

BUILDING PRIMARY CARE MEDICAL HOMES FOR HOMELESS VETERANS: A CASE STUDY OF THREE VA FACILITIES



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VA PACT Cyberseminar: November 20, 2013

Agenda

- Homeless adults and primary care
- Homeless Patient-Aligned Care Teams (HPACTs)
- Case study of three HPACTs
 - Clinic structures
 - Patient characteristics
 - Utilization patterns
- Conclusions and Implications



POLL QUESTION

Which of the following best describes your work with homeless Veterans?

- 1) I am a clinician who sees homeless Veterans in practice.
- 2) I am a researcher who studies homeless Veterans.
- 3) I am a policymaker/administrator involved in services for homeless Veterans.
- 4) I work with homeless Veterans in some other capacity.
- 5) I do not work with homeless Veterans.

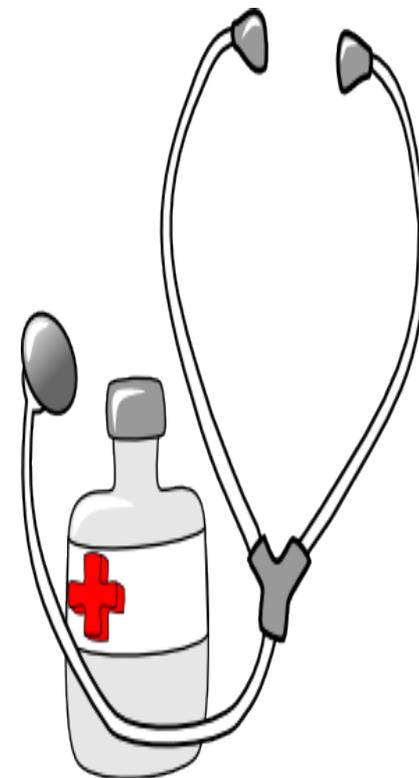
The VA aims to end Veteran homelessness



- On a single night in 2012, 62,619 Veterans were homeless (*13% of all homeless adults*)
- Veterans may be at higher risk for becoming homeless than the civilian population
 - Combat exposure, military sexual trauma
- Homeless Veterans are a vulnerable population
 - High rates of medical/mental illness, alcohol, tobacco, and other drug (ATOD) use
 - Fragmented health and social services
 - Age-adjusted mortality is 2-10 times that of housed peers

Little is known about best practices in homeless-focused primary care

- Primary care needs are complicated by poor social support and competing priorities
- Co-located VA primary care, mental health, and homeless services in Los Angeles, CA
 - Higher rates of primary and preventive care
- Homeless-focused VA primary care in Providence, RI
 - Greater improvements in chronic disease outcomes compared to a historical cohort of homeless Veterans in traditional VA primary care clinics
 - Fewer non-acute Emergency Department and inpatient admissions for general medical conditions

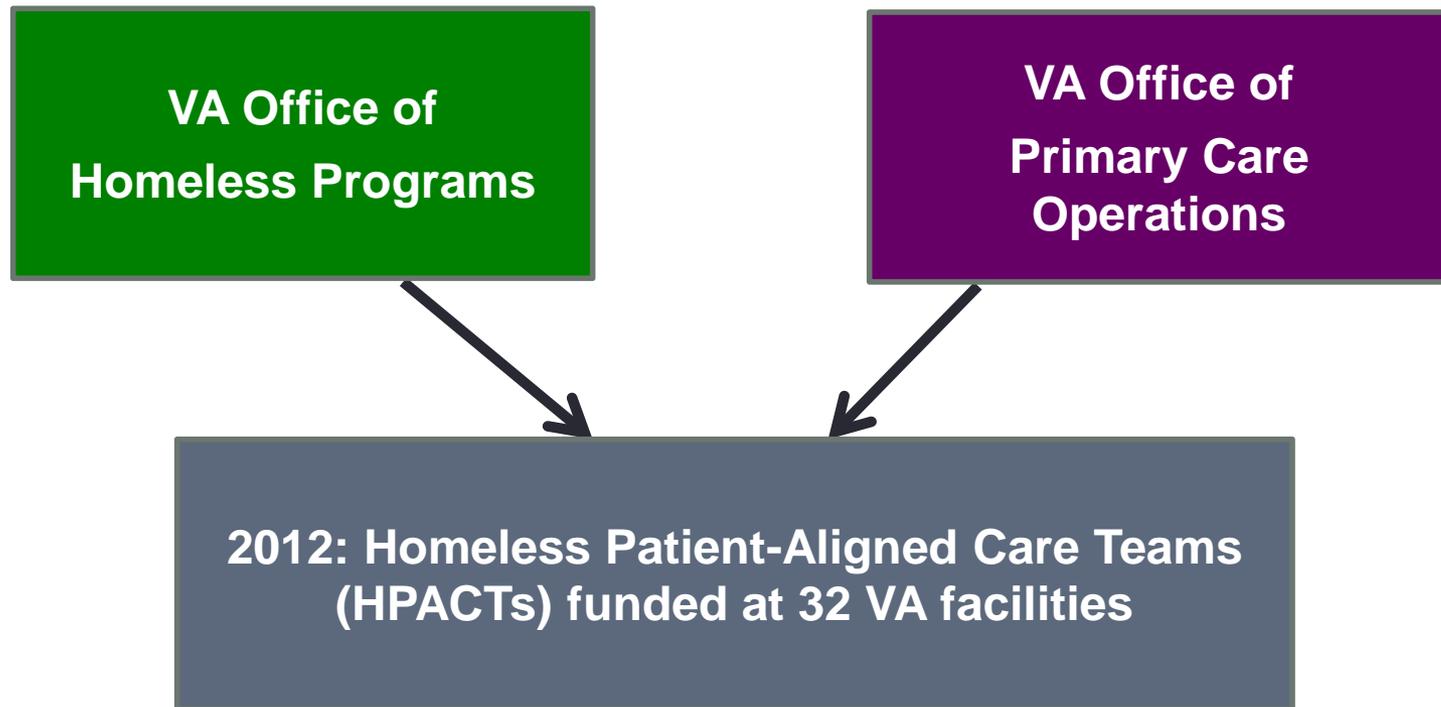


McGuire J, et al. Access to Primary Care for Homeless Veterans with Serious Mental Illness or Substance Abuse: A Follow-up Evaluation of Co-Located Primary Care and Homeless Social Services. *Adm Policy Ment Health*. 2009.

O'Toole TP, et al. Applying the chronic care model to homeless veterans: effect of a population approach to primary care on utilization and clinical outcomes. *Am J Public Health*. 2010.

The VA lacked a homeless-focused primary care initiative

- The Health Care for Homeless Veterans (HCHV) program already offered a host of services for homeless Veterans



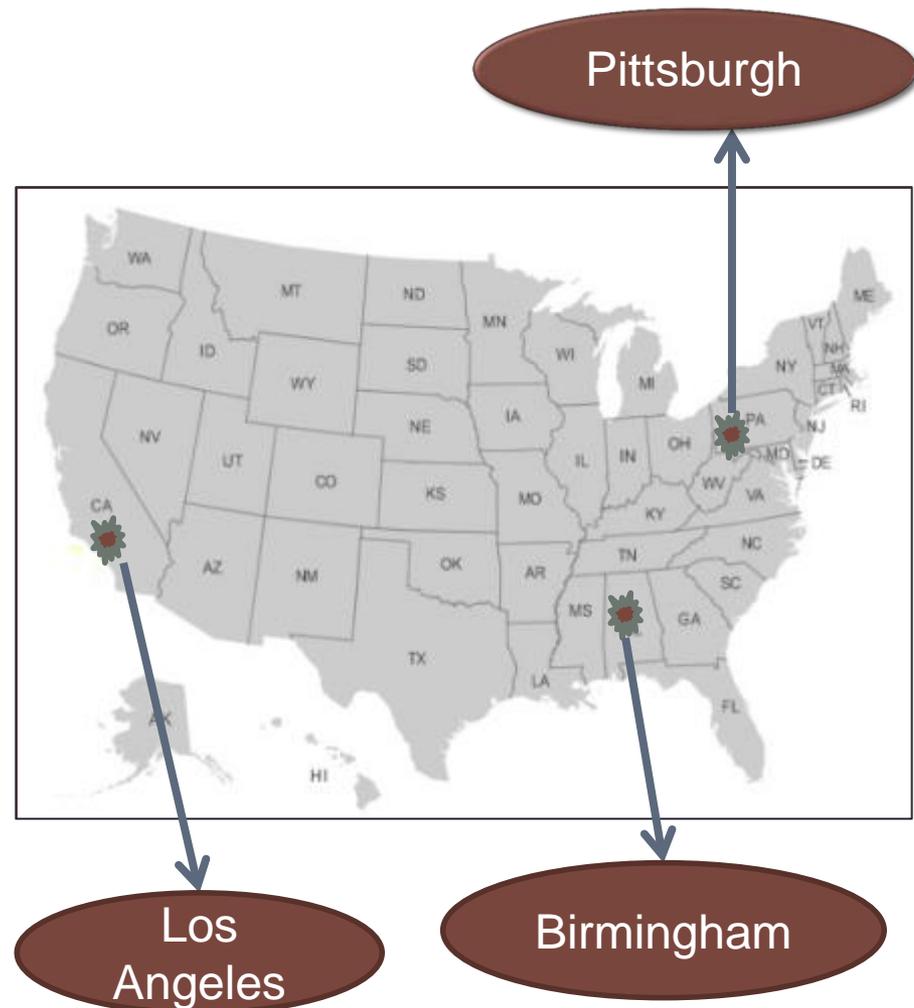
HPACTs are patient-centered medical homes for homeless Veterans

- Three features guided HPACT implementation nationwide:
 - Tailor clinical/social services to homeless Veterans
 - Establish processes to identify/refer appropriate Veterans
 - Integrate distinct services
- New programs must fit local contextual factors
 - Space, personnel, infrastructure, institutional/community resources
- Different models of homeless-focused primary care evolved nationwide

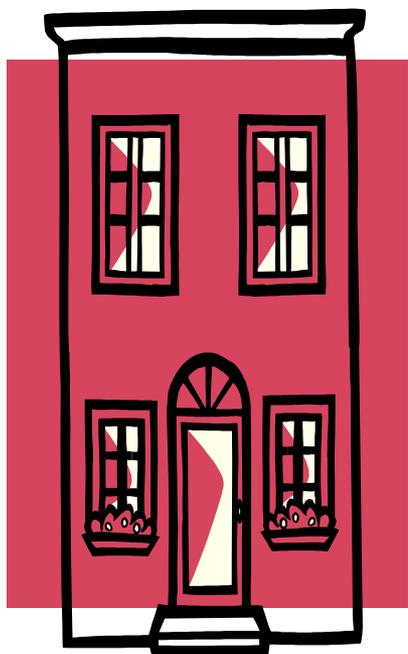
Each new HPACT affords an opportunity to explore how variations in initial service design may influence the types of patients seen and services delivered

Case study of three newly implemented HPACTs

- Convenience sample of HPACTs with contrasting clinic structures and geographic diversity
- Compared demographic, housing, medical, and health service utilization of initial patient cohorts
- Aimed to facilitate HPACT quality improvement and add to the paucity of literature about homeless-focused primary care



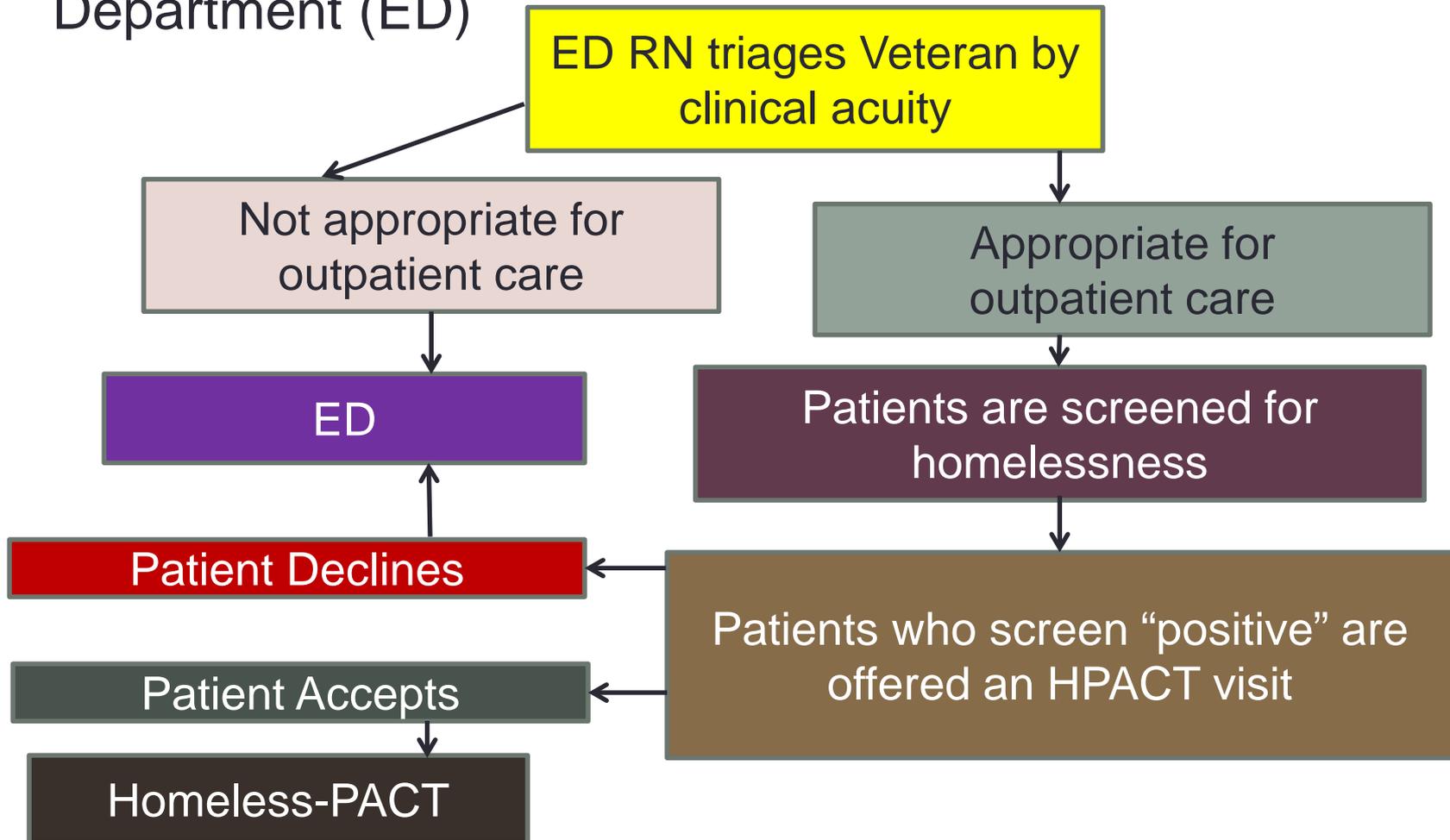
Methods



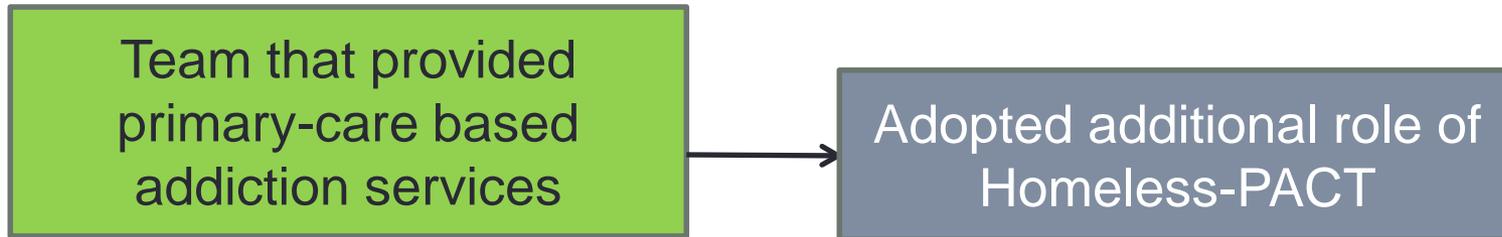
- Clinic Structures
 - Authors at each site independently developed a list of organizational domains by which to describe HPACTs, along the 3 guiding principles
- Patient Characteristics (enrolled in HPACTs from 4/30/12 – 9/30/12) abstracted from the electronic medical record
 - Baseline data: demographics, housing status, diagnostic information, VA healthcare utilization
 - After 6 months: housing status and VA healthcare utilization

HPACT Clinic Structure: Los Angeles

- Evening clinic, co-located with the Emergency Department (ED)



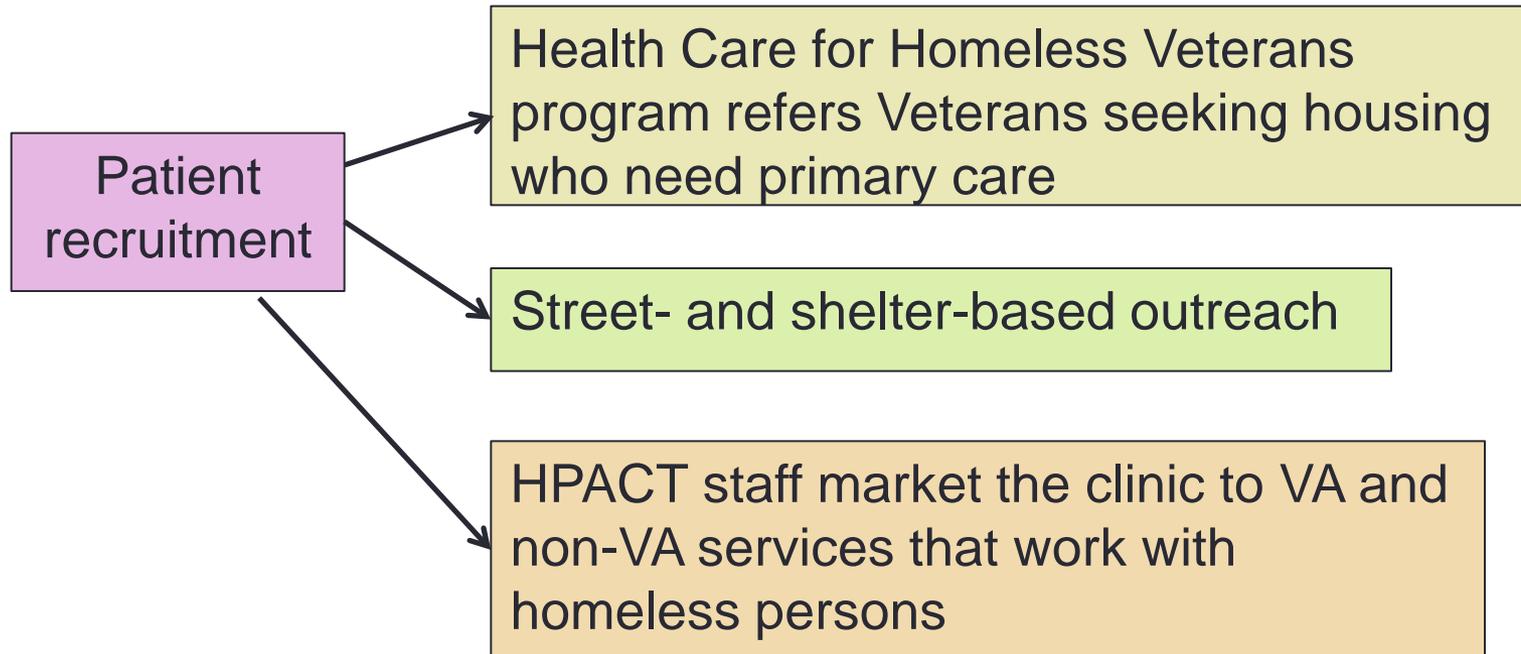
HPACT Clinic Structure: Pittsburgh



- The existing addiction-focused primary care team referred empanelled Veterans who were homeless or at-risk for homelessness
- Other VA providers referred Veterans who were homeless or at-risk for homelessness who did not have a primary care provider

HPACT Clinic Structure: Birmingham

- New homeless-focused team physically located within a traditional VA primary care clinic



Additional Clinic Characteristics

- All clinics employed a mix of open-access (drop-in) and scheduled appointments
- Across sites, primary care providers (PCPs) were chosen for their expertise in homeless populations

	Los Angeles	Pittsburgh	Birmingham
Mental Health	<ul style="list-style-type: none"> • Mental health clinical nurse specialist on team 	<ul style="list-style-type: none"> • PCPs with addiction expertise and buprenorphine certification 	<ul style="list-style-type: none"> • Psychiatrist within HPACT
and			
Alcohol, Tobacco, and Other Drug (ATOD) Services	<ul style="list-style-type: none"> • Specialty care referrals 	<ul style="list-style-type: none"> • Specialty care referrals 	<ul style="list-style-type: none"> • Specialty care referrals

Demographics

	Los Angeles (n = 47)	Pittsburgh (n = 43)	Birmingham (n = 35)
Males	94%	95%	94%
Age (mean)	53 years	53 years	52 years
White	49%	53%	34%
African American	45%	42%	66%
Hispanic	17%	0%	2%
Other or Unknown	4%	5%	0%

Housing Status (Baseline → 6 months)

	Los Angeles (n = 47)	Pittsburgh (n = 43)	Birmingham (n = 35)
Unsheltered Homeless	26% → 9%	2% → 2%	6% → 6%
Sheltered Homeless	68% → 85%	72% → 77%	88% → 77%
Housed	6% → 6%	26% → 21%	6% → 17%

- Los Angeles had high numbers of unsheltered homeless patients, many became sheltered homeless patients
- Pittsburgh had many patients at-risk for homelessness who lost their housing but obtained other shelter
- Birmingham saw gains in the number of housed patients

Selected Chronic Medical Conditions



	Los Angeles (n = 47)	Pittsburgh (n = 43)	Birmingham (n = 35)
Chronic Pain	30%	12%	51%
Diabetes	20%	5%	20%
Dyslipidemia	29%	9%	29%
Hepatitis C	17%	33%	17%
Hypertension	46%	51%	46%

Selected Mental Health and ATOD Diagnoses

	Los Angeles (n = 47)	Pittsburgh (n = 43)	Birmingham (n = 35)
Mood disorders	55%	42%	49%
Psychotic disorders	19%	7%	0%
Alcohol use disorder	35%	44%	60%
Cocaine use disorder	19%	23%	37%
Opioid use disorder	6%	21%	9%



VA Healthcare Utilization (6 Months Before HPACT → First 6 Months of HPACT)

	Los Angeles (n = 47)	Pittsburgh (n = 43)	Birmingham (n = 35)
Emergency Department / Urgent Care	62% → 70%	47% → 26%	46% → 29%
Mental health medication management	39% → 56%	56% → 64%	60% → 60%
ATOD treatment	9% → 37%	47% → 19%	34% → 34%

- At Pittsburgh and Birmingham there was a decrease in ED/Urgent Care use
- At Los Angeles and Pittsburgh, more patients grew engaged in mental health care

Limitations



- Limited longitudinal outcome data on a small sample size (ongoing)
- Reliance on VA medical record review
- Differences in community context (available non-VA resources, size of homeless population) are important but not included in this initial exploration of data

Conclusions

- Contrasting organizational structures were reflected in patient characteristics and changes in housing/VA health service use

Los Angeles	<ul style="list-style-type: none">• Co-located with Emergency Department (ED)• Highest rates of unsheltered patients, persons with psychotic disorders, prior ED use• Many patients became sheltered and engaged in substance abuse/mental health care
Pittsburgh	<ul style="list-style-type: none">• Grew from an addiction-focused team• Highest rates of opioid use disorder, Hepatitis C• Saw decrease in ED use• When patients lost housing, they stayed sheltered
Birmingham	<ul style="list-style-type: none">• Employed community-based outreach• Highest number of patients from emergency shelters• Many patients became housed and used the ED less

Acknowledgements

- Special thanks to the many dedicated HPACT clinicians and support staff at Los Angeles, Pittsburgh, and Birmingham
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Women Veterans' Experience With Intimate Partner Violence

Melissa E. Dichter, PhD, MSW
Center for Health Equity Research and Promotion
Philadelphia VA Medical Center

HSR&D Cyber Seminar
November 20, 2013

Funding: CEPACT #12-005; HSR&D CDA #10-202



Earlier cyber seminars addressing IPV (SoWH)

The Complex Dynamics of Intimate Partner Violence in the Lives of Veterans

April Gerlock, 11/17/2011

Intimate Partner Violence: An Overview for the VA Clinician

Megan Gerber, 11/27/2012

Clinical Utility of an Intimate Partner Violence Screening Tool for Female VA Patients

Kate Iverson, 2/13/2013

All available at: <http://www.hsrd.research.va.gov/cyberseminars/catalog-search.cfm>

Poll Question #1

How knowledgeable do you feel you are about IPV?

- I am an expert in this area
- I have extensive knowledge in this area but am not an expert
- I have a pretty good awareness of the issues
- I know a little bit about IPV
- I do not know much about IPV
- I do not know anything about IPV

Background: Intimate partner violence (IPV)

- IPV includes:
 - **Physical** violence (hitting, punching, stabbing)
 - **Psychological** violence (threatening, belittling)
 - **Social** violence (isolating, alienating, economically restricting)
 - **Sexual** violence (forced or coerced sexual behavior)
 - **Stalking** or **harassment** (following, spying, sending repeated unwanted messages, refusing to stay away)
- IPV can be perpetrated by a *current or former* romantic or sexual partner
- **More than 1 in 3 women in the United States** experience physical violence, rape, or stalking by an intimate partner in their lifetimes; women Veterans are at particular risk
- IPV is a major source of **morbidity** and **mortality** for women and is associated with:
 - A wide variety of acute and chronic physical and mental health problems
 - Social/economic impacts (financial insecurity, homelessness, unemployment)
 - Social/health risks (suicide/suicidal ideation, homicide, substance misuse, unplanned pregnancies)

“IPV assessment and response within the PACT model: Needs, barriers, and opportunities”

Funding: VISN 4 Center for Evaluation of Patient Aligned Care Teams (CEPACT 12-005)

Aims

- 1) To identify the scope of IPV experiences, and associated healthcare needs, among women Veterans receiving VHA care
- 2) To identify the opportunities and options for IPV assessment and care in the VHA setting under the PACT model

Methods

- Phase I: face-to-face surveys with women Veteran patients at Philadelphia VA Medical Center (N = 249)
- Phase II: face-to-face qualitative interviews with 10% of Phase I participants (N = 25)
- Phase III: telephone qualitative interviews with VISN 4 clinicians (PCPs, GYNs, WVPMs, MST Coordinators, MH providers, SWs)

Sample demographics – patients

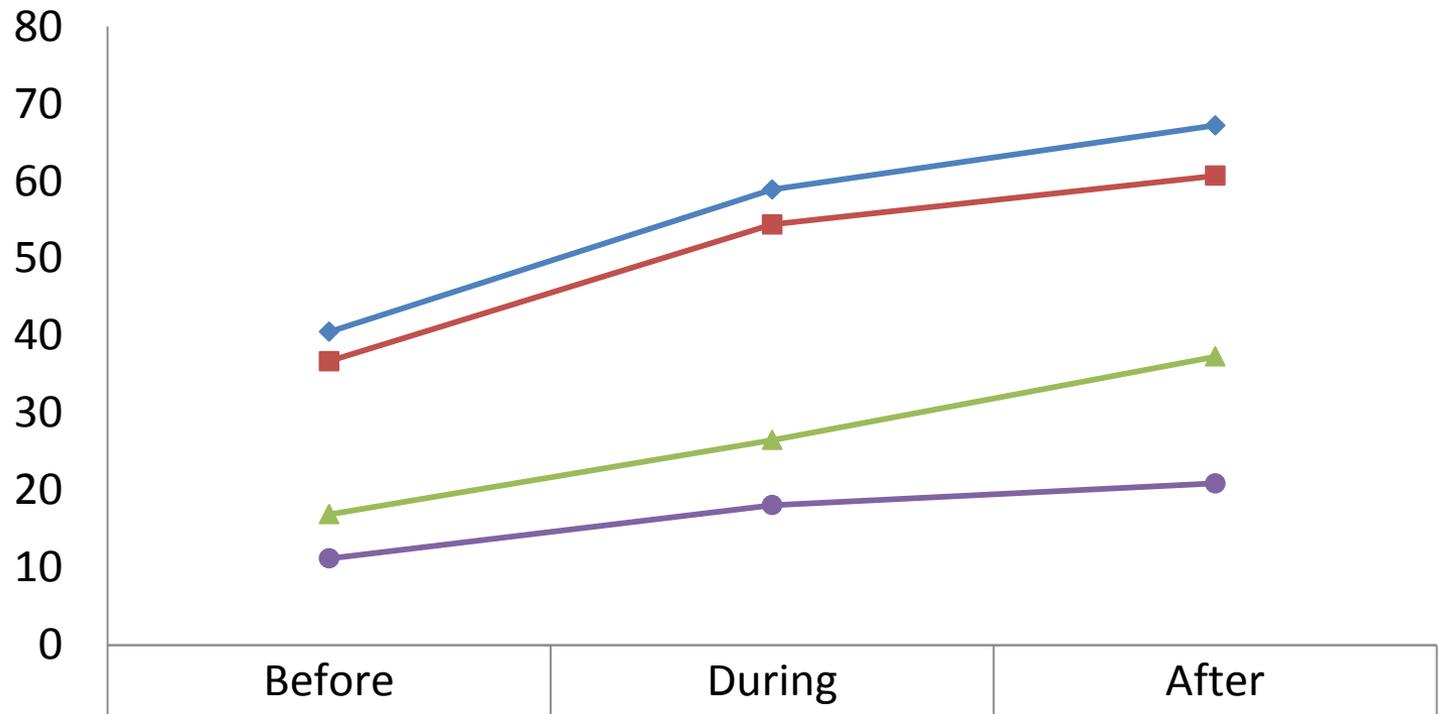
Demographic Characteristics		Survey (Phase I) (N = 249)	Interview (Phase II) (N = 25)
Age: Range (Mean)		22-64 (46.6)	22-58 (42.8)
Race/Ethnicity: %	Black/African American	69.4	54.2
	White/Caucasian	13.3	19.0
	Hispanic/Latina	8.1	19.0
	Other/Mixed	9.3	9.5
Education: %	No College	19.0	23.8
	Some College (No Degree)	37.9	38.1
	Associates or Bachelors Degree	43.1	38.1
Employment: %	Full-time	23.3	14.3
	Part-time	14.9	14.3
	Not Employed	61.8	71.4
Financial Situation: %	Can't make ends meet	29.8	33.3
	Have just enough to get by	46.4	52.4
	Are comfortable	23.8	14.3

IPV Experience (%)

	Lifetime	Past 12 Months
Any IPV	85.9	39.4
Psychological <i>partner insulted, swore, shouted, or yelled at me, or destroyed something belonging to me or threatened to hit me</i>	81.9	38.1
Physical <i>partner pushed, shoved, slapped, punched, kicked, or beat-me-up</i>	57.4	9.6
Sexual <i>partner insisted on sex when I did not want to, insisted on sex without a condom, or used force to make me have sex</i>	34.7	8.1

*IPV questions taken from CTS2S (Straus & Douglas, 2004)

Timing of IPV Experience Relative to Military Service



	Before	During	After
Any	40.5	58.9	67.2
Psychological	36.7	54.4	60.7
Physical	16.9	26.5	37.3
Sexual	11.2	18.1	20.9

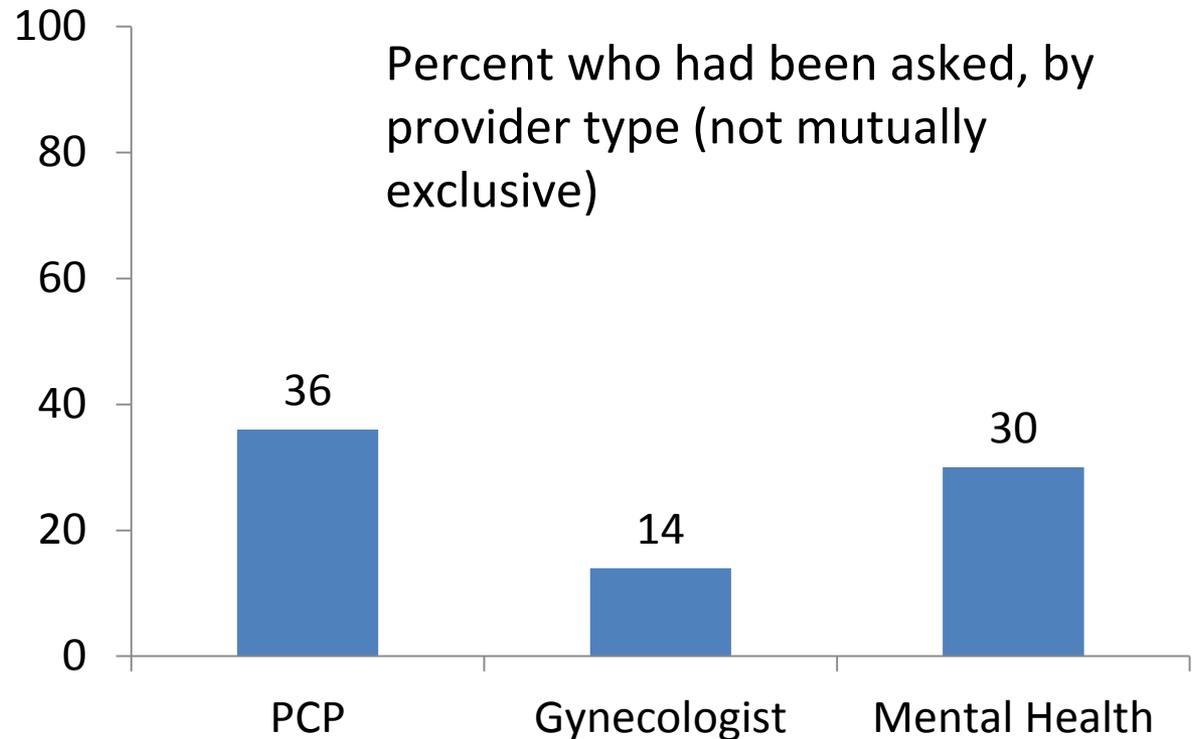
Poll Question #2

For clinicians (current or former), have you ever asked a patient about experiences with IPV?

- Yes, I routinely screen patients for experience of IPV
- Yes, I have asked patients about IPV but do not routinely screen
- No, I have never asked a patient about IPV
- I have never worked as a clinician

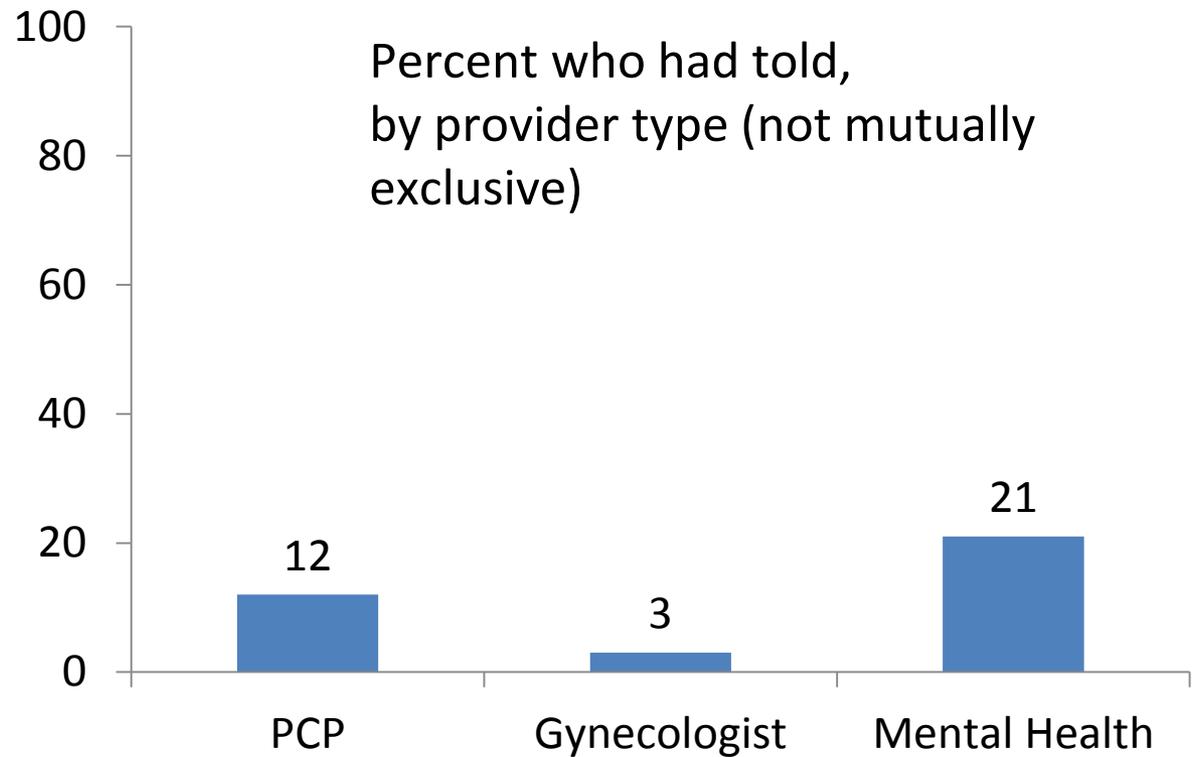
Has a healthcare provider ever *asked* you about safety, violence, or stress in your relationship or with an intimate partner?

Yes: 55%
No: 45%



Have you ever *told* a healthcare provider about violence or safety concerns you were having in an intimate relationship?

Yes: 27%
No: 73%



Do you feel that healthcare providers *should* ask about safety, violence, or stress in intimate relationships?

Yes: 83%

No: 6%

Not Sure / Don't Know / Depends: 11%

- Reason for visit
- Patient signs of violence or abuse (“red flags”)
- Patient-provider relationship, provider sensitivity

ASKING AND DISCLOSING: PATIENT AND PROVIDER PERSPECTIVES

Ask!

Asking facilitates disclosure

No one ever asked me about it. You know, I was walking around with a black eye and not a single question. So I may have talked about it if I had been given the chance, but I wasn't going to bring it up on my own.

Ask again!

Patients may not be ready to disclose the first (or second) time they are asked

I said “no” because I didn’t feel like talking about it. At that time, I wasn’t ready to talk about it or get in to it with anybody. There were a lot of things I didn’t tell her when I first started seeing her. But once you get to know a person and you know the doctor, you can start opening up and saying different stuff.

What I always feel is that by asking the questions each time, that the patient will know that this is a safe environment in which they can discuss these types of things. And they may not do it the first five times, but they might do it the sixth time.

Make it safe to disclose

Decisions to disclose may depend on comfort with provider

If you feel comfortable with your doctors, you can pretty much talk to them about anything. But if you don't feel comfortable with a certain doctor that you have, you'll never tell them anything.

I've had people disclose to me and they said they've never told anybody else. And if I look back and say, "Why is that?" I think it's because they know I'm listening.

Even if a patient doesn't disclose...

Asking shows you care

It's nice that somebody actually cares about stuff other than your blood pressure.

If you're not ready to tell, but you see that question, you know that they care and they're interested, and they may be able to help. It's like a signal that this is something we care about here.

Benefits of disclosure

Disclosure, itself, may be a therapeutic intervention

If I could have spilled my beans a long time ago when I started coming here, I definitely would have, and I think that would have made me feel so much better. Just to be able to talk, it probably would have prevented me from, you know, wanting to harm myself, if I felt like I had somebody to talk to. And I know I guess they're busy and they got to hurry up and see us and hurry up and get us out, but just that little talk, just the, you know – to speak with someone, it helps. It goes a long way.

RESPONDING TO DISCLOSURE: PROVIDER PERSPECTIVES ON THE VHA/PACT MODEL

What to do when they say “yes”?

I think the scariest thing is, if I ask the question, she says ‘yes’ and then we don’t have anything to offer her, well, how horrible is that for both of us?

You know, there’s not really back-up systems in place if somebody is seeing their primary care provider and they disclose, “Yes, my boyfriend is actively beating me up,” you know, do they have somebody to call? Do they have resources at their fingertips to say, “Hey, help me with figuring out what to do here”? Do they know resources within the VA who they can call and send them to? I don’t know.

VA-specific considerations: Barriers

- Policies of permitting family members/others in exam rooms
- Concern about attributing PTSD/other conditions to non-military IPV (C&P exams)
- Utilization of community-based services

In the private sector you're kind-of in the community so you're referring naturally into the community immediately. But in VA, you know, we kind-of only refer to ourselves. There are several restrictions, or bureaucracy. Getting through that sometimes can be a mine field. You know, and then we may lose that opportunity to effect change for that female that has expressed the need or at least showed us that she has a need.

Opportunities with the PACT model

- Holistic, patient-centered care
- Team-based approach
 - Strength: availability of SW and MH
 - Potential limitation: less confidentiality for the patient (multiple team members)

A good social worker or a well-trained RN, at that level of their license, should be able to more effectively either talk to [the patients] about a screening or to really do some in-depth counseling work with them. So the social worker perhaps more on the counseling intervention side, or, you know, a good RN with good training can do more of a little bit of an in-depth screening.”

- Integration of care

Conclusions

- WV VHA patients experience high rates of IPV – before, during, and after military service
- Healthcare providers can help patients through asking about IPV and connecting patients with services
- Inquiry about IPV should be repeated and conducted in a sensitive manner, in a setting safe for a patient to disclose
- Resources, protocols, and education needed to support providers encountering patients who have experienced IPV
- The PACT model may be used to facilitate IPV inquiry and support

Reading and Resources

National survey data: Black, M., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey: 2010 summary report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Recent VA-based literature on experience of IPV

- Dichter, M. E., Cerulli, C., & Bossarte, R. M. (2011). Intimate partner violence victimization among women veterans and associated heart health risks. *Women's Health Issues, 21*, S190-S194.
- Dichter, M. E., & Marcus, S. C. (2013). Intimate partner violence victimization among women veterans: Health, healthcare services use, and opportunities for intervention. *Military Behavioral Health, 1*: 107-113.
- Dichter, M. E., True, J. G., Marcus, S. C., Gerlock, A. A., & Yano, E. M. (2013). Documentation of intimate partner violence in women veterans' medical records: An in-depth analysis. *Military Behavioral Health, 1*: 114-120.
- Iverson, K. M., King, M. W., Resick, P., Gerber, M. R., Kimerling, R., & Vogt, D. (2013). Clinical utility of an intimate partner violence screening tool for female VHA patients. *Journal of General Internal Medicine, 28*, 1288-1293.
- Iverson, K. M., Wells, S. Y., Wiltsey-Stirman, S., Vaughn, R., & Gerber, M. R. (2013). VHA primary care providers' perspectives on screening female veterans for intimate partner violence: A preliminary assessment. *Journal of Family Violence, 28*, 823-831.
- Latta, R. E., & Horner-Johnson, W. (2013). Violence in the veteran home: Risk factors and implications for clinical care. *Federal Practitioner: 10S-15S*.
- Sweeney, A. C., Weitlauf, J. C., Manning, E. A., Sze, J. A., Waldrop, A. E., & Hasser, C. (2013). Intimate partner violence: Perspectives on universal screening for women in VHA primary care. *Women's Health Issues, 23*: e73-e76.

Web-based resources

- IPV Screening and Counseling Toolkit from Futures without Violence: <http://www.healthcaresaboutipv.org>
- VA National Center for PTSD: <http://www.ptsd.va.gov/public/pages/domestic-violence.asp>
- VA Women's Health: <http://www.womenshealth.va.gov/WOMENSHEALTH/intimatepartnerviolence.asp>

National Domestic Violence Hotline: 800-799-SAFE

THANK YOU!

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