



**VA NATIONAL CENTER ON HOMELESSNESS AMONG VETERANS**

*Promoting data-driven, evidence-based solutions to end Veteran homelessness*

## HOMELESS EVIDENCE AND RESEARCH SYNTHESIS (HERS) ROUNDTABLE PROCEEDINGS

### **Addressing Social Determinants of Health**

**Exploring Implications for Policy  
through the Veterans Health Administration s  
Universal Screening for Housing Instability  
among Veteran Outpatients**

September 13, 2018

## **Homeless Evidence and Research Synthesis (HERS) Roundtable Series**

The National Center on Homelessness among Veterans (the Center) in the Veterans Health Administration (VHA) established the Homeless Evidence and Research Synthesis (HERS) Roundtable Series in 2015 as a policy forum. The virtual symposium convenes researchers and subject matter experts to discuss research findings on key issues in homelessness. The online webinar is available to interested parties within and outside of the U.S. Department of Veterans Affairs (VA). Topics covered to date include: **Enumeration of Homelessness** (July, 2015); **Aging and the Homeless Community** (November, 2015); **Women Veterans and Homelessness** (May, 2016); **Opioid Use Disorder and Homelessness** (February 2017); **Rural Veterans and Homelessness** (June, 2017); **Suicide and Homeless Veterans** (February, 2018); and **Addressing Social Determinants of Health: Exploring Implications for Policy through the Veteran Health Administration’s Universal Screening for Housing Instability among Veteran Outpatients**. Links to the recorded webinars and proceedings are available on the Center website. <https://www.va.gov/HOMELESS/nchav/research/HERS.asp>

# Addressing Social Determinants of Health: Exploring Implications for Policy through the Veterans Health Administration's Universal Screening for Housing Instability among Veteran Outpatients

The Addressing Social Determinants of Health proceedings are a summary of the presentations and roundtable discussion that took place on September 13, 2018 in a virtual symposium. The recorded webinar and downloadable copies of the individual presentations are available here <http://va-eerc-es.adobeconnect.com/pl8nkw1pg969/>

## Moderator

**Roger Casey**, PhD, LCSW, Director of Education and Dissemination, VA National Center on Homelessness among Veterans

## Presenters

**John Blosnich**, PhD, MPH, Research Health Scientist, Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System; and Assistant Professor, West Virginia University and University of Pittsburgh

**Melissa Dichter**, PhD, MSW, Core Investigator, VA Center for Health Equity Research and Promotion (CHERP); and Assistant Professor, University of Pennsylvania Perelman School of Medicine, Department of Family Medicine and Community Health

**Ann Elizabeth Montgomery**, PhD, Researcher, National Center on Homelessness among Veterans; Health Science Specialist, HSR&D, Birmingham VA Medical Center; and Assistant Professor, University of Alabama at Birmingham School of Public Health

**Gala True**, PhD, Investigator, South Central Mental Illness Research, Education, and Clinical Center (MIRECC), Southeast Louisiana Veterans Health Care System (SLVCHS); and Associate Professor of Medicine, Tulane University

## Roundtable Panel

**Monica Diaz**, MBA, Executive Director, Homeless Programs Office, Veterans Health Administration

**Tracy Gaudet**, MD, Executive Director, National Office of Patient Centered Care and Cultural Transformation, Veterans Health Administration

**Laura Taylor**, MSW, LCSW, National Director of Social Work, Veterans Health Administration

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## Executive Summary

The VA has been a leader in incorporating screening in the health care setting to assess social determinants of Veterans' health, including lack of stable housing, intimate partner violence (IPV), military sexual trauma (MST), and food insecurity. Many studies cite the importance of screening for these conditions and have identified appropriate responses; however, scant research focuses on how that happens in practice, specifically how screening practically and logistically leads to connection with interventions.

A study of the Veterans Health Administration's (VHA) universal screen for housing instability—the Homelessness Screening Clinical Reminder (HSCR)—has examined Veterans' perceptions of this particular social experience to determine whether screening tools and methods measure concepts as intended and connect Veterans with appropriate interventions. In this Homeless Evidence Research Synthesis (HERS) symposium, researchers described how the process works for clinical providers, social workers, and the Veterans themselves, what happens when a Veteran screen is positive for homelessness or risk, and how different social risks intersect and interact.

Presenters described how the HSCR has been successful in identifying Veterans experiencing homelessness or risk who may previously have been undetected. Clinical providers who administer the HSCR view it favorably, as do the Veterans screened, but both groups express concern with a lack of services for Veterans who may not be literally homeless (i.e., living on the street or in an emergency homeless shelter). Physicians and nurses also believe they may not be in the best position to conduct the screening since they do not have the latest information about available services or the ability to determine what happens to their Veteran patients after they screen positive and a referral for housing services is made.

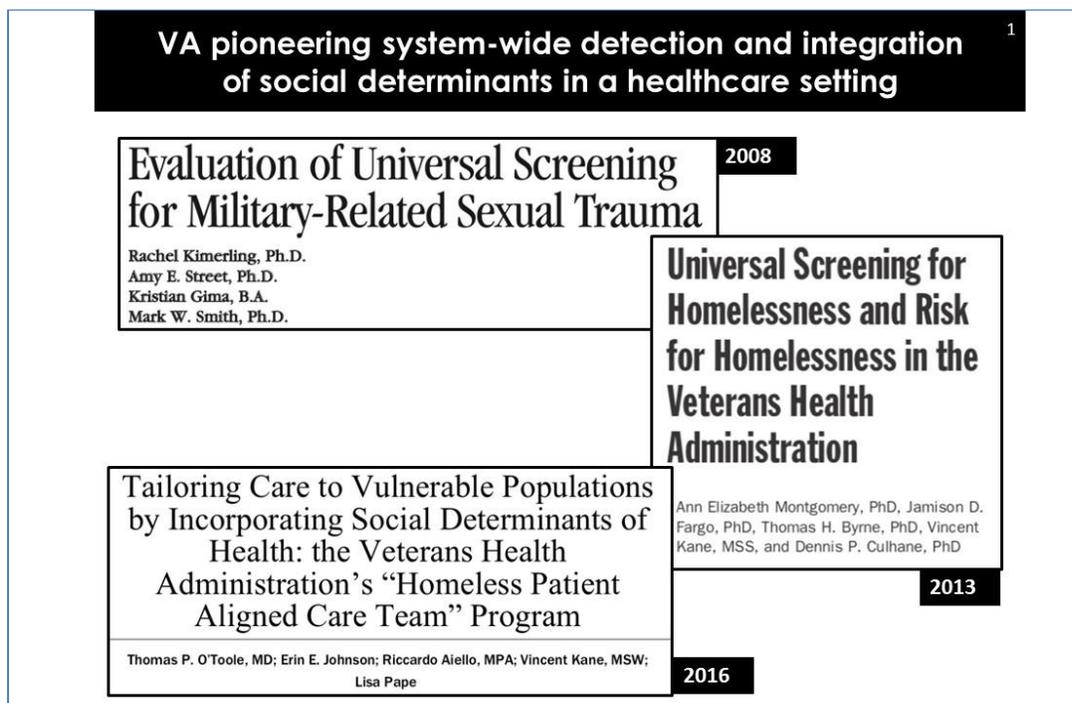
The HERS on *Addressing Social Determinants of Health: Exploring Implications for Policy through the Veterans Health Administration's Universal Screening for Housing Instability among Veteran Outpatients* provides useful information about current processes for screening and responding to housing instability and offers recommendations for improvement, as well as areas for further research. This work has the potential to impact the system of care by informing processes for assessing other social determinants of health and linking Veterans with needed resources.

## Presentations

### Screening for social determinants of health in VA: why should we pay attention?

John Blosnich, PhD

Social determinants of health, “the conditions in which people are born, grow, live, work, and age,” (1) are strong predictors of morbidity and mortality but have largely been ignored within health care systems. Only four years ago, the National Academy of Medicine issued a landmark report recommending the integration of social determinants into electronic health records (EHR) to provide more patient-centered care. (2) The VA has been a leader in this regard, using screening to identify and develop strategies to respond to social determinants of health such as military sexual trauma, intimate partner violence, food insecurity, and housing instability.



## The Homeless Screening Clinical Reminder: a case example of addressing a social determinant of health

**Ann Elizabeth Montgomery, PhD**

The National Center on Homelessness among Veterans developed the HSCR as part of a broad initiative to end Veteran homelessness launched by the VA in 2009. Since 2012, this brief EHR-based screen for homelessness and risk has been administered in the VA outpatient clinical setting with two primary objectives. The first was to identify Veterans who were experiencing housing instability but were not “known” to the VA and therefore not receiving services to address their housing needs. The second objective was to connect Veterans with needed services, particularly those provided through Supportive Services for Veteran Families (SSVF), a rapid rehousing program established around the same time that the HSCR was first deployed.

### *What the HCSR tells us about the prevalence of housing instability*

Since the institution of the HSCR, several operations and research studies have been conducted to better understand the prevalence of housing instability among Veterans who are accessing VA outpatient care, sociodemographic characteristics that may pose risk for housing instability among Veterans, the relationship between comorbid health conditions and housing instability, and the role of the HSCR in linking Veterans with services to address their housing instability.

One study assessed 5.8 million Veterans’ responses to the HSCR over a two-year period and found that experience of both current housing instability and imminent risk of housing instability are relatively rare events; less than one percent of Veterans screened reported currently experiencing housing instability (and only about two-thirds of those were living in a literally homeless situation) and about one percent reported risk.

## Prevalence & Risk of Housing Instability

- Among almost 5.8 million Veterans screened during FY 2013–2014
  - 0.8% reported current housing instability
  - 1.0% reported risk of housing instability
- Sociodemographic characteristics pose risk for housing instability
  - Late Baby Boomer birth cohort
  - Black/African American race
  - Unmarried
  - No service-connected disability

### *Risk factors for positive screens of housing instability or risk*

These studies have also identified both Veteran-level and contextual risk factors for a positive screen of current housing instability or risk. At the individual level, sociodemographic characteristics include middle to older age; identifying as Black or African American; reporting unmarried status (another social determinant of health); and not having a service-connected disability (often an indicator of lack of income, an additional social determinant of health). There is a significant positive relationship between a positive screen for housing instability and a Veteran having a diagnosis of post-traumatic stress disorder (PTSD), depression, psychosis, alcohol abuse, drug abuse, and previous suicide attempt or intentional self-harm.

In addition to Veteran-level risk factors, contextual factors are often associated with positive screens for housing instability. Specifically, Veterans who respond to the HSCR in mental health and substance abuse clinics have increased odds of screening positive, while those screened in rural environments have decreased odds of a positive screen.

### *Effectiveness of screening in linking Veterans to needed services*

Following several years of HSCR implementation, a mixed methods study was conducted to assess the effectiveness of the screener in linking Veterans to needed services; it used a combination of information from existing VA data sources and interviews with Veterans, clinicians, and homeless services providers.

Among 100,000 Veterans who screened positive for either current housing instability or risk between October 1, 2012 and September 30, 2015, approximately one third received a service from a VHA Homeless Program within 30 days. Veterans reporting currently experiencing housing instability—and reporting living in a non-permanent housing situation—have greater odds of accessing services compared with those reporting risk of housing instability or living in their own home. Veterans also have increased odds of receiving services if they request them and if they have previous experience with a VHA Homeless Program. This may be evidence of the importance of Veterans' proactiveness in accessing services as well as the perception that VHA Homeless Programs are helpful, based on their previous experiences. In addition, Veterans who are screened by behavioral health providers including social workers have greater odds of rapidly accessing services, likely due, at least in part, to these providers having a better sense of the services available to address Veterans' housing needs. Finally, Veterans with potentially lower levels of social support—demonstrated by unmarried status—and those with a history of mental health conditions and substance use disorders have greater odds of accessing services.

## Receipt of Post-Screening Services

- Approximately 1/3 of Veterans who screen positive for current or risk of housing instability receive services from VHA Homeless Programs within 30 days
- Veterans have greater odds of rapid services receipt if they
  - Screened positive for current housing instability
  - Were screened by a behavioral health provider or social worker
  - Indicated a desire to seek services
  - Previously participated in VHA Homeless Programs
  - Were living in a non-permanent housing situation
  - Were unmarried
  - Had evidence of prior suicide attempt or self-harm, alcohol use disorder, substance use disorder

### **Perspectives on screening for social determinants of health from three key stakeholders: Veterans, clinicians, and responders**

**Gala True, PhD**

To understand the process of screening and linking Veterans to services the study team conducted qualitative interviews with 60 Veterans who screened positive on the HSCR; 22 clinicians—physicians and nurse practitioners—who administered the HSCR; and 6 social workers or other staff who provided further assessment and services for Veterans who screen positive.

#### *Screening identifies a broader cohort of Veterans with housing needs*

Prior to the HSCR, most clinicians did not routinely assess housing instability as part of the Veteran's social history. Instead, inquiries about housing were prompted by other contextual disclosures and were often limited by providers' assumptions about who might be at risk. The HSCR identifies Veterans who would otherwise be missed by clinicians and VHA Homeless Program staff. Clinicians who administer the screen describe its utility for addressing an important social determinant of health and Veterans report that their understanding of the questions that comprise the HSCR are consistent with both physical (affordable, permanent, structurally and functionally adequate) and psychological (safe and comfortable) notions of "home."

#### *Challenges to screening process*

Interviews revealed a "clinical reminder burden," especially among physicians in primary care settings, and a lack of training in administering the HSCR. Physicians reported not knowing about services that are available and not enough follow up about what happens after a referral is made. In general, physicians felt they were not in the best position to do the screening; in fact, the study found that linkage with post-screening services was higher among Veterans screened by other providers. Many Veterans did not recall being asked questions, while others reported raised expectations about receipt of services.

### Discord between screening and policy

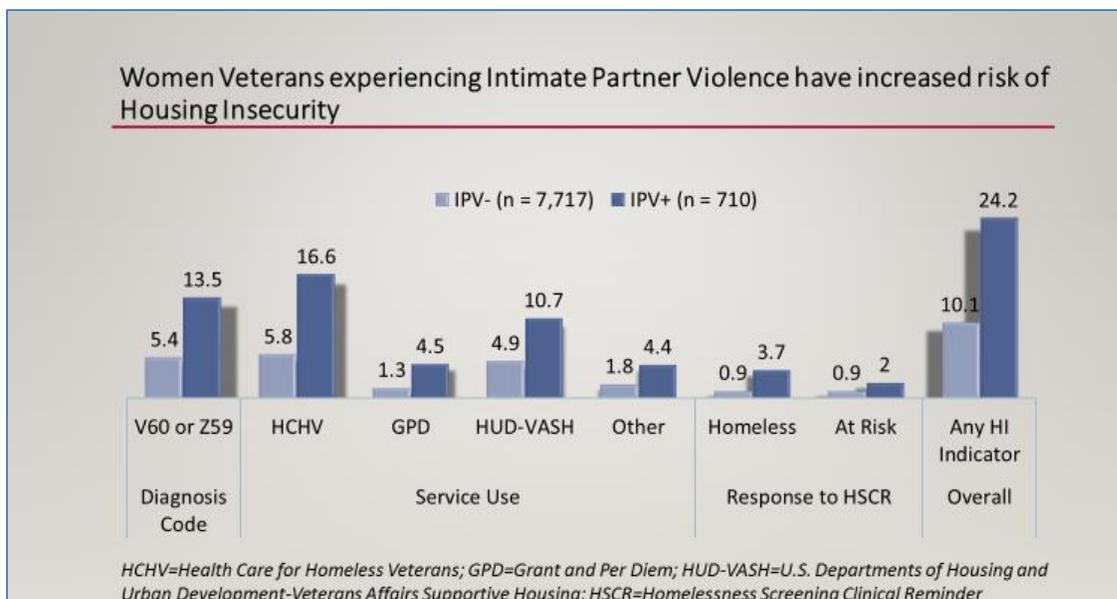
Providers, social workers, and Veterans described a disconnect between housing problems identified through screening and the definition of “homelessness” that guides provision of services. Each group expressed frustration with a lack of services for people who were about to be homeless but were not yet literally homeless. There is an inherent mismatch among Veterans’ needs, policies around eligibility for services, and availability of resources. This raises the question of how screening tools can keep up with changes in policy and programs.

## The intersection of social determinants of health: Case examples from Veterans screened for intimate partner violence and housing instability

Melissa Dichter, PhD

While Drs. Montgomery and True focused on what the HSCR studies tell us about homelessness and housing insecurity among Veteran outpatients in VHA and how this social determinant of health is associated with certain diagnoses and the likelihood of accessing needed services, Dr. Dichter provided a look at how multiple social determinants may interact. A case in point is the intersection of housing instability and intimate partner violence (IPV) experienced by women Veterans. Nearly one in four women Veterans who experienced recent IPV had an indicator of housing instability in their medical records during the six-month period following IPV screening. (3)

Personal safety-related concerns can impact help-seeking and service access. (4) For example, women experiencing intimate partner violence may need to conceal their attempts at help-seeking from their partner. They may not be able to ask for assistance in the presence of their partner (e.g., during a health care visit) or have concerns about documentation in a medical record. At the same time, abusive partners may directly interfere with service access by distancing the woman from social networks or disrupting transportation to appointments. It is also the case that women experiencing housing instability due to IPV may not believe that they fit the definition of homeless or are eligible for housing-related services. Finally, shame, stigma, and expectations of judgment related to experience of abuse can inhibit disclosure of abuse experience and related help-seeking. (5)



## Recommendations and Panel Discussion

The findings of Dr. Dichter's studies in combination with the HSCR work help to identify implications for practice and policy and raise questions for further exploration: How can we provide holistic care for intersecting social determinants of health? What do we need to consider when assessing and responding to social determinants of health? How do we bring VA's many support services for Veterans together? What lessons from housing insecurity screening can we apply to other social determinants of health?

Outlined below are recommendations for improving housing insecurity screening and response to risk, followed by comments from VHA leaders in VHA Homeless Programs, Patient Centered Care and Cultural Transformation, and the National Social Work Program on addressing social determinants of health in general within the VA health system.

### Recommendations for improving screening of and response to housing instability

#### *Recognize the full range of Veterans' vulnerabilities*

- Assess medical, mental health, substance use, and psychosocial needs when addressing social determinants of health
- Ensure that responses are sensitive to issues such as stage of life course, recent reintegration following military service, lack of social support, experience of trauma, and safety needs

#### *Respond to threats to housing stability*

- Provide connections to benefits and employment programs
- Increase financial literacy
- Provide legal assistance and landlord-tenant mediation

#### *Address inadequate housing through appropriate resources and services*

- Address housing affordability, permanence, and safety through VHA Homeless Programs such as Supportive Services for Veteran Families (SSVF) and U.S. Department of Housing and Urban Development (HUD)-VA Supportive Housing (VASH)
- Strive to create a "home" for Veterans that reflects their understanding of housing stability as encompassing affordability, permanence, comfort and safety, and structural and functional adequacy
- Remove barriers, such as lack of awareness of services, and address challenges to navigating resources by encouraging relationships with staff and improving processes to access services

#### *Improve screening and referral process*

- Provide updated training and information on appropriate referral follow-up and available services to clinicians
- Develop consult package/toolkit, including education for Veterans
- Utilize a team-based approach to care, shifting responsibility for screening to team members who may be better equipped to respond to positive screens
- Enhance social work services in primary care and mental health through embedded or co-located social workers, increased numbers of social workers, and/or a seamless referral process

#### *Facilitate provision of Veteran-centered services in homeless programs*

- Offer supports such as transportation subsidies and phones

- Incorporate trauma-informed care into services

### *Conduct further research*

- Investigate the factors that create risk for housing instability—and thereby pose risk for poor health outcomes—that can be intervened upon, such as poverty, employment status, or a recent and dramatic change in either, as well as other life changes such as health problems, release from incarceration, and the ending of a relationship that may have been supportive both financially and socially

## **Considerations for incorporating social determinants of health into clinical assessment and care planning**

The roundtable discussion, moderated by Dr. Roger Casey, featured leaders from the VA offices of Homeless Programs, Patient Centered Care and Cultural Transformation, and Social Work.

### *VHA has an important role to play in assessing and responding to social determinants of health*

According to Laura Taylor, Director of Social Work, it is VHA's responsibility to care for the whole person and to consider the Veteran in his or her environment and community when making treatment decisions. This would include consideration of the various conditions and experiences Veterans bring to the table when they have health concerns. VHA is uniquely qualified to do this through a social work response, which would focus on coordinating care, promoting Veteran's wellbeing, and helping meet their basic needs.

### *VHA should strive to integrate social determinants of health into a Veteran-centered "whole health" approach that promotes collaboration and informed care planning*

Dr. Tracy Gaudet, Executive Director of the National Office of Patient Centered Care and Cultural Transformation, maintained that VA has tremendous resources but faces the challenge of fragmentation. The whole health system model initiated by VA in 2012 strives to counteract the tendency to divide care into silos. It is a Veteran-driven strategy that shifts from a focus on episodic, disease management to an engagement with Veterans that considers the full range of physical, emotional, mental, social, spiritual, and environmental influences in their lives. The mechanism employed is a personal health plan developed by Veterans in partnership with their peers, which then follows them through their various encounters in the health system.

Monica Diaz, Executive Director of Homeless Programs, pointed out that the Homeless Programs Office (HPO) uses case managers to integrate services across its programs. HPO strives to be Veteran-centric in all that it does and to provide holistic services, which requires a team approach and flexibility where the system and structure of services need to support and sustain a whole health approach.

### *VHA must take steps to reduce the provider and patient burden as well as the piecemeal problem-solving that can arise with the ongoing expansion of screening tools and clinical reminders*

Dr. Gaudet suggested taking a systems approach to using screening tools and clinical reminders that would eliminate redundancy and integrate and align the elements that remain. "When we create reminders in their silos, we have failed the field."

***VHA should increase efforts to respond in a holistic way to co-occurring experiences, such as homelessness, unemployment, legal problems, or surviving violence, rather than addressing each experience in a silo***

“Treat every Veteran you’re serving as if they were a family member and you won’t go wrong,” said Ms. Taylor. VA has many good programs that can be helpful. The challenge is to maintain the integrity and scope of a program while keeping the Veteran at the center. One of the ways this can be accomplished is to pay attention to the language used in the program, to make sure that it is Veteran focused. For example, the Intimate Partner Violence Assistance Program refers to Veterans experiencing IPV, rather than battered women.

***VHA can play an important role in turning housing into a home by addressing the need for comfort and safety***

Ms. Diaz emphasized the importance of establishing partnerships and collaboration at all levels: federal, state, and local. “We can’t do this alone.” VA has entered into various partnerships to ensure that Veterans who move into permanent housing through HUD-VASH have furniture, household items, and other necessities. Partners include Military Outreach USA, PENFED Foundation, and the Veterans Matter Program. What is also critical is “how we interact with and take the Veteran through the process” so that they “feel that we are part of that home and the process.” Personal involvement matters; it’s not just the items we help them obtain.

## References

1. World Health Organization. *Social Determinants of health*. Retrieved from [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)
2. Institute of Medicine. (2014). *Capturing Social and Behavioral Domains in Electronic Health Records: Phase 1*. Washington, DC: National Academies Press.
3. Montgomery, A. E., Sorrentino, A. E., Cusack, M. C., Bellamy, S. L., Medvedeva, E., Roberts, C. B., & Dichter, M. E. (2018). Recent intimate partner violence and housing instability among women veterans. *American journal of preventive medicine*, 54(4), 584-590.
4. Yu, B., Montgomery, A. E., True, G., Cusack, M., Sorrentino, A., Chhabra, M., & Dichter, M. E. (in press). The intersection of interpersonal violence and housing instability: Perspectives from women veterans. *American Journal of Orthopsychiatry*.
5. Dichter, M. E., Wagner, C., Goldberg, E. B., & Iverson, K. M. (2015). Intimate partner violence detection and care in the Veterans Health Administration: patient and provider perspectives. *Women's health issues*, 25(5), 555-560.

## Participant Biographies



**John R. Blosnich**, PhD, MPH is a Research Health Scientist with the Center for Health Equity Research and Promotion at the U.S. Department of Veterans Affairs VA Pittsburgh Healthcare System, an Assistant Professor with the West Virginia University Injury Control Research Center, and an Assistant Professor in the Division of General Internal Medicine at the University of Pittsburgh. His areas of expertise include interpersonal and self-directed violence among lesbian, gay, bisexual, and transgender (LGBT) individuals, with specific attention to ways that data about social determinants of health (e.g., violence, homelessness, poverty, legal problems) can be integrated into adaptive health care systems.



**Roger Casey**, PhD, LSCW is the Director of Education and Dissemination for VA's National Center on Homelessness among Veterans. He has worked with VA homeless programs since 1986, providing direct services, implementing national pilot programs, and developing research initiatives regarding practice-informed residential treatment, housing, and case management design models.



**Monica Diaz**, MBA is the Executive Director of Homeless Programs in the Veterans Health Administration. Prior to assuming this role, she was a governor's appointee for the California Department of Veterans Affairs, where she oversaw programs and services from 2012 to 2018 at the largest Veterans home in the nation, Yountville Veterans Home, which serves Veterans from all walks of life, including the elderly, individuals with disabilities, and people experiencing homelessness. Ms. Diaz is a native of Puerto Rico and the spouse of an Air Force Veteran. She earned a bachelor's degree in forensic psychology and a Master's degree in healthcare management administration.



**Melissa Dichter**, PhD, MSW is a Core Investigator at the VA Center for Health Equity Research and Promotion (CHERP) and Assistant Professor at the University of Pennsylvania Perelman School of Medicine, Department of Family Medicine and Community Health. Dr. Dichter's research focuses on social determinants of health, with specific attention to intimate partner violence and healthcare system response. She has published extensively on social determinants of health among women Veterans, including addressing experiences of housing instability and intimate partner and sexual violence.



**Tracy Gaudet**, MD is the Executive Director of the VHA National Office of Patient Centered Care and Cultural Transformation. This office is leading VA’s transformation to Whole Health, a redesign of health care to empower people to take charge of their health. Dr. Gaudet previously served as Executive Director of Duke Integrative Medicine and was the founding Executive Director of the University of Arizona Program in Integrative Medicine. She is Board Certified in Obstetrics and Gynecology. Dr Gaudet also co-founded the Academic Consortium for Integrative Health. A recognized leader in the transformation of health care, Dr. Gaudet was featured on the PBS special “The New Medicine;” honored as one of the “Top 25 Women in Healthcare 2011” by Modern Healthcare; featured as a Game Changer in Fortune Magazine; and selected as the recipient of the Bravewell Leadership Award for her significant contributions to advancing the field of medicine.



**Ann Elizabeth Montgomery**, PhD is a researcher with the VA National Center on Homelessness among Veterans; a Health Science Specialist with Birmingham VAMC Health Services Research & Development; and an Assistant Professor at the University of Alabama at Birmingham, School of Public Health, Department of Health Behavior. Her work—including research, evaluation, and policy analysis—informs programs and policies at the national level and focuses on several substantive areas, including identifying homelessness and risk among Veterans seeking healthcare, assessing interventions intended to mitigate this risk, and studying vulnerable populations and related health disparities.



**Laura Taylor**, LCSW is the National Director of Social Work in the Veterans Health Administration, where she serves as the principal advisor on Social Work Professional Practice, including providing guidance to the Chief Consultant, Care Management and Social Work, as well as Network and Medical Center Directors, other Patient Care Services program offices, and VA and VHA offices. Ms. Taylor is responsible for the professional practice of 13,000 Masters-prepared VHA social workers, the largest single employer of social workers in the U.S. Ms. Taylor provides orientation to the role of social work executive and oversees the graduate social work training program, with over 900 stipends, the largest social work training program nationwide. Ms. Taylor develops national policy for professional social work for VA Central Office, VISN and medical center leaders. In addition, she provides guidance and consultation on social work practice within VHA.



**Gala True**, PhD is an Investigator with the South Central Mental Illness Research, Education, and Clinical Center (MIRECC) at the Southeast Louisiana Veterans Health Care System (SLVCHS) and Associate Professor of Community and Population Medicine at LSU School of Medicine. With a background in anthropology, her work focuses on improving access to care and the health of individuals and communities through patient-centered and community-engaged research approaches. Her most recent research employs participatory action research methods to collaborate with Veterans and other key stakeholders on identifying barriers to post-deployment care and proposing solutions for improving community reintegration after separation from military service.