder (including substance-related disorders and all mental illness), traumatic brain injury (TBI), co-occurring psychiatric diagnoses, and major depression in comparison to housed veterans.[2, 3] Unhoused veterans are also more likely to report a chronic medical condition, two or more mental health conditions, and higher rates of hepatitis/cirrhosis and post-traumatic stress disorder (PTSD) compared to homeless persons without veteran status.[4]

The Department of Veterans Affairs (VA) offers a breadth of health care services for veterans, yet a substantial number of veterans without housing choose to access HCH services instead. Given these rates of utilization, this study sought more information about this subset of the veteran population and how it was served by HCH grantees. Below is an overview of the study's objectives, methods, results, and conclusions:

Objectives. We explored the demographics, health status, service utilization, and unmet needs of veterans accessing care from HCH grantees. Additionally, we investigated how HCH grantees identified consumers with veteran status, what veteran-specific services were offered, and the scope and strength of their existing collaborations with local VA medical centers.

Methods. We conducted three key expert interviews with an HCH clinician, administrator, and veteran consumer in February 2012. Based upon the initial findings, three focus groups were conducted with HCH clinicians and administrators in March 2012. Preliminary findings from the qualitative research informed the development of a needs assessment survey of HCH administrators, which was administered online in September 2012 and achieved a 50% response rate (110 of 221 grantees responded). Frequencies were analyzed, then data was stratified by geographic population served to identify variances among urban, rural, and mixed areas.

Results. Most (98%) HCH grantees identified veteran status, but procedures varied. The majority of veterans were 36 to 65 years old, male, Caucasian, chronically homeless, uninsured, and served in the Vietnam and Gulf wars. The three most prevalent diagnoses were hypertension, alcohol use, and depression. The most frequently utilized services included primary care, dental/oral health, mental health, counseling, social services, and enabling services. Greatest unmet needs were housing, oral health care, mental health services, and chronic disease management. Veteran preference for HCH services was most influenced by past negative experiences at VA Medical Centers, transportation barriers to VA Medical Centers, ineligibility for VA benefits, and geographic accessibility of HCH grantees. The majority of grantees (61%) had communicated with local VA Medical Centers, but most often this communication was on an occasional basis (50%). The most common types of collaboration were making referrals to VA Medical Centers and receiving referrals from VA Medical Centers. Only 9.5% reported receiving reimbursement from the VA to provide services to veterans.

Conclusions. HCH grantees should streamline the identification process for veteran status to get a more accurate count. Through streamlined identification, grantees could more effectively link consumers with available veteran-specific services offered in-house, at local VA Medical Centers, and at veteran organizations in the community. HCH grantees should also target veterans' unmet needs to improve health status and quality of life. Strengthening relationships with local VA Medical Centers—especially through reimbursement programs, cross-training, joint outreach, and streamlined referral systems—could build grantee capacity to serve veterans and meet their unmet needs.

INTRODUCTION

On a single night in January 2012, an estimated 62,619 veterans were homeless in the United States, accounting for 13 percent of the adult homeless population.[5] The number of veterans experiencing homelessness has decreased 17.2% since 2009.[5] This has been attributed to improved collaboration between the Department of Housing and Urban Development (HUD) and the Department of Veterans Affairs (VA) and increased federal funding for programs targeting at-risk veterans and those experiencing homelessness. However, veterans returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) may impact rates of veteran homelessness in future years, given the higher homeless incidences among OEF/OIF veterans after five years of military separation compared to non-OEF/OIF veterans.[2]

Following separation from the military, veterans may experience a host of service-connected and non-service-connected health issues. However, veterans without stable housing are more likely to receive military sexual trauma (MST)-related treatment, have higher disability ratings, and be diagnosed with a mental disorder (including substance-related disorders and all mental illness), traumatic brain injury (TBI), co-occurring psychiatric diagnoses, and major depression in comparison to housed veterans.[2, 3] Unhoused veterans are also more likely to report a chronic medical condition, two or more mental health conditions, and higher rates of hepatitis/cirrhosis and post-traumatic stress disorder (PTSD) compared to homeless persons without veteran status.[4]

According to a 2010 survey, the greatest unmet needs identified by veteran consumers experiencing homelessness were welfare payments, child care, legal assistance for child support issues, family reconciliation assistance, and guardianship (financial).[6] Medical services, help with medication, tuberculosis testing and treatment, substance abuse treatment, and food ranked in the top five met needs identified by consumers, which the authors attributed to access to the VA's specialized homeless services.

Veterans may qualify to receive health care services from several federally funded sources, including the Department of Defense's (DoD) Military Health System (MHS), the VA's Veterans Health Administration (VHA), and the Health Center Program grantees funded by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA).[7] While the Military Health System primarily operates on military bases for active-duty service members and reservists, the VA's health care system—which includes VA Medical Centers, community-based outpatient clinics, community living centers, Domiciliaries, and Vet Centers—provides health care to 36% of all veterans.[7, 8] Eligibility for VA health benefits is contingent upon active service in the military, naval, or air service; serving 24 continuous months or the full period called to active duty (for those who enlisted after September 7, 1980, or who entered active duty after October 16, 1981); and discharge or release under conditions other than dishonorable.[9] In addition to eligibility requirements, another barrier to VA services may be limited knowledge of health benefits, as 48% of veterans from the Afghanistan and Iraq wars reported little or no understanding of the VA health care benefits due to them, according to analysis of the VA's 2010 National Survey of Veterans.[10]

HRSA Health Center Program grantees provide another federal source of health services for veterans. These grantees are funded by section 330 of the Public Health Service Act to provide care to medically underserved populations and/or special populations, including migrant and seasonal farmworkers, persons experiencing homelessness, and residents of public housing.[11] The Health Center Program grantees that receive section 330(h) special population funding to serve individuals experiencing homelessness are known as Health Care for the Homeless (HCH) clinics. In 2011, 249,548 veterans received services from Health Center Program grantees; of those veterans, 22,486 (9.01%) were homeless and received care from HCH clinics.[1]

Given the breadth of health care services offered by the VA, it is unclear why some veterans without stable housing utilize HCH services instead. Research on veterans experiencing homelessness is predominantly

focused on those receiving care within the VA setting, despite the fact that substantial numbers receive services elsewhere. This gap in literature leaves many questions unanswered regarding this subset of the veteran population and how it is served outside the VA setting.

Therefore, the National Health Care for the Homeless Council investigated the veteran population receiving care from HCH clinics through a needs assessment survey of HCH clinic administrators. The survey collected aggregate, agency-level data on veteran demographics, health status, unmet needs, and factors influencing veteran preference for HCH services, as well as identification processes for those with veteran status. In addition to analyzing frequency distributions, data was stratified by geographic population served to identify variances among unstably housed veterans in urban, rural, and mixed areas.

METHODS

Preliminary Qualitative Research

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 National HCH Council 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.

Needs Assessment Survey

The literature review and qualitative research culminated in a needs assessment survey of all HCH grantees. All known HCH grantees (224) listed in our organizational database at the time of the study were included. The HCH coordinators associated with each HCH grantee were invited to complete the survey based upon their knowledge of administrative operations and access to patient data.

Institutional Review Board (IRB) approval for the study was obtained from the Migrant Clinicians Network. The survey was conducted online using Survey Monkey in September 2012. Unique collector links were established for each of the 224 HCH coordinators and disseminated via email. We provided reminder emails and phone calls to ensure a high participation rate. 110 HCH coordinators completed the survey, resulting in close to a 50% response rate.

Survey Instrument

Development of the survey instrument was informed by a review of existing literature and themes identified in the preliminary qualitative research. The survey instrument consisted of 50 open- and close-ended questions, which collected data on the following measures.

HCH Grantee Profile: The survey obtained basic information about the HCH grantees, including the HHS Regions in which they were located, geographic populations served (rural, urban, or mixed), and federal funding sources.

Identification Process: The survey collected data on whether HCH clinics identified veteran status, how they identified veteran status, and how veteran status affected the services or resources offered to individuals who self-identified.

Demographic Profile: The survey collected estimates of demographic data regarding the veteran population served by HCH clinics, including the number of veterans served annually, period(s) of military service, branches of military service, length of homelessness, race/ethnicity, gender, age, and insurance status.

Respondents were asked to provide the exact percent distribution or estimate the percent distribution if exact data on veterans was unavailable. Participants were asked to list any defining demographic characteristics of women veterans served.

Health Status: The survey collected data on the most prevalent diagnoses and the frequency of trauma-related issues encountered (PTSD, MST, and TBI). To determine the most prevalent diagnoses of veterans seen at HCH clinics, participants were asked to select all the conditions that their veteran patients had from a predetermined list and could also list additional diagnoses in the "other" category. Participants were asked to rate how similar the health status of veteran consumers was to the general consumer population, as well as describe any similarities and/or differences. Participants were asked to describe the key health issues they observed among women veterans.

Unmet Needs: The survey identified the greatest health-related unmet needs among veteran consumers. Respondents could select all unmet needs that applied from a predetermined list, as well as list additional needs in the "other" category.

Service Utilization: The survey identified the services veteran consumers utilized at HCH grantees and identified any veteran-specific services that were offered. Respondents could select all services that applied from a predetermined list, as well as list additional services in the "other" category. Participants also rated how accessible VA Medical Center services were for veteran consumers in their communities and the adequacy of women's services offered by VA Medical Centers and their own HCH projects.

Factors Influencing Veteran Preference for HCH Services: The survey collected data on the factors that influence veteran preference for accessing HCH services instead of VA services. Respondents could select all factors that applied from a predetermined list, as well as list additional factors in the "other" category.

VA Collaboration: The survey collected data on the relationships HCH grantees had with local VA Medical Centers. Participants indicated whether they received reimbursement from the VA for the cost of providing services to veterans. Those grantees that did receive reimbursement were asked to identify the source(s) and how it was obtained. Those that did not receive reimbursement were asked to rate how much the cost of serving veterans impacted their financial resources. Participants were asked if they had ever communicated with the local VA Medical Center, how this communication was initiated, how often they communicated, in what ways they collaborated, and rated the strength of their relationship. Participants were asked to identify facilitating factors and barriers in their working relationships with the VA.

Analysis

We analyzed quantitative data with IBM SPSS Statistics 20. Because this survey explored a field without existing data, descriptive statistics were used to generate an exploratory understanding. Frequency tables were calculated for all quantitative measures. Additionally, data was stratified by geographic population served using crosstabulation to identify variances among urban, rural, and mixed areas. As Gordon et al. found, significant differences exist between unstably housed veterans residing in metropolitan versus nonmetropolitan areas in terms of personal, medical, and health care utilization characteristics.12 Qualitative data collected from the open-ended questions were analyzed with ATLAS.ti 6.2. Responses were manually coded to identify emerging themes.

RESULTS

HCH Grantee Profile

The 110 participating clinics were geographically representative of all 10 regions designated by HHS, although the highest response (17.5%) came from Region 4 (Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Florida, Alabama, and Mississippi), followed by 16.5% in Region 9 (Nevada, California, Arizona, and Hawaii), 15.5% in Region 5 (Minnesota, Wisconsin, Illinois, Indiana, Michigan, and Ohio), 10.7% in HRSA Region 2 (New York and New Jersey), and less than 10% each from the remaining HHS regions. In terms of geographic population served, 61.3% of respondents served an urban population, 30.2% served a mixed (urban and rural) population, and 8.5% served a rural population.

Responding grantees reported diverse federal funding sources. In addition to receiving Public Health Service (PHS) Act section 330(h) HCH funding, 50.5% of responding grantees received PHS section 330(e) Community Health Centers funding, 27.2% received Ryan White HIV/AIDS funding, 12.6% received PHS section 330(g) Migrant Health Centers funding, 12.6% received Department of Housing and Urban Development (HUD) Continuum of Care (CoC) funding, and 10.7% received PHS section 330(i) Public Housing funding. A small number received funding from Title X Family Planning, HRSA Maternal and Child Health, Substance Abuse and Mental Health Services Administration (SAMHSA), and HUD Housing Opportunities for Persons with AIDS.

Identification Process

In line with focus group findings, the survey revealed that the vast majority of HCH clinics (98%) identified consumers with veteran status, although methods for doing so varied. Of those who identified veterans, 63% reported that staff asked about veteran status during intake, 25% reported that consumers self-reported veteran status on intake forms, 8.7% reported that identification procedures varied by staff person, and 3.3% reported using other methods for identification.

Language used to identify veteran status varied in exact wording but generally used a similar approach to obtain this information. The most common phrasing was "Are you a veteran? Yes or No," followed by "Have you ever served in the military? Yes or No." Only 4% reported using follow-up questions to ask about discharge status, eligibility for VA benefits, utilization of VA services, or satisfaction with VA services.

Focus groups revealed that the number of veteran consumers was under-reported due to issues with self-identification. 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.

Identifying as a veteran affected the services and resources offered to consumers at the majority of HCH clinics, while others offered no veteran-specific services or resources (24.5%). Most commonly, clinics linked consumers to veteran-specific services in the community (59.6%), referred consumers to VA Medical Centers (45.7%), assisted consumers with the VA benefits application process (25.5%), linked consumers to veteran-specific services within HCH clinics (11.7%), and employed trauma-informed care and/or military cultural competence (5.3%).

Demographic Profile

HCH clinics usually reported serving 100 or fewer veterans experiencing homelessness in 2011 (69.2%). The majority of HCH veteran consumers were Caucasian (61%) males (92.1%), of middle to older age (49% were age 36-50; 37.7% were age 51-65; 20.4% were age 66 and older), uninsured (62.2%), chronically homeless (59.4% were homeless one or more years), served in the Army (95.6%), and veterans of the Vietnam (85.7%) and Gulf (73.6%) wars (Table 1). Women composed 10.5% of veteran consumers,

followed by less than one percent each of trans-female and trans-male veterans. In an open-ended survey question, some participants stated that there must be unstably housed women veterans in their communities, but they don't encounter many; veteran patients were overwhelmingly male. However, some focus group participants noted a recent increase of women veterans with children.

When asked to describe a general profile of their veteran consumers experiencing homelessness, HCH clinics reported that this population was African American or Caucasian; male; single; middle-aged or older; served in Vietnam, Gulf, Iraq, or Afghanistan wars; dishonorably discharged; and experienced mental health, substance use, alcohol use, and tobacco use issues.

Health Status

Respondents identified several prevalent diagnoses among the veteran consumers served (Table 2). Hypertension, alcohol use, depression, diabetes, substance use, tobacco use, PTSD, and co-occurring mental illness with alcohol and/or substance use were most frequently reported (all reported >50%). When stratified for geographic population served, some variance emerged among most prevalent diagnoses (Table 4). Of the diagnoses, the greatest variance existed for diabetes and hypertension, which were reported most frequently in HCH clinics serving an urban population of veterans compared to clinics serving rural or mixed populations.

Based upon open-ended responses, key health issues specific to women veterans included chronic disease (especially asthma, diabetes, and hypertension), depression, anxiety, PTSD, reproductive health issues, oral health issues, sexual abuse, and alcohol and substance use.

The majority of respondents (57.1%) reported that the health status of veteran consumers was similar to that of the general consumer population. However, according to respondents that did observe differences in health status, veteran consumers were more withdrawn; experienced greater trauma, more significant chronic illness, PTSD, depression, acute psychiatric issues, substance use, alcohol use, and tobacco use; waited longer to access care; and had higher needs.

Respondents reported that trauma-related issues—including PTSD, MST, and TBI—were encountered in varying frequencies, but had profound effects on health status. Of these issues, PTSD was encountered most frequently with a rating average of 2.87 (on a rating scale of 1=never, 2=sometimes, 3=frequently, 4=very frequently). Using the same rating scale, the rating average for encounters of TBI was 1.95, while the rating average for encounters of MST was 1.56.

When asked how issues of trauma—before, during, and after military service—affected the health status of veteran consumers, respondents reported that it hindered veterans' ability to access care, advocate for themselves, self-manage chronic conditions, and navigate social services, housing, and employment; severely impacted mental health; increased alcohol and substance use; and created barriers to trust, relationships, and compliance.

Unmet Needs

Respondents identified a number of health-related unmet needs among veteran consumers. Housing (79.4%) was the greatest unmet need, followed by oral health care (73%), mental health services (66.7%), chronic disease management (50.8%), lack of VA benefits (47.6%), affordable medications (41.3%), access to complementary health care/alternative treatments (22.2%), health literacy (19%), women's services (11.1%), and elder health care (9.5%). In the "other" open-ended category, respondents reported substance abuse and co-occurring disorders treatment, transportation, and vision services as other unmet needs.

The greatest unmet needs of veterans varied among the HCH clinics serving urban, rural, and mixed populations (Table 4). In urban areas, oral health care and housing were more frequently reported as unmet

needs in comparison to rural and mixed areas. Meanwhile, the lack of VA benefits was the greatest unmet need among veterans at rural HCH clinics.

Service Utilization

Veteran consumers utilized a variety of HCH services (Table 5), though primary care (95.2%), dental/oral health (71.4%), mental health (69.8%), counseling (61.9%), social services (57.1%), and enabling services (54%) were utilized most frequently. In the "other" open-ended category, respondents reported other services utilized by veterans, including screening for mental health and substance abuse, hygiene services (including showers, laundry, and supplies), employment services, vision services, the provision of meals, nutrition education, HIV/AIDS screening, Hepatitis C screening, and pharmacy services.

The majority of grantees (81%) did not offer veteran-specific services, while 12.7% did and 6.3% were unsure. For the grantees that did offer veteran-specific services, referrals to VA Medical Centers and HUD-VASH program were most frequently reported. Other veteran-specific services included assistance with discharge status upgrade applications, help understanding and applying for VA benefits, assistance with GI Bill education applications, and operation of a VA Compensated Work Therapy site. A few grantees had specific veteran departments, service units, or multi-disciplinary teams.

Respondents were divided regarding the perceived level of accessibility of VA Medical Center services to unstably housed veterans in their communities. This reiterated a focus group finding that the VA's accessibility and quality of services tailored for veterans experiencing homelessness varied from community to community. Respondents most frequently rated VA Medical Center services as slightly accessible (34.9%), followed by a tie between moderately accessible and very accessible (each 28.6%), and 7.9% as not accessible.

When posed with the statement, "Based on your observations and consumer feedback, women veterans experiencing homelessness receive adequate women's services (including pap smears, mammograms, pre-natal care, trauma-informed care)," the rating average for VA Medical Centers (on a scale of 1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree) was 2.54, while HCH grantees received a rating average of 3.19. This finding indicated that respondents believed that HCH grantees offered more adequate women's services than VA Medical Centers. The theme of inadequate women's services at VA Medical Centers also emerged in key expert interviews and focus groups. In one case, HCH services funded through the VA Grant and Per Diem Program only served male veterans, while one clinician with VA and HCH experienced described the VA's women's services as "patched together from partial resources."

Factors Influencing Preference for HCH Services

With the breadth of homeless and health services offered by the VA, it has been unclear why some unstably housed veterans accessed HCH services instead. To determine this, respondents were asked to identify factors that they believed influenced this preference for HCH services among their veteran consumers (Table 3). Past negative experiences at VA Medical Centers (66.7%) was the most frequently identified factor, followed by transportation barriers to VA Medical Centers (65.1%), and ineligibility for VA benefits due to less than honorable discharge status (61.9%). Specific traits of HCH clinics also influenced veteran preference, including geographic accessibility of HCH clinics (58.7%), positive connections with HCH providers (54%), and less financial barriers to HCH services (39.7%).

In the "other" category, respondents reported additional influencing factors, including the rigid service system of the VA being difficult to navigate due to homeless-specific barriers and the lack of available appointments at VA Medical Centers.

Geography again had an effect on the influencing factors identified by respondents. In rural settings, the geographic accessibility of HCH clinics (66.7%) was the most influential factor in preference for HCH

services; past negative experiences at VA Medical Centers (55.6%) and transportation barriers to VA Medical Centers (55.6%) were also more frequently reported as influences in rural settings compared to urban or mixed settings. The top influencing factor reported by urban HCH clinics was past negative experiences at VA Medical Centers (44.6%), while HCH clinics in mixed settings reported that veterans' positive connections with HCH providers (28.1%) were most consequential in determining their preferences for HCH services.

VA Collaboration

The majority of grantees (60.6%) had ever communicated with local VA Medical Centers, but most often this communication was on an occasional basis (50%) (Table 6). Lines of communication with VA Medical Centers was initiated in numerous ways, with the three most common being participation in Stand Down events (19.1%), making one strong VA contact and building a relationship around it (13.6%), and physician-to-physician communication (11.8%). In the "other" category, respondents identified additional ways they initiated communication, including the region's Veterans Integrated Service Network (VISN) putting pressure on the VA Medical Center to get involved with community partners, the HCH grantee doing administrative outreach to the VA Medical Center, serving as client advocates for those eligible for VA services, participating in a local homeless collaborative group with the VA, and having staff that are military veterans and linked in to the VA Medical Center.

Nearly 16% of grantees reported no collaboration with local VA Medical Centers. For those grantees that did collaborate, the most common types of collaboration were making referrals to VA Medical Centers (39.1%) and receiving referrals from VA Medical Centers (11.8%). A small number of grantees (<10% each) reported that they received reimbursement through the VA's Grant and Per Diem Program, had inter-agency agreements with VA Medical Centers, had VA outreach workers come to their health centers, performed joint outreach with VA staff, co-located services with VA Medical Centers, or attended cross-training that involved VA Medical Centers. In the "other" category, respondents identified additional ways they collaborated with VA Medical Centers, including having bi-weekly meetings, having HCH case managers communicate with VA personnel, contracting with the VA for detox services, and establishing a relationship with the VA for resource sharing and partnering outreach services.

Only 9.5% of HCH grantees reported receiving reimbursement from the VA or another source to provide services to veterans, while 76.2% said they did not and 14.3% were unsure. Grantees that did receive reimbursement were asked to identify the source(s) in an open-ended question. Respondents reported that reimbursement was received through contracting with the VA to provide specific services (e.g., detox services, dental services), participating in the VA's Grant and Per Diem Program, and receiving a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to provide outreach to veterans. Those that did not receive reimbursement were asked to rate how much the cost of serving veterans impacted their health center's financial resources. Respondents reported a rating average of 2.04 (on a scale of 1=not at all, 2=slightly, 3=moderately, 4=significantly), indicating that serving veterans slightly impacted financial resources.

When asked to rate the strength of their relationships with local VA Medical Centers (on a scale of 1=very weak, 2=weak, 3=strong, 4=very strong), participants reported a rating average of 2.19. This indicated that their relationships with local VA Medical Centers were perceived to be somewhat weak, although 36.5% reported that their relationships were strong and 3.2% reported that their relationships were very strong.

Grantees reported several factors that facilitated their working relationships with local VA Medical Centers. The most frequently reported factors included the assistance of VA outreach workers and case managers (21.8%) and gaining better contact information of VA Medical Center staff (16.4%). Some respondents (16.4%) reported that no factors facilitated their working relationships. In terms of barriers to their working relationships with local VA Medical Centers, 20.9% reported the insular or isolated culture of VA Medical

Centers and 20% reported communication issues. Meanwhile, 23.6% reported that no factors are barriers to their working relationships.

Training Needs

Survey respondents identified several training needs that could increase their capacity to serve unstably housed veterans. The top identified topic was relationship-building with VA Medical Centers (75%), followed by trauma issues (post-traumatic stress disorder, traumatic brain injury, military sexual trauma, and trauma informed care) with 68.3%, and military cultural competence (general military knowledge, understanding of military culture, understanding of VA system, knowledge of how military culture impacts veterans' world views) with 61.7%.

DISCUSSION

While most research on veterans experiencing homelessness is focused in the VA setting, our study explored the population accessing services from HCH grantees. Although the identification of veterans is required by HRSA, our findings revealed that no streamlined procedure is in place for all HCH grantees, which could affect the accuracy of the data reported. Prior research has identified several issues with the veteran identification process, including who should ask about veteran status, when this question should occur, how this question should be phrased, and how to overcome the prevalence of veterans not self-identifying due to less than honorable discharge status, gender, negative experiences in the military, or confusion over the definition of veteran.[12] Our findings revealed that the identification of veterans at HCH grantees is prevalent, but lacking uniformity.

In addition to standardizing when veteran status is identified and which staff person is responsible, reformulating the question could yield more accurate results. The VA's Screening for Military Service guide recommends that staff ask: "Have you ever served in the military?"[13] If consumers answer "yes," the guide provides follow-up questions to learn more about the veterans' service histories, which can inform treatment planning. This line of questioning may be more effective than the varied phrasing currently used by HCH grantees, especially the most common question, "Are you a veteran? Yes or No."

Streamlined identification of veterans is important for many reasons. In addition to improved reporting accuracy, our survey findings demonstrated that knowing veteran status influenced how the majority of clinicians served veterans and connected them with veteran-specific resources within their clinics and communities. More strategic identification could also improve the engagement of hard-to-reach veterans who are not accessing the VA services and benefits for which they may be eligible. For those veterans who do not qualify for VA benefits due to less than honorable discharge—which 61.9% of respondents identified as a factor influencing veteran preference for HCH services—HCH grantees offer an important alternative for care. Knowledge of military history is an essential component for providing culturally competent and trauma-informed care that considers the characteristics and needs of veterans who are homeless.

Our findings produced a general understanding of this previously unexplored subset of the veteran population. Prior research had found that, in comparison to the non-veteran homeless population, unstably housed veterans were more likely to experience longer periods of homelessness and be of older age, minorities, and more educated.[14, 15] Our survey findings confirmed this prevalence of chronic homelessness and middle- to older-age among unstably housed veterans, although veterans in the HCH setting were most often Caucasian and educational attainment data was not collected through our survey. Although the majority of veterans accessing HCH services were male, survey respondents reported that 10.5% were female. Focus groups suggested that there was an increase of women veterans with children.

Consistent with literature that demonstrated higher rates of chronic illness among unstably housed veterans[16], HCH grantees—especially those in urban areas—reported a high prevalence of hypertension and diabetes. Other prevalent diagnoses were alcohol, substance, and tobacco use; PTSD; and co-occurring mental illness with alcohol/substance use. The key health issues among women included the chronic diseases and substance and alcohol use issues common among men, as well as depression, anxiety, reproductive health issues, oral health issues, and sexual abuse. Almost half of respondents (41%) reported that PTSD was encountered frequently among veteran consumers, while TBI and MST were encountered less frequently.

For the veterans engaged in HCH services, unmet needs remained, including housing, oral health care, mental health services, and chronic disease management. The greatest unmet needs in urban areas were oral health care and housing, while the lack of VA benefits was the greatest unmet need in rural areas. These health-related unmet needs vary from those identified in the 2010 Project CHALENG survey, in which medical and mental health issues ranked among the top 10 met needs of veterans experiencing

homelessness. Perhaps this reflects the variance in needs between the unstably housed veterans who are able to access VA services and those who cannot and rely upon HCH services instead.

Providing explanation for some veterans' preference for HCH services over VA services, the factors deemed most influential in choice of service provider were past negative experiences at VA Medical Centers, transportation barriers to VA Medical Centers, ineligibility for VA benefits due to less than honorable discharge, and geographic proximity of HCH clinics. In rural settings, the geographic accessibility of HCH clinics was the most influential factor in preference for HCH services, reiterating the importance of proximity and transportation options in facilitating access to care.

Our research found that unstably housed women veterans may have special motivations for accessing HCH services. Survey respondents rated the women's services at HCH grantees as more adequate than those offered by VA Medical Centers. Previous research has found that unstably housed women veterans were hesitant to access VA services because they were perceived to be male-oriented.[17] HCH grantees can fill this void for women veterans by offering more women- and family-friendly programs, providing culturally competent and trauma-informed care, and increasing awareness of HCH services among women veterans in their communities.

The majority of HCH grantees (61%) reported that they had communicated with local VA Medical Centers, although there was variance in communication methods, types of collaboration, facilitators and barriers to collaboration, and strength of relationships. The most common types of collaboration were making referrals to VA Medical Centers and receiving referrals from VA Medical Centers. Only 9.5% of respondents reported receiving reimbursement from the VA to provide services to veterans, despite the wide range of funding opportunities offered through the VA, including the Grant and Per Diem Program and Supportive Services for Veteran Families Program. Strengthening relationships with local VA Medical Centers—especially through reimbursement programs, cross-training, joint outreach, and streamlined referral systems—could build grantee capacity to serve veterans and meet their unmet needs.

Interestingly, the top-identified training need of HCH grantees was relationship-building with VA Medical Centers. In response, the National HCH Council has already offered a webinar on this topic entitled "Joining Forces: Improving Care for Veterans through HCH-VA Collaborations" (https://www.nhchc.org/2012/10/joining-forces-improving-care-for-veterans-through-hch-va-collaborations/). The other major training need identified was trauma issues, including PTSD, MST, TBI, and trauma-informed care. The Department of Labor offers a valuable resource on this topic entitled "Trauma-Informed Care for Women Veterans Experiencing Homelessness: A Guide for Service Providers" (http://www.dol.gov/wb/trauma/). This guide provides information on the emotional and instrumental support services that HCH grantees could incorporate to better tailor their services to meet the needs of unstably housed veterans.

Through review of this study's findings and participation in trainings on VA collaboration and trauma issues prevalent among veterans, HCH grantees will be better positioned to serve this population. Pursuing strategic partnerships with local veterans' organizations and VA Medical Centers could also increase their knowledge, cultural competency, and resources. Capacity-building to increase HCH grantees' ability to serve this population will be important given some veterans' preference for accessing HCH services and the potential for an increased veteran population without housing as service members return from the current conflict at a greater risk for homelessness.[2]

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TABLE 1 – Characteristics of Veterans Accessing Services at Health Care for the Homeless (HCH) Grantees

Characteristic	%*
Veterans Served by Health Care for the Homeless Grantees in 2011	
0-100	69.2
101-200	17.6
201-300	7.7
301-400	2.2
401-500	1.1
Over 500	2.2
Period of Military Conflict	
WWII	11.0
Korea	14.3
Vietnam	85.7
Gulf War	73.6
Operation Enduring Freedom	38.6
Operation Iraqi Freedom	40.7
Operation New Dawn	14.3
Branch of Military	
Army (including Army Reserve and Army National Guard)	95.6
Marine Corps (including Marine Corps Reserve)	69.2
Navy (including Navy Reserve)	46.2
Air Force (including Air Force Reserve and Air National Guard)	42.9
Coast Guard	20.9
Length of Homelessness	
Less than 3 months	7.7
3-6 months	14.3
More than 6 months, but less than 1 year	18.7
More than 1 year, but less than 2 years	19.8
More than 2 years	39.6
Race/Ethnicity	
Caucasian	61.0
African American/Black	34.9
American Indian/Alaska Native	2.6
Native Hawaiian/Pacific Islander	1.7
Asian	1.2
Hispanic/Latino	14.2
Other	15.0
Gender	
Male	92.1
Female	10.5
Trans-female	0.6
Trans-male	0.6
Other	24.0
Age	
18-25	7.6
26-35	23.6

36-50	49.0
51-65	37.7
66 and older	20.4
Insurance Status	
Privately Insured	2.9
Uninsured	62.2
Medicaid	31.6
Medicare	13.6
VA Coverage	36.0
Other	17.4
**Note: Percentages are aggregates of percentage distributions reported by respondents and do not sum 100%.*	

TABLE 2 – Most Prevalent Diagnoses among Veterans Accessing Services at Health Care for the Homeless (HCH) Grantees

Diagnoses	(n)	%*
Hypertension	52	82.5
Diabetes	42	66.7
Heart disease	25	39.7
Arthritis	15	23.8
Lung disease	15	23.8
Hepatitis C	18	28.6
Asthma	20	31.7
HIV/AIDS	8	12.7
Alcohol use	46	73.0
Substance use	44	69.8
Tobacco use	44	69.8
Anxiety	30	47.6
Depression	46	73.0
Eating disorder	2	3.2
Post-Traumatic Stress Disorder (PTSD)	42	66.7
Military Sexual Trauma (MST)	4	6.3
Co-occurring mental illness with alcohol/substance use	35	55.6
Physical disability	20	31.7
Traumatic Brain Injury (TBI)	11	17.5

**Note: Respondents selected all that applied so percentages do not sum 100%.*

TABLE 3 – Unmet Needs among Veterans Accessing Services at Health Care for the Homeless (HCH) Grantees

Unmet Needs	(n)	%*
Dental/oral health care	46	73.0
Chronic disease management	32	50.8
Mental health services	42	66.7
Access to complementary health care/alternative treatments	14	22.2
Housing	50	79.4
Health literacy	12	19.0
Affordable medications	26	41.3
Elder health care	6	9.5
Lack of VA benefits	30	47.6
Women's services	7	11.1

**Note: Respondents selected all that applied so percentages do not sum 100%.*

TABLE 4 – Services Utilized by Veteran Consumers at Health Care for the Homeless (HCH) Grantees

Service	(n)	%*
Primary care	60	95.2
Urgent care	28	44.4
Dental/oral health	45	71.4
Mental health	44	69.8
Counseling	39	61.9
Housing	18	28.6
Social services	36	57.1
Aging/disability services	7.9	5.0
Substance abuse treatment	26	41.3
Enabling services	34	54.0
Legal services	6	9.5
Women's services	25	39.7
Depression	46	73.0

**Note: Respondents selected all that applied so percentages do not sum 100%.*

TABLE 5 – Factors Influencing Veteran Preference for Health Care for the Homeless (HCH) Services

Factor	(n)	%*
Transportation barriers to Veterans Affairs (VA) Medical Center	41	65.1
Past negative experience(s) at VA Medical Center	42	66.7
HCH clinic is more geographically accessible	37	58.7
Less financial barriers to HCH services	25	39.7
Positive connection with HCH provider	34	54.0
Privacy concerns at VA Medical Center (especially for mental health/substance use issues)	12	19.0
Dislike recovery focus of VA's Health Care for Homeless Veterans service model	8	12.7
Difficulty obtaining VA benefits	31	49.2
Ineligible for VA benefits due to less than honorable discharge status	39	61.9
Other	5	7.9

**Note: Respondents selected all that applied so percentages do not sum 100%.*

TABLE 6 – Collaboration between Health Care for the Homeless (HCH) Grantees and Veterans Administration (VA) Medical Centers

Element of Collaboration	%*
Has your health center ever communicated with your local VA Medical Center?	
Yes	60.6
No	18.2
Unsure	21.2
How was this communication initiated? (Check all that apply)	
Physician-to-physician communication	11.8
Partnered on grant initiative	1.8
VA Medical Center did administrative outreach to your health center	7.3
Made one strong VA Medical Center contact and built relationship	13.6
Participated in Stand Down event together	19.1
Other	8.2
How often do you communicate with the local VA Medical Center?	
Rarely	17.5
Occasionally	50.0
Frequently	22.5
Very frequently	10.0
In what way, if any, does your health center collaborate with the local VA Medical Center? (Check all that apply)	
No collaboration	15.5
Makes referrals to the VA Medical Center	39.1
Receives referrals from the VA Medical Center	11.8
Receives reimbursement through the VA Grant and Per Diem Program	4.5
Inter-agency agreement with the VA Medical Center	2.7
VA Medical Center outreach worker comes to your health center	5.5
Perform joint outreach with VA Medical Center outreach staff	8.2
Co-location of services with the VA Medical Center	2.7
Cross-training that involves the VA Medical Center and your health center	2.7
Other	9.1
How would you describe the strength of your health center's relationship with the local VA Medical Center?	
Very weak	23.8
Weak	36.5
Strong	36.5
Very strong	3.2
What factors facilitate your health center's working relationship with the local VA Medical Center? (Check all that apply)	
Assistance of VA outreach workers and case managers	21.8
Dynamic leadership at your health center and local VA Medical Center	8.2
Gaining better contact information of VA Medical Center staff	16.4
Establishing formal collaboration agreements	9.1
No factors facilitate our working relationship	16.4
Other	7.3
What factors are barriers to your health center's working relationship with the local VA Medical Center?	

Insular or isolated culture of the VA Medical Center	20.9
Communication issues	20.0
Your health center lacks the time and resources to collaborate	8.2
No factors are barriers	23.6
Other	8.2
Do you get any reimbursement for the costs of providing services to veterans experiencing homelessness form the VA or elsewhere?	
Yes	9.5
No	76.2
Unsure	14.3
If you do not receive reimbursement, how much does the cost of serving veterans impact your health center's financial resources?	
Not at all	26.3
Slightly	47.4
Moderately	22.8
Significantly	3.5
**Note: For questions that allowed respondents to "check all that apply," percentages do not sum 100%.*	

TABLE 7 – Prevalent Diagnoses, Unmet Needs, and Factors Influencing Veteran Preference for Health Care for the Homeless (HCH) Services Stratified by Geographic Population Served

Category	Rural Population, %*	Urban Population, %*	Mixed Population, %*
Prevalent Diagnoses			
Hypertension	33.3	56.9	37.5
Diabetes	11.1	50.8	25.0
Heart disease	~	29.2	18.8
Arthritis	~	20.0	6.3
Lung disease	~	18.5	9.4
Hepatitis C	~	21.5	12.5
Asthma	~	20.0	21.9
HIV/AIDS	~	9.2	6.3
Alcohol use	22.2	50.8	34.4
Substance use	11.1	49.2	34.4
Tobacco use	22.2	49.2	31.3
Anxiety	22.2	33.8	18.8
Depression	33.3	50.8	31.3
Eating disorder	~	3.1	~
Post-Traumatic Stress Disorder (PTSD)	44.4	41.5	34.4
Military Sexual Trauma (MST)	~	4.6	3.1
Co-occurring mental illness with alcohol/substance use	22.2	36.9	28.1
Physical disability	~	23.1	15.6
Traumatic Brain Injury (TBI)	11.1	13.8	3.1
Unmet Needs			
Dental/oral health care	33.3	55.4	21.9
Chronic disease management	22.2	38.5	15.6
Mental health services	44.4	44.6	28.1
Access to complementary health care/alternative services	11.1	12.3	15.6
Housing	22.2	55.4	37.5
Health literacy	~	13.8	9.4
Affordable medications	11.1	32.3	12.5
Elder health care	~	6.2	6.3
Lack of VA benefits	44.4	33.8	12.5
Women's services	~	9.2	3.1
Factors Influencing Veteran Preference for HCH Services			
Transportation barriers to Veterans Administration (VA) Medical Center	55.6	44.6	21.9
Past negative experience(s) at VA Medical Center	55.6	44.6	25.0
HCH clinic is more geographically Accessible	66.7	35.4	25.0

Less financial barriers to HCH Services	11.1	27.7	18.8
Positive connection with HCH Provider	11.1	36.9	28.1
Privacy concerns at VA Medical Center (especially for mental health/substance use issues)	11.1	13.8	6.3
Dislike recovery focus of VA's Health Care for Homeless Veterans service model	11.1	9.2	3.1
Difficulty obtaining VA benefits	44.4	33.8	15.6
Ineligible for VA benefits due to less than honorable discharge	44.4	43.1	21.9

**Note: Respondents selected all that applied so percentages do not sum 100%.*