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Homeless Veterans in Nursing Homes: Care for Complex Medical, Substance Use, and Social Needs

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Abstract

OBJECTIVES: The homeless population is aging, and their use of nursing homes is not well understood. We compared comorbidities (substance use, mental health conditions, and physical illness) and nursing home measures (source of admission, length of stay, and mortality in the facility) of veterans who were homeless, at risk for being homeless, or stably housed in the year prior to admission.

DESIGN: Cross-sectional analysis.

SETTING AND PARTICIPANTS: All veterans admitted to a nursing home between January 2010 and December 2016 and their housing status in the year prior to their nursing home admission.

MEASUREMENTS: Adjusted relative risks (ARRs) for the association between housing status, comorbidities, and nursing home measures.

RESULTS: Veterans who were homeless in the year prior to their community nursing home admission were younger ($n = 3355$; 62.5 years [$SD = 10.3$ years]) at admission compared to stably housed veterans ($n = 64\,884$; 75.3 years [$SD = 11.9$ years]). After adjustment for demographic characteristics, homeless veterans were more likely to have diagnoses for alcohol abuse ($ARR = 2.18$; 95% confidence interval [CI] = 2.05–2.31), drug abuse ($ARR = 3.03$; 95% CI = 2.74–3.33), mental health condition ($ARR = 1.49$; 95% CI = 1.45–1.54), dementia ($ARR = 1.14$; 95% CI =

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article.

1.04-1.25), liver disease (ARR = 1.32; 95% CI = 1.23-1.41), lung disease (ARR = 1.08; 95% CI = 1.04-1.13), and trimorbidity (co-occurring substance abuse, mental illness, and physical illness) (ARR = 2.57; 95% CI = 2.40-2.74) compared to stably housed veteran nursing home users. Homeless veterans were more likely to be admitted to a nursing home from a hospital (ARR = 1.13; 95% CI = 1.08-1.17) and remain in the nursing home 90 days after admission (ARR = 1.10; 95% CI = 1.04-1.16), but were less likely to die in the facility (ARR = 0.72; 95% CI = 0.67-0.78) compared to stably housed veterans.

CONCLUSIONS: Homeless veteran nursing home users have different characteristics than stably housed veteran nursing home users. These differences may challenge nursing home staff caring for homeless patients. Nursing homes should assess resident housing status to help provide linkages with existing social services.

Keywords

homelessness; long-term care; nursing homes; veterans

The veteran population is aging, and the number of veterans eligible for Veterans Health Administration (VHA)–funded long-term care services and supports (LTSS) is projected to increase.¹⁻⁴ Homeless veterans are an important constituency within the veteran population.^{5,6}

Homeless veterans experience accelerated aging,⁷⁻¹¹ and they often have complex substance use, medical, trimorbidity (substance use, mental illness, and physical illness), and social needs.¹²⁻¹⁴ The VHA offers comprehensive substance use, medical, and social services for homeless veterans¹⁵; nevertheless, homeless veterans may be at greater risk of needing LTSS and entering nursing homes.¹⁶⁻¹⁹

While the homeless veteran population is aging, to our knowledge, no studies have documented nursing home use in this vulnerable population. In this exploratory study, we examine the association between veteran nursing home users who were homeless, at risk for being homeless (an economically disadvantaged group who could become homeless), or stably housed in the year prior to their nursing home admission and their comorbidities and measures of nursing home use (source of admission, length of stay, and mortality in the facility). Understanding the characteristics of veterans who have experienced homelessness and use nursing homes can inform a framework for understanding the LTSS needs of this vulnerable population.

METHODS

Study Design and Sample

We conducted a cross-sectional analysis of all veterans admitted to a community nursing home between January 2010 and December 2017. A community nursing home is not owned or operated by the VHA but is paid by the VHA on a per diem basis. We focused our analysis on veteran community nursing home users because its use is of great interest to operations management. We identified three cohorts of veterans based on their housing status/level of economic insecurity in the year prior to their nursing home admission.²⁰

Homeless—Homeless was defined as veterans with an *International Classification of Diseases, Ninth Revision/Tenth Revision (ICD-9/10)* record for homelessness in the year prior to their nursing home admission (Supplementary Table S1 provides *ICD-9/10* codes).

At Risk for Being Homeless—The veterans at risk for being homeless were veterans who did not meet the definition of homelessness, but had an *ICD-9/10* record for unstable housing, poverty, or economic instability in the year prior to their nursing home admission (Supplementary Table S1 provides *ICD-9/10* codes).

Stably Housed—Stably housed veterans were veterans who did not meet the definition of homelessness or being at risk for homelessness in the year prior to their nursing home admission.

We excluded veterans from our analysis who received short-stay, postacute care (nursing home stay of 30 days or less and where the veteran lived greater than 14 days post-discharge). To ensure we did not double count veterans and that our measure of economic security was mutually exclusive, we limited our analyses to a veteran's first nursing home admission during the period of observation.

The study was reviewed and approved by the Providence Veteran Affairs Medical Center (VAMC) Institutional Review Board and Research and Development committees.

Data

We used the Veterans Affairs' Corporate Data Warehouse to obtain veterans' demographic characteristics, healthcare utilization, comorbidities, and housing status.

Demographic Characteristics and VHA-Provided LTSS Utilization Prior to Nursing Home Admission

We identified the demographic characteristics of veteran nursing home users at the time of their admission, their VHA priority status (priority 1 or other), if the veteran served in combat, if the veteran resided in a rural or urban area prior to admission, and if the veteran served after September 11th, 2001. VHA priority status is based on a veteran's degree of service-connected disability and is used to determine eligibility for VHA paid institutional LTSS. We also captured community-based VHA-funded LTSS used by the veterans in the year prior to their nursing home admission. Finally, we documented the VHA medical center that was financially responsible for nursing home stay.

Outcomes: Comorbidities and Nursing Home Measures

We determined if veterans had a record at any time in the 3 years prior to their nursing home admission for substance use disorder (alcohol and/or drug abuse), mental health diagnosis, and/or a diagnosis for physical comorbidities that are commonly associated with nursing home utilization, including dementia, congestive heart failure, paralysis, spinal cord injury, diabetes, renal failure, liver damage/failure, lung disease, obesity, or rheumatic disease.²¹ We documented the occurrence of trimorbidity, which is the co-occurring presence of substance use disorder, mental illness, and physical illness.

To provide insight into the care received during the nursing home stay, we captured nursing home measures, including source of admission (hospital or community), length of stay (greater than 90 days and greater than 365 days), and if the veteran died in the nursing home.

Statistical Analysis

We descriptively compared homeless and at-risk veterans to stably housed veterans (referent group) across the measures of the population characteristics.

We examined the association between housing status in the year prior to nursing home admission and comorbidities by estimating a series of logistic regression models in which the outcome represented the presence of each comorbidity (yes/no) and the primary independent variable represented housing status in the year prior to nursing home admission. In these models, we controlled for veteran demographic characteristics and use of VHA-provided LTSS in the year prior to nursing home admission. To account for variation across the VHA in the use of community nursing homes, we controlled for calendar year and the VHA medical center that was financially responsible for the community nursing home stay.

We estimated a second series of logistic regression models to examine the association between housing status in the year prior to nursing home admission and nursing home measures. In these models, nursing home measures represented the outcome; and housing status in the year prior to nursing home admission represented the primary independent variable. We controlled for veteran demographic characteristics, comorbidities, veteran use of VHA-provided LTSS in the year prior to nursing home admission, calendar year, and the medical center financially responsible for the nursing home stay.

From the logistic regression models, we estimated the adjusted relative risk (ARR) of each condition/nursing home measure in homeless veterans compared to stably housed veterans and in at-risk veterans compared to stably housed veterans.²²

RESULTS

We identified the first nursing home admission for veterans that occurred between January 2010 and December 2017 ($n = 114013$). We excluded 29 510 veterans admitted for short-stay postacute care. Of the 84 503 veterans admitted to a nursing home who met our inclusion criteria, 3355 (4%) were homeless in the year prior to admission, 16 264 (19%) were at risk for being homeless, and 64 884 (77%) were stably housed.

Demographic Characteristics and VHA-Provided LTSS Utilization Prior to Nursing Home Admission

At the time of nursing home admission, veterans who were homeless in the year prior to admission were younger, less likely to be white, less likely to be married, and less likely to have used VHA-provided community-based LTSS compared to stably housed veterans (Table 1). The demographic profile of at-risk and stably housed veterans was similar.

Association Between Housing Status and Comorbidities

At the time of nursing home admission, homeless veterans were significantly more likely to have had a diagnosis for a substance use disorder (alcohol [$ARR_{\text{homeless}} = 2.18$; 95% confidence interval [CI] = 2.05-2.31] and/or drugs [$ARR_{\text{homeless}} = 3.03$; 95% CI = 2.74-3.33]) and a mental health condition ($ARR_{\text{homeless}} = 1.49$; 95% CI = 1.45-1.54) compared to those who were stably housed (Figure 1A). Homeless veterans were also more likely to have dementia ($ARR_{\text{homeless}} = 1.14$; 95% CI = 1.04-1.25), liver disease ($ARR_{\text{homeless}} = 1.32$; 95% CI = 1.23-1.41), lung disease ($ARR_{\text{homeless}} = 1.08$; 95% CI = 1.04-1.13), and trimorbidity ($ARR_{\text{homeless}} = 2.57$; 95% CI = 2.40-2.74) compared to stably housed veterans.

Veterans who were at risk of being homeless were more likely to have a diagnosis for a substance use disorder (alcohol [$ARR_{\text{at risk}} = 1.15$; 95% CI = 1.09-1.21] and/or drugs [$ARR_{\text{at risk}} = 1.16$; 95% CI = 1.05-1.27]), a mental health condition ($ARR_{\text{at risk}} = 1.15$; 95% CI = 1.13-1.17), and all comorbidities, except congestive heart failure, renal failure, liver disease, obesity, and rheumatic disease, compared to stably housed veterans (Figure 1B).

Association Between Housing Status and Nursing Home Measures

Homeless veteran nursing home users were more likely to be admitted to a nursing home from a hospital ($ARR_{\text{homeless}} = 1.13$; 95% CI = 1.08-1.17) and were more likely to remain in the nursing home at 90 days than stably housed veterans (Figure 2A). However, homeless veterans were less likely to die in the nursing home ($ARR_{\text{homeless}} = 0.72$; 95% CI = 0.67-0.78) compared to stably housed veterans.

At-risk veterans were less likely to be referred to the nursing home from the hospital ($ARR_{\text{at risk}} = 0.83$; 95% CI = 0.82-0.85), but were more likely to remain in the facility at 90 and 365 days than stably housed veterans (Figure 2B).

DISCUSSION

At the time of nursing home admission, homeless veterans, compared to their stably housed counterparts, were significantly younger, but were more likely to have substance use diagnoses, mental health diagnoses, trimorbidity, and dementia. Our results support findings that homeless veterans experience geriatric conditions significantly earlier in their life and have complex medical and social needs.²³⁻²⁶ While homeless veterans admitted to nursing homes have unique needs, it is unclear if facilities can provide the care this population requires (eg, substance abuse treatment). From a policy perspective, adapting nursing homes to the needs of this growing veteran population will require training staff on homeless-specific issues. From a VHA perspective, an administrative system that flags veterans admitted to a nursing home with a history of homelessness could serve as a powerful opportunity to connect veterans with homeless services.

In adjusted analyses, homeless and at-risk veterans remained in the nursing home longer than their stably housed counterparts. We also found that homeless and at-risk veterans were less likely to die in the facility than stably housed veterans. These findings suggest that at least for homeless veterans, who may have nowhere to go in the community, nursing homes

provide a stable environment for medical care and avoidance of drugs/alcohol. There are complex factors at the medical center and nursing home level (availability of community nursing homes, local policy, and rurality of the veteran) that determine the placement of veterans in community nursing homes compared to VHA-owned/operated nursing facilities, and these factors may affect our length-of-stay estimates.

For homeless veterans, the hospital served as the primary source of nursing home referral. Homeless veterans may access nursing homes because they initially seek care through hospitals and then during the discharge process, without a place to go, are sent to a nursing home.^{14,27,28} In contrast, at-risk and stably housed veterans may access nursing homes due to more traditional long-term care needs. For inpatient homeless veterans without stable housing or social supports, the nursing home may represent a viable medical/social intervention.

Our study has several limitations. First, we only capture services paid by the VHA. We were unable to determine if a veteran transitioned to Medicaid. Veterans who experience economic insecurity are more likely to transition to Medicaid, so for these veterans we would underestimate length of stay. Second, our data reflect a subset of homeless individuals who accessed VHA care within the 12 months preceding admission to a nursing home. Due to limitations in administrative data, there may be under-coding of homelessness/at-risk codes. Related, veterans obtained *ICD-9/10* codes for homelessness/at risk during VHA service encounters. Veterans who entered a nursing home without a service encounter in the preceding 12 months could not be identified as being homeless or at risk. A review of the data identified a small proportion of stably housed veterans (3.62%; $n = 2346$) who did not have any VHA-related service encounter and could potentially be misclassified. We limited our analysis to the veteran's first nursing home admission. For veterans who experience multiple nursing home admissions, we may underestimate the severity of illness of the population. Finally, we only evaluated the characteristics of veterans admitted to community nursing homes. Veterans may also receive nursing home care in VHA-owned and operated facilities.

CONCLUSION AND IMPLICATIONS

Homeless veteran nursing home users have substantially different needs than stably housed veteran nursing home users. These differences may challenge nursing home staff caring for homeless patients. At-risk veterans appear to have strong social supports that may protect them from early nursing home utilization. Nursing homes should assess the housing status of newly admitted veterans to help identify care need and provide linkages to VHA social services.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1.

Adjusted relative risks for chronic conditions in homeless compared to stably housed veterans (A) and at-risk compared to stably housed veterans (B). Adjusted for demographic characteristics and use of Veterans Health Administration–provided community long-term care services and supports in the year prior to nursing home admission. CI indicates confidence interval.

Figure 2.

Adjusted relative risks for nursing home measures in homeless compared to stably housed veterans (A) and at-risk compared to stably housed veterans (B). Adjusted for demographic characteristics, comorbidities, and use of Veterans Health Administration–provided community long-term care services and supports in the year prior to nursing home admission. CI indicates confidence interval.

Veteran Characteristics

Table 1.

Characteristics	Homeless veterans (n = 3355)	At-risk for homelessness veterans (n = 16 264)	Stably housed veterans (referent) (n = 64 884)
<i>Demographic characteristics at time of nursing home admission</i>			
Age, mean (SD), y	62.5 (10.3)	75.8 (11.9)	75.3 (11.9)
Male, No. (%)	3200 (95.4)	15 740 (96.9)	62 970 (97.1)
Race, No. (%)			
White	2039 (60.8)	11 387 (70.0)	47 001 (72.4)
African American	1022 (30.5)	2725 (16.8)	9292 (14.3)
Other	294 (8.8)	2152 (13.3)	8591 (13.4)
Marital status, No. (%)			
Married	393 (11.7)	7683 (47.2)	30 774 (47.4)
Never married	964 (28.7)	1651 (10.2)	6505 (10.0)
Widowed/divorced/separated	1978 (59.0)	6848 (42.0)	27 182 (41.9)
Priority 1, No. (%)	1036 (30.9)	8617 (53.0)	32 334 (49.8)
Served in combat, No. (%)	234 (7.0)	2733 (16.8)	10 313 (15.9)
Lives in a rural area, No. (%)	522 (15.6)	4597 (28.3)	21 624 (33.3)
Served after September 11th, 2001, No. (%)	77 (2.3)	123 (0.8)	490 (0.8)
<i>Comorbidities in 3 y prior to nursing home admission, No. (%)</i>			
Alcohol abuse	1381 (41.1)	1591 (9.6)	5996 (9.3)
Drug abuse	596 (17.7)	547 (3.3)	1899 (2.9)
Mental health diagnosis	2161 (64.3)	7665 (46.1)	24 664 (38.2)
Dementia	723 (21.5)	5129 (30.9)	19 083 (29.6)
Congestive heart failure	418 (12.4)	2405 (14.5)	7310 (11.3)
Paralysis	42 (1.3)	362 (2.2)	952 (1.5)
Spinal cord injury	1230 (36.6)	7698 (46.3)	27 669 (42.9)
Diabetes	674 (20.1)	4887 (29.4)	17 865 (27.7)
Renal failure	924 (27.5)	1463 (8.8)	6058 (9.4)
Liver disease	1468 (43.7)	6825 (41.1)	25 345 (39.3)
Lung disease	741 (22.0)	3540 (21.3)	13 342 (20.7)
Obesity	90 (2.7)	626 (3.8)	2251 (3.5)

Characteristics	Homeless veterans (n = 3355)	At-risk for homelessness veterans (n = 16 264)	Stably housed veterans (referent) (n = 64 884)
Rheumatic disease	723 (21.5)	5129 (30.9)	19 083 (29.6)
Trimorbidity	1110 (33.0)	1314 (7.9)	4479 (6.9)
<i>Nursing home measures, No. (%)</i>			
Hospital as referral	2281 (68.0)	5270 (32.4)	26 485 (40.8)
Length of stay >90 d	799 (23.7)	5233 (31.5)	17 366 (26.9)
Length of stay >365 d	245 (7.3)	2136 (12.9)	6473 (10.0)
Died in facility	379 (11.3)	4082 (25.1)	18 779 (28.9)
<i>Long-term care service utilization in year prior to admission, No. (%)</i>			
Home-based primary care	203 (6.0)	3786 (23.3)	7772 (12.0)
Homemaker and home health aide	210 (6.3)	4857 (29.9)	10 553 (16.3)
Community residential and medical foster care	44 (1.3)	395 (2.4)	417 (0.6)
Adult day care	19 (0.6)	914 (5.6)	1504 (2.3)
Respite	13 (0.4)	929 (5.7)	2063 (3.2)
Hospice	154 (4.6)	957 (5.9)	4828 (7.4)