Journal of Primary Care & Community Health
Volume 13: 1–10

DOI: 10.1177/21501319221112585
journals.sagepub.com/home/jpc
SAGE

Responding to COVID-19 While Serving Veterans Experiencing Homelessness: The Pandemic Experiences of Healthcare and Housing Providers

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Abstract

The U.S. Department of Veterans Affairs (VA) provides essential care through transitional housing and healthcare for Veterans experiencing homelessness through the Grant and Per Diem (GPD) program and the Homeless Patient Aligned Care Team (HPACT), respectively. At the onset of the SARS-CoV-2 pandemic, GPD organizations and HPACT clinics faced the challenge of being essential providers tasked with ensuring the well-being of Veterans under their care. Through semi-structured interviews with 13 providers (6 HPACT health care providers representing 2 HPACT programs, and 7 GPD staff members) across the U.S., this study explored their experiences navigating the tasks of keeping Veterans safe and providing ongoing care from the start of the pandemic up to the 2021 interview dates. Both GPD and HPACT providers reported amplified safety concerns about COVID-19 infection among staff at the start of the pandemic, which diminished to a lower, stable level after a few months as adaptations made for safety became embedded in their routines. However, ongoing challenges included isolation and mental health challenges among Veterans, inherent limitations of telehealth as a care delivery avenue, provider frustration and burnout due to increased workload and frequent change, and the logistics of administering testing for Veterans to enter GPD housing. Enhanced pandemic preparedness planning for GPD organizations, funding for personal protective equipment (PPE) and providing technology to facilitate Veterans' telehealth access, and strategies for preventing provider burnout are critical to both sustaining homeless providers' capabilities during this pandemic and enhancing readiness to respond to the next public health emergency.

Keywords

homelessness, primary care, transitional housing, vaccination, healthcare, access to care, clinician burnout, healthcare providers, Veterans, COVID-19

Dates received: 5 May 2022; revised: 20 June 2022; accepted: 22 June 2022.

Introduction

The effects of the SARS-CoV-2 pandemic have been felt worldwide, with the U.S. having over 80 million infections and over 950 000 lives lost as of spring 2022. People experiencing homelessness are susceptible to community transmission of COVID-19 in shelters[1,2] and face an elevated risk of contracting COVID-19 and experiencing adverse health effects and death due to limited access to hygiene and sanitation facilities and a heightened prevalence of comorbidities.[3-10] During the pandemic, concerns about continued access to health care and residential transitional housing services has become increasingly challenging.[6-9]

Community-based organizations (CBOs) and health care systems have experienced significant challenges, having to rapidly pivot to emergency operations and focusing on infection control amid increased service demand from a high-risk client population.[8,9] The pandemic highlighted gaps in pre-disaster readiness among these providers,[11,12] as supply shortages and inadequate infectious disease prevention plans

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left homeless service organizations and health care providers scrambling at the onset.[8,9] Many homeless serving CBOs lacked policies specifically geared toward pandemic response despite having detailed procedures for natural disasters.[9] Further, staff burnout and concerns over COVID-19 exposure and the need to adapt to new modes of service delivery and safety protocols were identified in initial studies exploring challenges that CBOs navigated in the initial pandemic response.[8,9] Such vulnerabilities in CBOs suggest that secondary impacts of the pandemic: social isolation. disrupted care, and substance use relapse may be just as significant risks for unhoused Veterans.[8,13]

Except for a few studies that examined the experiences of homeless service providers[8,9] and health care providers serving homeless populations,[7] very little research has investigated the impact of the COVID-19 pandemic on these sectors, resulting in missed opportunities to correct deficiencies and improve access to and quality of care for these groups. Within the U.S., many unhoused Veterans receiving health care from the U.S. Department of Veterans Affairs' (VA), and are enrolled in supportive health care and transitional housing programs through the Veterans Health Administration (VHA). The VHA has established a significant array of programs and wraparound services designed to support Veterans experiencing homelessness, encompassing health care, employment training, housing assistance, and mental health. The VA Homeless Patient Aligned Care Team (HPACT) and the VA Grant and Per Diem (GPD) programs are two of VHA's signature programs designed to support Veterans experiencing homelessness through the interrelated health care and housing sectors, respectively. HPACT provides multi-disciplinary health care at clinics located in VA medical centers (VAMCs) and community-based outpatient clinics (CBOCs) across the country. It consists of primary care providers, nurses, social workers, and mental health counselors who provide medical care, case management, housing and social services, community referrals, and substance use and mental health treatment.[12,14-20] The VA GPD program funds non-VA organizations to provide transitional housing for Veterans who are homeless for up to 2 years,[12,17-20] In examining the pandemic experiences of both GPD and HPACT providers, this study has implications for the interrelated housing and health care sectors serving unhoused populations. Including the perspectives of providers from both sectors and diverse professional disciplines within the VA's nationally integrated healthcare system enables a comprehensive exploration of the full array of challenges that providers faced, both within their sector and in coordinating between sectors to provide ongoing care, so that VA and other providers can better weather such emergencies in the future.

Methods

The study population included individuals who were employed at either (a) a VA HPACT clinic or (b) a GPD program. Both HPACT and GPD studies were reviewed and approved by the Institutional Review Board at (Institution). All participants provided verbal informed consent. Semi-structured, 60 min telephone interviews were conducted with 6 HPACT providers in California (CA, n = 4), and North Dakota (ND, n = 2), and 7 GPD organization staff in Florida (FL), Iowa (IA), Kentucky (KY), Massachusetts (MA), New Jersey (NJ), northern California (N.CA), and southern California (S.CA). In addition to the sample's geographic diversity, providers included leaders, case managers, nurses, primary care providers, a social worker, and a clinical psychologist. Interviews with GPD staff occurred from January to April 2021 and interviews with HPACT providers occurred in July and August 2021. The study interview guide included questions about providers' experiences providing care/services during COVID-19; their Veterans' COVID-19 vaccine uptake rates; efforts to increase vaccine uptake, as well as additional suggestions for increasing vaccine uptake rates; challenges in Veteran vaccinations; and their Veterans' attitudes regarding vaccination and the pandemic. Interviews were audio recorded, transcribed, and analyzed using the rapid analysis approach.[21-23] Qualitative findings were analyzed thematically, which involved the development of a summary table document organized by deductive themes based on the interview guide. The transcripts were divided and summarized by 2 team members and the summary document was modified to reflect inductive themes that emerged during analysis. Summaries were then combined into a single, high-level document to identify commonly occurring themes across interviews. Findings are reported based on their substantive significance,[24,25] or how they inform the existing literature. Further details regarding the recruitment methods, interview guide, and data collection and analyses are available elsewhere.[22]

Results

The 2 HPACT and 7 GPD programs in this study varied in size and Veteran patient population. The HPACT program in CA is a large program consisting of 13 clinical teams serving approximately 2600 Veterans. The 4 CA HPACT providers interviewed represented 3 clinical teams from 2 VAMC care sites and 1 CBOC, serving a combined total of 1052 Veterans. The 2 HPACT providers in ND is a small and relatively new program housed in a VA community resource and referral center (CRRC) and served 110 Veterans. The GPD programs were all male only facilities. The largest program, NJ, served 62 Veterans at the time of the interview while the smallest program, IA, served 5. Three themes emerged from the qualitative interviews: (1) provider safety concerns due to lack of personal protective equipment (PPE); (2) safety adaptations, disruptions in access to care, and quality of care compromised due to pivot to telehealth; and (3) challenges in testing and communications. These themes suggest areas where the health care and

Table 1. Health Care and Housing System Challenges Identified by HPACT and GPD Providers.

1. During pandemic's first months, CA HPACT clinic faced challenges obtaining N-95 masks and were mandated not to use them during patient care unless performing intubation. Providers were forced to violate facility rules to use N-95 masks.
2. Lack of any mask availability in GPD transitional housing facilities in the pandemic's early days (some had to sew their own masks and purchased sewing machines for this purpose).
3. Providers worried about contracting COVID-19 at work and infecting family at home, since many Veterans did not follow precautions, such as isolating when ill or wearing
4. Lack of pre-existing infection control policies at GPD housing sites.
5. GPD decisions to remove social work case managers from face-to-face care at housing sites hindered elderly and visually impaired Veterans' capacity to make phone calls.
6. Lack of consistent standard operating procedures and policies on how and when to offer virtual vs. in-person care in the CA HPACT program.
7. CA HPACT providers experienced "change burnout" from the constantly changing processes
8. Telehealth care, particularly virtual mental health, was not clinically appropriate for many Veterans in HPACT, leading to a perceived decrease in quality of care at one HPACT program.
9. Social isolation for unhoused Veterans leading to relapse and other mental health concerns.
10. CA HPACT clinic lacked standardized or consistent information about GPD COVID-19 testing requirements (eg, PCR vs. antigen tests, how often testing was required for each GPD).
11. ND HPACT clinics relied on non-VA entities (county clinics, shelters, non-profit providers) to carry out COVID-19 testing due to lack of access to testing at VA.
12. Lack of access to rapid antigen testing for unsheltered Veterans led to 72 h delays in their ability to access GPD housing.
13. GPD facilities required negative test or 14 day waiting period before admitting Veterans to their program, but tests were unavailable at first, and some Veterans refused to test, hindering VA's ability to house unsheltered Veterans.
14. Lack of access to shelters for the purpose of isolating and quarantining Veterans awaiting COVID-19 test results or Veterans who tested positive for COVID-19.

housing safety net systems can strengthen their pandemic preparedness and response plans and infrastructure to avoid burnout, staffing disruptions, and other barriers to supportive care. Table 1 lists the systemic challenges identified by providers.

Theme 1: Provider Experienced Safety Concerns Due to Lack of PPE

In both HPACT clinics and GPD programs, respondents expressed that safety concerns for themselves and their families, as well as the Veterans they serve, were amplified, and caused stress among staff and leaders, especially at the start of the pandemic. HPACT clinicians were particularly concerned about workplace personal safety at the beginning of the pandemic, because of both the and Veterans' refusal to wear masks in the clinic, which were mentioned at both HPACT sites surveyed. CA HPACT leaders described a lack of personal protective equipment (PPE) at the pandemic's onset, and having to go against written policy to keep clinicians safe:

> *"The supply chains for some of the PPE were not great. And some of the guidance that we got seemed a little bit out of keeping with common sense. . . we were told that because we weren't doing any (procedures involving intubation) we didn't need to have any N-95s. Even our primary care providers were sometimes doing very up-close exams where they had to look inside somebody's mouth. So. . . we were kind of always fighting to follow common sense and not just all the strict guidance. But that meant we somehow had to get N-95s even though we weren't technically allowed to have them and kind of keep ourselves supplied with N-95s in situations where they were necessary." (CAHPACT4)*

GPD organization staff also experienced significant concerns about responding to the pandemic's onset A NJ leader mentioned that the shortage of PPE created a situation requiring unusual workarounds:

> *"I went to Wal-Mart and bought three sewing machines and we sat in the conference room and just sewed masks. We made 200 masks the first day. . .I don't think it's melodramatic to say it felt like life or death." (NJGPD)*

Both GPD and CA HPACT service providers expressed worries about bringing the COVID-19 virus home to vulnerable family members. CAHPACT3, an HPACT primary care provider serving a neighborhood with many homeless individuals, described frequent exposure to COVID-19 positive patients arriving at the clinic, and the consequences for his multi-generational household. He described adopting the following household precautions:

> *"I have elderly parents and I have a dad who suffers from cancer and so they live with me, and I have two young kids, so. . .thinking: 'What are you going to do?'. . . My wife is a provider herself, so we had to have a contingency plan in the sense if we are the ones who catch it and if we're exposed.*

So. . .we had converted our garage into. . .an area where we would sleep, . . . the days that I got exposed, I kind of bunked out in the garage area and not go in. . .we both would. . . disrobe in the garage, so we had an area where we'd take our clothes off, then we would put a bedsheet on or a towel on, and then go into our house. And. . .put our scrubs and clothes into—because we have our laundry in the garage. And. . . it was very hectic, to say the least. And. . .she got recruited to work in a COVID ER. . .." (CAHPACT3)

Veterans' close trusting relationships with HPACT providers sometimes created safety concerns for providers when Veterans felt comfortable enough to remove their masks upon entering the exam room. Because many Veterans felt comfortable at the HPACT, they often entered the clinic while infected with COVID-19 or when they were supposed to be quarantined due to COVID-19 outbreaks at congregate housing facilities. HPACT and GPD providers both noted that many Veterans were *"not worried enough"* about the COVID-19 pandemic, and 1 GPD leader, N.CAGPD, noted that they were *"careless"* and *"should be a little more worried than they are"*. Two CA HPACT providers expressed frustration that many Veterans they saw did not believe that COVID-19 was real, and that some Veterans believed in conspiracy theories.

Theme 2: Safety Adaptations Disrupted Access to Care, and Telehealth Compromised Quality of Care

At the pandemic's onset, GPD and HPACT programs developed and adopted safety measures to mitigate the risk of COVID-19 spread for staff and Veterans. As 1 GPD leader in CA recounted:

> "A*t first it was a disorganized nightmare. . . But within a few months, . . . thanks to our [VA] liaisons, we started putting policies in place. . . .We've created new positions where we would drop off PPE gear and make sure that it was stocked weekly. And then we also kind of pivoted the janitor's position where he would go and wipe down the common areas of each unit twice a week. So. . .the first three months it was just chaos. But we finally found a groove." (N.CAGPD)*

In addition, the VA National GPD Office implemented a requirement that all Veterans entering the program had to be tested for COVID-19. All GPD programs provided face masks and other supplies such as hand sanitizer and disinfectant cleaning wipes to Veterans, and mandated mask-wearing in common areas. Some programs implemented shelter-in-place protocols and strict curfews on residents. Others received additional funding from VA and other sources that enabled them to implement safety programs such as food delivery, and quarantine COVID-19 positive Veterans in hotel rooms. The S. CA program asked Veterans to monitor themselves daily for COVID-19 symptoms:

> *". . .we do self-monitoring with them every day. They have this form that they fill out to check off the symptoms of COVID-19. And if they have any symptoms, they immediately report to us. And so, they're also self-monitoring and being responsible themselves to let us know and watch themselves for symptoms. We're also doing temperature checks too every day." (S.CAGPD)*

Adoption of virtual care for COVID-19 safety occurred among some GPD and HPACT providers, while others, particularly HPACT primary care providers, continued offering face-to-face care. GPD case managers in 2 programs transitioned to a remote work format, while the majority continued in-person services. GPD staff provided tablets and Wi-Fi access to enable Veterans to transition to virtual case management and telehealth. Veterans' Alcoholics Anonymous meetings and apartment searches also transitioned online at GPD sites.

Curtailment of services and the transition from in-person health care to virtual appointments sometimes resulted in challenges for Veterans. KY GPD noted that clients' communication with case managers was disrupted because GPD organization staff were not present to help Veterans make phone calls and appointments. ND HPACT providers were keenly aware that isolation, mental health challenges, and relapse were risks from pandemic-caused disruption. For those reasons, they opted to encourage continued in-person care:

> *"It's been a really important role for all of us to still see people face-to-face. . .COVID, has been very, very isolating to people who are already often very isolated and so being able to have the [clinic] be open and still continuing to meet with Veterans face-to-face. . . I'd like to think we've prevented a lot of relapse and a lot of other issues by maintaining that direct patient care." (NDHPACT2)*

CA HPACT providers also continued offering in-person primary care but reported that many patients either stopped coming in for care or switched to telehealth, particularly for mental health, internal medicine, and social work. CA HPACT providers noted that clinic staff had a difficult transition to telehealth, given the lack of clear standard operating procedures and policies on how and when to offer virtual care. Processes changed constantly, with new procedures every 2 weeks, leading to *"change burnout"* for providers. It took roughly 4 months from the beginning of the pandemic to finally settle into a consistent way of providing telehealth care. Two providers mentioned that HPACT Veterans were often not *"tele-appropriate"* due to their lack of access to phones or private space for sessions. One CA

HPACT psychologist noted that virtual mental health appointments were not appropriate for many HPACT Veterans because of their unique challenges. However, the risks of COVID-19 created tradeoffs, he noted, and safety concerns won out:

> *"Clinically, my concern, and I think everybody else's concern, was that the care that we've provided since COVID started has been, you know we keep aiming for the best we can do under the circumstances, but we all know that the quality of care has [decreased]. Right, there's no way to do predominantly telehealth appointments for primary care and not have some things get missed that otherwise would get caught, same thing for mental health. Once we start offering tele-mental health, there's Veterans who are probably not appropriate for it where we kind of let it slide and say you know what? Even though I'm not offering the best quality care for this person because they're not really super tele-appropriate, the risk of telling them 'no, you have to get on a bus and you have to come in and see me and you have to sit in the waiting room and you have to sit in a room with me just so I can offer the best mental health', you know the risk of COVID doesn't outweigh the slightly poorer quality in mental health care that I'm providing. But that's been a very tough thing for our clinicians." (CAHPACT4)*

Yet CA HPACT clinicians struggled with the belief that the quality of care they were able to provide via telehealth was perceived to be less effective than in-person appointments for many of their Veterans.

Theme 3: Staff Experienced Major Challenges in Testing and Communications

GPD programs and HPACT clinics, whose mission includes housing assistance, had challenges coordinating the new task of administering the National GPD requirement that all Veterans entering the program had to be tested for COVID-19. This requirement, along with individual GPD programs' regular testing requirements for residents, created testing needs that increased the HPACT's workload. Providers at the CA HPACT noted that they had difficulty tracking whether Veterans who came in needing COVID-19 testing for GPD programs should be given PCR or antigen tests. Veterans often could not remember which test they needed, and came to the clinic without such information, placing a significant burden on HPACT staff:

> *"In terms of placing our patients into transitional housing or GPD programs, that was really, really rough. And. . .it was really difficult keeping track of which transitional housing programs, the GPD programs, what kind of COVID testing, and a lot of these programs required different upkeep of the COVID status. Like I know (one GPD) required, at one point, their residents to get tested once a week. Some other programs required once a month. It was just really hard to keep track of what facilities required to get admitted and stay admitted. So that was very, very challenging." (CAHPACT5)*

Providers suggested that consistent and clear communication between different programs could help the HPACT clinic anticipate and manage this additional workload.

Testing for GPD programs posed a different challenge for the ND HPACT clinic, which did not have access to antigen tests for several months into the pandemic. PCR tests were impractical for use with Veterans experiencing homelessness, they recounted, because Veterans testing positive often could not be reached when results arrived 72 h later. Also, a 72 h turnaround meant that the HPACT was unable to place many Veterans into desperately needed transitional housing during that period. Veterans needing antigen testing had to be referred to county testing sites, until local CBOs stepped up to offer antigen testing on-site at the HPACT. NDHPACT1 describes the challenge involved:

> *"Just getting the test to begin with was difficult because they couldn't walk through the ambulance bay and you didn't wanna put them on a bus, the city bus, and the social workers couldn't transport them so we had to reach out to services outside of the VA, like the county or shelters, to do the rapid testing for us. . . We could do the swab and send it in but it was a 72 hour delay, so then certain shelters, for example, one of our contract beds at one of the shelters that's four beds in one room, you couldn't quarantine people so just the act of getting somebody tested. . . became an issue. . . it was more the truly homeless that became a little bit harder to us to figure out what to do with."*

Lastly, the COVID-19 testing requirement also proved problematic for GPDs. Early in the pandemic, testing was scarce, and NJGPD was concerned about admitting new Veteran residents without knowing their COVID-19 infection status, a challenge to the VA's desire to quickly admit as many Veterans experiencing homelessness into GPD housing as possible. He described this difficult situation:

> *"I was in a bit of a headbutt situation with the VA. Because they wanted us to take Vets. And I said, I have no way to know if they have COVID" (NJGPD)*

He found a compromise by asking local homeless shelters to temporarily house Veterans for 2 weeks while being monitored for COVID-19 symptoms before being admitted to the GPD. Even after testing became widely available, IAGPD found that some Veterans could not be enrolled into transitional housing because they did not want to get tested:

> *"We have had Veterans that refused to come into shelter because they refused to have a test. Because they either have to have a negative COVID result within 24 hours of admission to the GPD program. Or they have to self-isolate for 14 days prior to admission." (IAGPD)*

Discussion

Within GPD and HPACT, 2 of VA's signature programs addressing the needs of unhoused Veterans, providers spent the pandemic's earliest days navigating through 2 major concerns: (1) providers' lack of confidence around safety while providing services, and (2) system-level barriers to providing and maintaining continuity of clinically appropriate care to meet Veterans' needs. HPACT providers had to balance their efforts to build trust and rapport with Veterans with asking them to avoid coming in when they were experiencing COVID-19 symptoms or removing their masks in the examination room. Providers also reported that Veterans often dropped out of virtual care because some were not clinically "tele-appropriate" or failed to access virtual care resources due to other barriers. Some HPACT providers recognized concerns about social isolation leading to relapse and other mental health risks and opted to continue in-person care, while in-person services were curtailed in some GPD programs, contributing to disconnected systems of services for Veterans. These experiences suggest that VA Homeless Programs such as GPD and HPACT can enact measures aimed toward avoiding disrupted care during pandemics, from increasing clinicians' confidence in their facilities' pandemic response plans to developing protocols to ensure Veterans' ability to continue accessing the support they need through either telehealth or in person care during surges in COVID-19 or other health emergencies.

Maintaining Clinician Confidence Through Preparedness Planning

Since the beginning of the COVID-19 crisis, hospitals have experienced a shortage of PPE needed by frontline healthcare workers to protect themselves and their patients. A survey conducted by National Nurses United (NNU) found that just 24% of respondents reported that their employer had sufficient PPE and 45% reported having access to N95s in their units (NNU 2020). In order to conserve supply, many hospitals restricted the use of N95s for those who provide direct care to suspected or known COVID-19 patients, so providers often brought their own PPE to work; however, many facilities did not allow staff to wear gear that was not issued by the hospital. As a result, numerous healthcare providers either left their jobs or were fired for going against hospital policy.[26,27]

These challenges in obtaining and receiving authorization to access PPE during the early days of the pandemic affected providers in GPD and HPACT programs. One GPD leader took it upon himself to purchase a sewing machine to produce masks for staff and Veteran clients. Meanwhile, the CA HPACT elected to secure sufficient PPE for providers rather than follow the VAMC's strict guidance. Such inconsistencies exacerbated providers' lack of confidence in the health care system's ability to ensure their safety while performing their jobs during an infectious disease outbreak. Regardless of variations in Veterans' adherence to safety guidelines, these concerns could be addressed through ensuring sufficient clinician access to N-95 masks and other PPE, which providers identified as significant concerns. Given the strong association between homeless shelter workers' close contact with clients and testing positive for COVID-19,[28] these issues illustrate the need for adequate supply stockpiles and consistent policies to ensure providers' confidence in safely providing patient care. The absence of pre-existing policies to address pandemic safety is consistent with previous research identifying gaps in perceived pandemic preparedness reported among homeless service providers[9] and in the VA.[11]

This study's findings underscore the importance of enhancing preparedness planning to encompass a broader range of disasters[12,29] and address providers' needs regarding fears of COVID-19 infection and exposure, burnout, and resources for both their own and Veterans' mental health. Providers' fears about being exposed to COVID-19 and bringing it home to vulnerable family members have been found to contribute to burnout among staff in homeless health care and shelter organizations.[8,9] Additionally, previous studies have shown that healthcare workers did not feel prepared to respond to infectious disease outbreaks,[30,31] did not feel confident in their medical facility's ability to respond to outbreaks,[11,32] and providers desired additional training to prepare for pandemics.[33,34] Strategies to improve preparedness and increase providers' confidence in pandemic response could include trainings to improve understanding of critical staff roles[11,30] through simulations or tabletop exercises, ensuring sufficient supplies of PPE and other protective measures[6] or modifying policies to allow providers to bring PPE from outside sources, regularly updating and disseminating the facility's disaster plan,[33,35] encouraging household preparedness.[33,36] The VA could also enhance coordination within its homeless programs by developing standardized communication between HPACT clinics and GPDs regarding the frequency and type of required testing for GPD programs, as well as enhancing training and assistance to support GPDs' development of pandemic preparedness plans.[12,37] Telehealth and transitioning activities online were major components of continuity of care efforts in both GPD and CA HPACT programs. However, technology barriers, lack of privacy, and limits on trust-building associated with virtual interactions hindered providers' ability to continue providing Veterans with high quality care. Prior research has identified lack of technology access or familiarity[6-8] and clients dropping out of care[8,9] as significant challenges for delivering appropriate care to Veterans in homeless programs through virtual telehealth modalities. Structural supports to facilitate their access, by referring patients to the Federal Communications

Commission's Affordable Connectivity Program,[38] the VA's iPad program, which provides cellular-enabled tablets to patients to access tele-services,[39] and the VA's Digital Divide Consult, which connects Veterans to a social worker to assist their enrollment in VA's telehealth services programs,[40] may help address these barriers. Peer support, digital literacy, and motivational interviewing can also help some Veterans sustain their engagement with video-based care modalities.[39]

However, the reduced ability to build rapport and trust[8] through virtual care modalities has also been identified as a significant challenge in providing telehealth and other remote services to people experiencing homelessness, which CA HPACT leaders emphasized in this study. Such extended disruptions to trusted care and support networks can be devastating to people experiencing homelessness. From April 2020 to 2021, Los Angeles (LA) County saw a 78% increase in drug overdose deaths among people experiencing homelessness, attributed to pandemic isolation and disruptions in substance use treatment and support.[13] Veterans experiencing homelessness actively using substances often find virtual visits challenging due to difficulties with concentration and keeping appointments.[41] Such concerns were undoubtedly on the minds of clinicians who described this population as "*not really super tele-appropriate*," as exemplified by CAHPACT4's description of concerns about patient-provider communications.

Burnout and compassion fatigue, partly caused by anxiety around infection risks associated with patient care, appeared to be a serious concern for providers, highlighting the need for strategies to prevent provider burnout and improve emotional preparedness for disasters. The VA is currently developing such provider self-care resources and interventions.[42-46] These approaches are especially critical to avoid large-scale provider turnover in homeless services and health care, particularly when the daily emotional labor of caring for traumatized populations is exacerbated by emergency conditions. Enhancing the emotional well-being of individual providers could better enable them to offer face-to-face care for Veterans, helping clients feel more connected and less prone to isolation, adverse mental health, and relapse risks. These measures would increase these systems' ability to seamlessly continue providing homeless services in future emergencies.

Maintaining Continuity of Care Through Telehealth and Its Limitations

HPACT providers continued providing in-person care, despite the personal risks to themselves and their families. Similarly, NJGPD's concerns about safety and desire to protect existing residents ran counter to the VA's efforts to rapidly place unsheltered Veterans in GPDs, until a compromise enabled them to be admitted after a 2 weeks stay in a local homeless shelter. These safety adaptations are all examples of the "adaptive capacity"[8,47] of the VA and its GPD partners in identifying ways of working around pandemic-imposed limitations to ensure safety while delivering services. As the nation continues to experience ongoing struggles with new COVID-19 surges, VA and other homeless-serving organizations can mitigate these concerns by incorporating lessons learned into pandemic surge preparedness procedures. For example, continued and additional funding to support quarantining COVID-positive Veterans in hotels prior to entry to housing programs or ensuring the availability of accessible COVID-19 tests at all VA facilities would ensure a safe environment for both providers and Veterans.

Similarly, other VA studies found that Veterans experiencing homelessness[25] and patients with multiple comorbidities were less likely to use telemedicine[33] and reported a higher patient preference for telephone or in-person visits.[48] Noting that Veterans experienced adverse mental health and increased relapse risks associated with isolation that virtual care failed to adequately address, ND HPACT leaders decided that their clinic would continue providing in-person primary care, given this vulnerability. The ND clinic was more effective at promoting continued in-person care than the much larger CA clinic, which struggled with *"change burnout"* among providers and Veterans, some of whom dropped out of care altogether. Such accounts suggest that virtual care may not be clinically appropriate for all Veterans, particularly Veterans experiencing homelessness. Ensuring that patients always have necessary in-person support is especially vital for Veterans who also have substance use disorders, offering a vital lifeline to those who may otherwise fall out of care.

As of this writing, the VA appears to be initiating an effort to address some of these concerns in guidance with a newly issued Veterans Health Administration (VHA) COVID-19 Operational Plan.[49] Concerns about Veteran patients' access to clinically appropriate care are addressed in suggestions that (1) in-person care continue to be offered and encouraged when community transmission is at "low" or "medium" levels as defined by the Centers for Disease Control and Prevention (CDC)'s Level of Community Transmission; (2) only offering virtual appointments over in-person care "where clinically appropriate" (3) and staffing levels be maintained through workforce recruitment and retention strategies, contracting for additional staff, and activating the VHA Disaster Emergency Medical Personnel System (DEMPs). Concerns about providers' authorization to access PPE are addressed through recommendations that N95 respirators be provided to all staff and following CDC recommendations for use of N95 respirators for all patient care encounters.

Limitations and Future Research

These findings are not generalizable to all homeless health care and service providers. Further, only one staff member was interviewed at each of the 7 GPD sites, and other staff members at those sites may have experienced the pandemic differently. Only 2 HPACT sites were examined, and their experiences may only accurately reflect conditions at those sites, which may be substantially different from other VA HPACT locations. However, the 9 care sites surveyed do provide insights into the experiences, tradeoffs, and challenges providers faced during the pandemic, and reported experiences across sites had many similarities. These lessons learned are likely to be transferable to homeless service providers beyond those serving Veterans; some of the interviewed GPD sites also housed non-Veteran individuals experiencing homelessness. Future research and practice examining how homeless service programs can shift to a post-emergency phase of service provisions while ensuring that clients can safely receive services while mitigating mental health isolation would be a valuable part of preparedness planning. Establishing peer support systems[50] and reducing actual and perceived barriers to telehealth utilization through supportive interventions such as digital literacy for Veterans experiencing homelessness[39,41] have been found to be effective in preventing isolation and service disruption when care shifts online. The effectiveness of such pandemic emergency preparedness strategies is largely untested, and little is known about their feasibility for being used to reduce isolation for traumatized populations.

Conclusion

Health care safety net systems such as GPD and HPACT are vital to the well-being of Veterans experiencing homelessness.[15] COVID-19 placed these systems under enormous strain, particularly for staff. "Change burnout," as 1 HPACT leader described, characterized the chaotic changes to care protocols and ad hoc adjustments that regularly occurred during the pandemic's first year, leading to reduced provider confidence in the VA and GPDs' ability to respond to disasters. Similarly, structural challenges in connecting Veterans with care delivery reflect lack of uniform policies about in-person care for Veterans across homeless programs, variations in Veterans' ability to access telehealth, and questions about the clinical appropriateness of telehealth for Veterans experiencing homelessness or substance use disorders. Such gaps in care during long-term emergencies can often translate into adverse outcomes such as disrupted services, social isolation, and substance use relapse for Veterans experiencing homelessness. As the LA County data illustrates,[13] people experiencing homelessness are at risk of addiction relapse and death from drug overdoses if health emergencies disrupt the care and support systems they rely on. While GPD and HPACT programs rapidly adapted to these challenges and implemented protective strategies to prevent infection outbreaks, these experiences illustrate that more robust advance planning and addressing system vulnerabilities identified in this research would help ensure continuity of care and prevent provider burnout and client relapse due to disrupted health services and social isolation. Understanding how the pandemic effected a "new normal" in the daily operations of VA's healthcare and housing programs is vital to enhancing their resilience and success in the next endemic phase of COVID-19.

Acknowledgments

This material is based upon work supported by the United States Department of Veterans Affairs, Veterans Health Administration, Office of Patient Care Services. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

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.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was funded by (Author's Institution). The funder did not participate in the design of the study, collection, analysis, and interpretation of data or writing this manuscript.

Ethical Approval and Consent to Participate

These two studies were reviewed and approved by the (Author's Institution) Institutional Review Board (Project Numbers: 1616126 [GPD] and 1628537 [HPACT]). All methods were carried out in accordance with relevant guidelines and regulations. Verbal informed consent was obtained from each participant prior to study inclusion. Involvement in the study was voluntary and there were no repercussions for non-participation. Anonymity and confidentiality of the information was maintained by removing personal identifiers from the data. The notes and audio tapes are kept in secured password protected electronic device accessible only to the first author and the co-authors.

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