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Increasing Primary Care Engagement Among Homeless-Experienced Veterans Following an Emergency Department Visit: Qualitative Insights From Los Angeles County

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Abstract

Background: Homeless-experienced persons that present in the Emergency Department (ED) often fail to receive follow-up primary care. To inform implementation of a post-ED patient navigation model, we engaged homeless-experienced Veterans to identify barriers to primary care and the acceptability of a peer-led intervention within the ED. **Methods:** Between August and November 2023, 3 focus groups (n = 14) and 2 interviews were held (total n = 16) with homeless-experienced Veterans who sought care in the Department of Veterans Affairs' (VA) Greater Los Angeles (GLA) ED. We inquired about barriers to primary care post-ED visit, ways to improve connection, and the acceptability of a peer-led intervention. Fieldnotes were taken and coded using rapid qualitative methods. **Results:** Participants noted challenges receiving adequate information about and support connecting with primary care; challenges included lengthy appointment wait times, lack of knowledge regarding clinic walk-ins, and challenges with social needs. Recommendations for facilitating connection comprised support with patient navigation, including obtaining timely appointments, addressing social needs, and identifying healthcare priorities. Participants noted numerous benefits to having peers in the ED to assist with healthcare and resource connection. **Conclusions:** Data will inform future work to adapt and pilot a peer-led patient navigation model for homeless-experienced Veterans in VA GLA's ED.

Keywords

homeless, veterans, Emergency Department, primary care, care continuity, patient navigation, peers

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Homelessness is a growing concern in the United States, with over 650 000 people experiencing homelessness on a single night in 2023.[1] Homelessness, lacking a fixed, adequate nighttime residence (staying in a homeless shelter, ie, "sheltered homelessness" and on the streets or in places not intended for human habitation, ie, "unsheltered homelessness"), is associated with a range of physical and psychiatric conditions, and increased risk for all-cause mortality.[2-4] In addition to high health needs, people experiencing homelessness face numerous barriers accessing health care services,[5,6] and have high utilization of inpatient and emergency care.[7,8] People experiencing homelessness are 4 times more likely to use the Emergency Department (ED) than their housed peers.[5,6] Patients that do not engage with primary care following an ED visit are more likely to return to the ED and are at higher risk for adverse health events, including double the risk of 30-day post-discharge mortality.[9-11] However, accessing primary care can be difficult for people experiencing homelessness due to limited availability and fragmentation of health care services, difficulty scheduling and keeping appointments, social isolation, and competing social needs.[12,13]

Veterans are overrepresented among people experiencing homelessness in the United States,[14] and experience complex health challenges and elevated care needs.[15] To address barriers to care, the Department of Veterans Affairs (VA) implemented homeless-tailored primary care (ie, Homeless Patient Aligned Care Teams [HPACTs]) that

empanels homeless-experienced Veterans (HEVs) and offers service designs to mitigate access barriers and address salient social needs (eg, housing, transportation, and other basic needs).[16] HPACTs increase care access for HEVs through flexible scheduling (ie, extended hours, walk-in appointments); emphasize alignment between mental health and social services; provide onsite tangible supports (eg, food pantries); and offer smaller panel sizes enabling providers to dedicate greater time and resources to patients.[17] Once empaneled in HPACT, HEVs show greater use of primary care, improvements in housing stabilization, and better care experiences.[18,19] However, despite VA efforts to tailor primary care, many HEVs are not empaneled in care and fail to receive recommended follow-up post-ED visits, suggesting the need for additional targeted interventions.

Outside of VA, peer-led patient navigation has effectively reduced barriers to care and facilitated timely access to health care services following an ED visit.[20-22] Within VA, peer support specialists—Veterans with lived expertise in substance use and/or mental illness who are in recovery and trained to support Veterans with similar issues—are employed across a range of clinical settings and have been part of interventions to reduce the use of acute care among HEVs within the VA healthcare system.[23,24] However, these interventions have rarely focus on patient navigation or the challenges HEVs face connecting to primary care post-ED, and have not been based in the VA ED, a critical space to identify HEVs disconnected from primary care.[25,26] To inform future work to develop and pilot a peer-led patient navigation model, we conducted a case study at VA Greater Los Angeles (GLA) where we engaged HEVs to examine barriers to primary care connection post-ED visit and the acceptability of a peer-led intervention within VA GLA's ED.

Methods

Setting

This case study was conducted at VA GLA Healthcare System, which has VA's largest homeless program. In 2022, VA GLA documented 2110 ED visits by HEVs; 34% of patients were not empaneled in primary care, and only 5% were seen by a primary care provider within 30 days of ED discharge.[27]

Data Collection

Between August and November 2023, we conducted 3 focus groups (n = 14) and 2 interviews with HEVs who sought care in the VA GLA ED (total n = 16). Interviews were conducted with HEVs whose schedules did not permit participation in focus groups. Participants were recruited through VA GLA's on campus homeless programs, including transitional housing and residential treatment settings. Recruitment was done using flyers and through onsite announcements during community events in homeless services at VA GLA. To participate, individuals had to have a current or previous experience of homelessness and used the VA ED at least once in the 2 years prior to recruitment (August 1, 2021 to November 1, 2023). A review of participants' VA electronic health records (EHR) was conducted to verify eligibility. In addition to ED use, we abstracted participants' gender, age, race/ethnicity, and number of ED and primary care visits from January 1, 2022 to December 31, 2023, from the EHR.

Focus groups and interviews were semi-structured, conducted in person, and approximately 60-min. Focus groups and interviews inquired about barriers connecting with primary care post-ED, recommendations for addressing challenges to primary care follow-up, and the acceptability of a peer-led intervention based in the ED. Focus groups were facilitated by 2 authors (MC, KPS). In lieu of audio recordings, MC and EJ took detailed fieldnotes. Participants were compensated with $50 gift cards. This project was reviewed and approved by VA GLA's Institutional Review Board and classified as a quality improvement project.

Analyses

Detailed fieldnotes were coded by the primary author (MC) using rapid qualitative methods, an analytic approach using structured templates to conduct quick, iterative analyses in

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Table 1. Participant Characteristics and Health Service Use 2022 to 2023.

Characteristic	# of participants	Health service use	# of visits
Gender		ED (2 years; 2022-2023)	
Female	3	0-1	4
Male	13	2-4	7
Age range		5-8	3
25-34	1	9-14	1
35-44	3	14 and above	1
45-54	1	Primary care (2 years; 2022-2023)	
55-64	7	0	4
65 and over	4	1-3	2
Race/ethnicity		4-6	6
Black/African American	7	7-9	3
Latino/Hispanic	4	10 and above	1
Unknown	5		

applied research settings.[28] Fieldnotes were organized into templated summaries based on interview and focus group guides and included the following a priori domains of inquiry: (i) participants' experiences with primary care following an ED visit; (ii) ways the VA ED can improve primary care connection post-ED; and (iii) acceptability of a peer-led intervention based in the VA ED. The primary author engaged in iterative discussion of analyses with co-authors (SG, KPS, EJ) to ensure adequate interpretation of findings based on authors' experience during data collection and/or clinical expertise.

Results

Participants

Table 1 describes our sample. Most participants were male (n = 13); a few were female (n = 3). Participants ranged from 26 to 78 years of age. Nearly half (44%) of participants identified as Black/African American, 25% as Hispanic/Latino, and 31% declined to identify their race/ethnicity. On average, participants had 4.6 ED visits (standard deviation [SD] 5.2 visits) from 2022 to 2023, ranging from 1 to 14 visits over 2 years. Primary diagnoses associated with ED visits varied from minor health needs, such as COVID-19 testing, to alcohol withdrawal, chest pain, hypertension, and suicidal ideation. On average, participants had 4.2 primary care visits (SD 3.5 visits) over 2 years; the number of visits ranged from 0 to 11 visits.

Experiences With Primary Care Following an ED Visit

Several participants stated that primary care appointments were frequently difficult to obtain—"the [ED] will tell you to follow up in 5-days, but appointments are far out." A participant described the gap in care as a "stressful time," characterized by heightened health concerns. While several participants mentioned appreciating the availability of walk-in appointments through HPACT, others were unaware of the option or felt that walk-in services were inadequate. One participant shared that, in his experience, walk-in services only allowed him to see a nurse versus a doctor, which he found inadequate given his care needs. Participants added that a lack of transportation and challenges with physical mobility frequently contributed to difficulties getting to medical care. Participants also described efforts to access VA resources, such as housing, and scheduling challenges that forced them to choose between receiving medical care or attending scheduled meetings to obtain resources for social needs.

Participants were asked what factors might facilitate engagement in primary care. Responses included having good communication with their care team, receiving appointment reminders through various mediums (eg, text, email, phone calls, card with appointment), and having social needs met (eg, housing). Additionally, participants with smart phones noted that virtual appointments could be helpful in preventing missed appointments, and that having options for both in-person and virtual care was ideal. Participants also shared that engagement in primary care was tied to personal motivation and could be a result of achieving housing stability and feeling more "grounded" or making personal decisions to work toward substance use recovery and prioritize one's health. One participant described forgetting appointments or ignoring physical signs of illness due to drug use, and only becoming engaged in care after deciding to pursue recovery.

Improving Connections Between the Emergency Department and Primary Care

Participants shared their thoughts on ways the ED could be improved to better serve HEVs that require follow-up care. System improvements included having a follow-up appointment scheduled at the time of discharge, scheduling appointments within 1 week of an ED visit, and prioritizing HEVs with a recent ED visit for HPACT walk-in care. Participants stressed that, prior to discharge, ED staff should assess Veterans' social needs that function as barriers to primary care. Participants specifically noted the importance of connecting unsheltered Veterans with housing at discharge. As one participant stated, "social work [in the ED] should place unhoused Veterans in housing instead of letting them go back outside then come back into the ED again." Several participants also shared that they would have benefitted from a warm handoff to primary care and more detailed information on how to access VA health and social needs resources. Participants mentioned that it would be helpful if

ED staff were able to provide more "on-on-one support." One participant described challenges obtaining information regarding VA resources as having to go "from one place to another" and "ping-ponging across different people" to receive information. This participant stated that it would be helpful to have a point person who HEVs could contact and shared that some of the most useful information he had obtained—including guidance on receiving dental services, housing resources, and VA disability benefits—had come from fellow Veterans.

Experiences With Peer Support and Their Potential Role in the ED

Participants reported positive experiences working with peer support staff through VA programs, specifically interim and permanent housing programs and as part of HPACT. Peer supports were described as working to ensure that Veterans had the support they needed. Participants shared that peer support had been critical in helping them connect with VA services, assisting them with everything from obtaining legal counsel to housing. Peer support was described as going "above and beyond," making themselves available after hours, and following up to ensure that HEVs had the information they needed. One participant stated, "I get better treatment from peer support than my care provider." Another participant added that once connected, "peer supports go out of their way" to help Veterans. Furthermore, participants acknowledged the importance of motivation and support in fighting addiction and added that peers had been, or could be, impactful for Veterans addressing substance use.

When asked whether having a peer support specialist in the ED would be helpful, participants overwhelmingly agreed they would be a positive addition. When asked what it would be like to have peer support approach him in the ED to provide information on VA resources and help connect to follow-up care, one participant stated, "it would be amazing!" Other Veterans added, "I would respond pretty positively," "I would be grateful," and that a fellow Veteran would "better understand [their] needs." Participants believed that peer support could function as a central point of contact for HEVs needing assistance navigating the VA system. The peer could help HEVs "feel understood," "motivate Veterans to seek care," and help Veterans "understand the importance of primary care engagement." Participants shared that a peer support could be particularly helpful for getting a Veteran to "open up" about the challenges they were experiencing and to develop trust in the VA system—"I can tell them anything. They understand my experience and perspective." Participants believed that a peer support would be particularly helpful in working with Veterans to identify and prioritize personal goals, including at point of ED discharge, and navigate the process from ED to primary care.

Discussion

HPACT adapts standard care delivery models to make care more accessible,[16] but care transitions from ED to primary care remain a challenge. Participants had trouble obtaining timely follow-up appointments and experienced a lack of coordination between health care and social needs programs. Participants also noted initial challenges obtaining information regarding HPACT walk-in hours or how to receive assistance for social needs that functioned as barriers to primary care. Care coordination may be critical for improving transitions of care,[29] including efforts to enhance coordination between ED and outpatient providers, scheduling follow-up appointments at the time of ED discharge, education services, and developing a post-ED plan for care.[29] Research indicates that having a patient navigator in the ED whose role includes care coordination can increase primary care use and decrease ED visits.[30,31]

Participants highlighted the potential benefits of having peer supports in the ED who could assist with patient navigation, build trust with HEVs, and serve as a key contact for HEVs seeking information regarding VA health and social needs resources. Patient navigation is a support service that helps patients navigate complex healthcare systems, while attending to social needs that function as barriers to care. Patient navigation works best when undertaken by peer navigators who share similar characteristics with program participants,[21] and when implemented among homeless populations can effectively reduce barriers to care and facilitate timely access to health care services.[20] While VA peer support has not yet been based in the ED or focused on patient navigation,[25,26] as noted by participants, peers may have an important role to play in facilitating primary care linkage and encouraging care engagement.[30,32] Common functions of patient navigation for homeless populations include care coordination, accompanying to health-related appointments, giving practical assistance (eg, transit), and providing emotional support.[21] Based on participant responses, a peer-led patient navigation model may be highly welcomed by HEVs who often struggle to trust the VA system and may need significant encouragement and support to address health challenges.

Our project had several limitations. Participants were recruited from VA GLA's on campus homeless programs, which meant that many were engaged in VA healthcare services (ie, primary care). As a result, participants may have experienced challenges recalling initial barriers to primary care connection. Time and resource constraints prevented us from recording and transcribing interviews and focus groups. While fieldnotes are commonly used in qualitative

studies, there are limitations to this approach, including the potential for lost data.[33] However, notes were taken by multiple authors to ensure information was adequately captured. This study was also conducted in 1 VA healthcare system among Veterans eligible for VA care, findings may differ across VA medical centers and may not be generalizable to non-Veteran populations. Lastly, our sample size was limited to 3 focus groups and 2 individual interviews and may not ensure data saturation. Nonetheless, findings from this case study capture critical insights from HEVs that will inform future research efforts.

Conclusions

Our project identifies opportunities to improve connections with primary care among HEVs following an ED visit. Areas for improvement include important system changes to facilitate timely care appointments and greater one-on-one support for HEVs. Project participants were particularly accepting of a peer-led intervention to improve care engagement. These data support and will inform future work to adapt and pilot a peer-led patient navigation model for implementation in VA GLA's ED.

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Author Contributions

Kian Preston-Suni led study conception and design, and supported data collection. Participant recruitment and chart reviews were led by Edwin Jacobo. Melissa Chinchilla supported data collection, led data analysis, and drafted the manuscript. Kian Preston-Suni and Sonya Gabrielian discussed and helped finalized results with Melissa Chinchilla. All authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Ethics Considerations

This project was reviewed and approved by VA Greater Los Angeles' Institutional Review Board and received a determination of non-research, instead classified as a quality improvement project.

Consent to Participate

Written, informed consent was obtained from all participants.

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