

## Current Issues in Practice

# Serving Our Homeless Veterans: Patient Perpetrated Violence as a Barrier to Health Care Access

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*In 2009, the Department of Veterans Affairs (VA) set a goal to end veteran homelessness by 2015. Since then there has been a 36% reduction in homelessness due, in part, to the VA Supportive Housing (HUD-VASH) program. These services include the receipt of home-based services to the veterans' home. However, safety concerns and the threat of violence toward health care workers remain problematic in non-institutional care settings. This article discusses the concept of access to care and how safety concerns act as a barrier to services and optimal patient outcomes. Our study provides information on the prevalence of patient violence toward health care workers in the HUD-VASH program in a large veterans' health system. Results suggest 70% of home-based service providers were exposed to violence and aggression. Providing services to veterans outside of institutional care settings, and the goal of eradicating homelessness among veterans, warrants further examination of access barriers.*

Keywords: Homeless Veterans, Access, HUD-VASH, Patient Perpetrated Violence

The United States Department of Veterans Affairs (VA) has made great strides toward decreasing homelessness among veterans, but the problem has not yet been eradicated. In 2009, the VA set a goal to end homelessness among veterans by 2015. From 2009 to 2015, the percentage of homeless veterans decreased by 36%. This reduction was accomplished in part through a partnership with the U.S. Department of Housing and Urban Development through a program better known as VA Supportive Housing (HUD-VASH) in which housing vouchers are furnished to qualifying veterans (Office of Housing Choice Vouchers, 2017). Currently, the HUD-VASH program serves approximately 10,000 veterans per year, serving more than 100,000 veterans since 2008 (Crone, 2016). Because homeless veterans often face negative circumstances or conditions that have an impact on eligibility for and the retention of permanent housing, the program also provides health care and case management services. Encompassed in these services is the critical element of receiving home-based health services outside of the traditional institutional care setting to improve health care access. The affiliated medical facility sends interdisciplinary teams comprised of nurses, social workers, psychologists, psychiatrists, occupational therapists, and dieticians to the veteran's home.

While access to health and case management services remains a necessary component to ensure success of this program, offering home-based health care to HUD-VASH recipients greatly improves the multifaceted domains of access (Levesque, Harris & Russell, 2013; Penchansky & Thomas, 1981). Being able to receive quality care in the home for those who are unable to go to a facility and community setting is essential to reintegration. However, concerns of safety or the threat of violence toward health care workers visiting veterans' homes can present significant barriers to access (Barling, Rogers & Kelloway, 2001; Bussing & Hodge, 2004; Campbell, 2016; Campbell, McCoy, Burg & Hoffman, 2013; Hutchings, Lundrigan, Mathews, Lynch & Goosney, 2011; Janocha & Smith, 2010). Reports show frequent incidents of veteran clients engaging in

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violent attacks against health care workers (Beech & Leather, 2006; Blow, Barry, Copeland, McCormick, Lehmann & Ulman, 1999; Campbell, Burg, & Gammonley, 2015; Hodgson et al., 2008; Silver, Keefer & Rosenfeld, 2011). To highlight this issue, in 2016, the U.S. Government Accountability Office (GAO) released a report detailing the prevalence of violence and aggression against health care workers by patients in the workplace. The types of incidents reported were both sexual and nonsexual in nature (GAO, 2016).

The VA has the oldest violence prevention program to be applied in a hospital setting. Entitled the Veterans Health Administration (VHA) Workplace Violence Prevention Program, it addresses issues of violence in the workplace by using a “flagging” system to identify patients who have exhibited disruptive or dangerous behaviors (GAO, 2016). Veterans who have demonstrated such behaviors toward their health care providers are referred to the Disruptive Behavior Committee, which creates a specific plan to reduce the risk of further violence (GAO, 2016). In addition to this flagging system, the VA also trains staff in various techniques to promote staff safety through online and in person training. Recognizing that home-based care is expanding, the VHA has begun to address staff safety in non-institutional settings because these settings may have different safety needs and concerns. In 2016, the VA Central Office implemented a community risk-assessment checklist as a new protocol, which, among other things, requires staff members who have been away from the VA Medical Center for more than two consecutive hours to communicate with their local facility through phone, email, or text to confirm their safety status. Additionally, it calls for mandatory trainings on the prevention of disruptive behavior for all health care workers who work outside the facility.

Despite these efforts to promote staff and patient safety, research specifically examining this topic in relation to HUD/VASH clients or providers remains scarce. A recent database search of PubMed, EBSCO, Academic Search Premier, ProQuest, and Google Scholar yielded no articles that provide information on violence prevention or incidences against providers servicing the needs of HUD/VASH recipients. A study by Campbell (2016) suggests that almost 70% of 236 health care employee respondents, surveyed from September 2015 to January 2016, who provide homebased services, experienced verbal, physical, or sexual patient perpetrated violence and aggression. Even with prevention mechanisms in place, violence in home health care settings remains a challenge and often goes under-reported (Campbell et al., 2013; Campbell, 2016). Studies have reported on the negative impact that these types of incidents have on personnel productivity, employee turnover, and the organizational costs, thus creating a financial loss and a decrease in the quality of care received by the patient (Kelloway & Day, 2005; Campbell et al., 2015). Therefore, this important topic is worthy of attention.

## **Purpose**

The aims of this article are twofold. First, this article will briefly discuss the concept of access and how safety concerns can serve as a barrier to health care services access and patient outcomes. Second, it will report on findings from a pilot study that provides information on the prevalence of patient violence toward health care workers in the HUD-VASH program at the second largest veterans’ health system in the United States.

## **Safety Concerns as a Barrier to Access**

The literature shows that the impact of violence or aggression against health care professionals is a barrier to health care access and adequate delivery of care. Penchansky (1977) defined

“access” as a multidimensional concept composed of five essential elements: (1) *availability*, which is the number of health care personnel or services present or on call to service the needs of the patients; (2) *accessibility*, the spatial or geographic association between the providers and consumers of health care; (3) *accommodation*, explains the institution and/or content of the health care system as it pertains to the ease in which patients can encounter and/or utilize services through the facilitation of adequate hours of operation, timely delivery of care, and the length of time to be seen by a professional; (4) *affordability*, the financial ability of the population served to utilize the services delivered by the system and their opinion on the value of the services available; and (5) *acceptability*, which exemplifies the attitudes of the consumers of health services toward the professional supplying services and vice versa. In a later article, Penchansky and Thomas (1981) added the consideration of consumer satisfaction as an important measure and component with which to assess access. Consumer satisfaction considers whether services meet expected quality standards and the evaluation of whether the health care system is responsive to the needs of consumers. Fortney and colleagues (2011) also conceptualized access as a multidimensional concept. For a health care system to deliver and increase the possibility of utilization of services in the 21st century, the system must observe its geographical, temporal, financial, cultural, and digital dimensions, to increase access (Fortney, Burgess, Bosworth, Booth, & Kaboli, 2011).

Violent or aggressive incidents against health care professionals affect different aspects of health care professionals’ employment life, directly having an impact on *availability*, *accommodation*, *acceptability*, and *customer satisfaction*. These have been described as dimensions of access by other researchers (Roghmann, Hengst & Zastowny, 1979; Tessler & Mechanic, 1975). Violence also has a negative impact on personnel productivity, personal health, and organizational efficiency, often causing financial loss in the form of employee compensation claims (Campbell, 2016; DiMartino, 2003; Hesketh et al., 2003; Kelloway & Day, 2005).

Studies have reported the association between workplace violence and employee absenteeism, intentions to quit, and turnover (Beech & Leather, 2006; Campbell, 2016; Heponiemi et al., 2008; Jackson, Clare, & Mannix, 2002; Kelloway & Day, 2005; McGovern et al., 2000; Sherman et al., 2008). Staff shortages caused by workplace violence have a direct impact on the provision of health care (Blegan, Goode, & Reed, 1998; Brewer, 2005; Heponiemi et al., 2008). A 2016 study by the Joint Commission reporting on the Special Focused Surveys on VA health care facilities found that poor staffing was a barrier to providing access to timely care to veterans and/or the increase of wait times to obtain an appointment (Office of Public and Intergovernmental Affairs, 2016). Timely care in turn may have an impact on community reintegration and health. The topic of patient perpetrated violence should be considered among the multidimensional topics needing further research and interdisciplinary policy analysis to inform policies supporting positive reintegration outcomes for veterans and their families (Lazier, Gawne, & Williamson, 2016).

Reduced personnel productivity due to the resulting increased job stress and emotional distress has led to declines in job performance, all of which threatens an organization’s ability to provide and/or maintain quality of care to patients (Barling et al., 2001; Beech & Leather, 2006; Hesketh et al., 200; Kelloway & Day, 2005; Sherman et al., 2008). A study by Hanson, Perrin, Moss, Laharnar, and Glass (2015) of 1,214 homecare workers who experienced aggression and violence revealed that exposure to such incidences was related to increased depression ( $p < 0.001$ ), sleep problems ( $p < 0.001$ ), burnout ( $p < 0.001$ ), and stress ( $p < 0.001$ ).

Research regarding nurses who encountered increased levels of burnout due to violence reported that those employees were more likely to transfer out of their profession and leave their

institution (Gerberich et al., 2004; Leiter & Harvie, 1996; Raquepaw & Miller, 1989; Sherman et al., 2008). The need to hire and train new staff as a result of staff turnover and the organizational memory loss resulting from seasoned staff departures are financially and operationally detrimental to an organization's ability to remain effective and efficient, which, in turn, can have an impact on health outcomes (Jones, 2005, 2008; Misra-Hebert, Kay, & Stoller, 2004; Temkin-Greener & Winchell, 1991; Waldman, Kelly, Arora, & Smith, 2004). Vacancy costs, that is, the expenditures associated with the replacement of new nurses, are the largest expense during staff turnover (Jones, 2005, 2008). The turnover cost is much higher when the vacancies are filled by registered nurses (RNs) who have very little experience, with the turnover costs ranging from \$82,000 to \$88,000 (Jones, 2008). The fact that new RNs receive a lower salary than experienced nurses does not compensate for the cost of decreased efficiency due to turnover rates (Tiaki, 2012). Nursing directors have explained that, on an average, it takes 14 weeks to reach 90% productivity when hiring nurses with less than a year of experience. In addition, nurse turnover can influence the quality of care when facilities have higher nurse-to-patient ratios and an increase in inexperienced nurse graduates (Jones, 2008; Tiaki, 2012). Thus, employee safety concerns create major obstacles in improving health care access.

### **Safety Concerns Involving HUD-VASH Recipients**

Homeless and previously homeless population is highly stigmatized, often stereotyped by an association with violence (Fisher, Mayberry, Shinn, & Khadduri, 2014; Sard & Rice 2014; Cunningham, Gillespie & Anderson, 2015). In addition to safety concerns for the health care workers delivering patient care, other environmental factors can exacerbate this concern. In their efforts to secure permanent housing, homeless individuals are more likely to find housing in neighborhoods experiencing social ills involving violence and illegal drug use (Cunningham, Gillespie & Anderson, 2015; Fisher et al., 2014; Sard & Rice 2014). This, in turn, can have an impact on health care workers' sense of security, and some staff may refuse to provide services in high crime areas or require an escort.

To assess whether being homeless was associated with displaying violent or aggressive behaviors, the authors conducted a literature search to answer the question. The following search terms guided the search: "homeless" or "homelessness" and "violence" or "aggression" excluding domestic violence, family violence, youth, and adolescents. Databases used were ProQuest, Academic Search Premier, and PubMed. The searches yielded 47,435 results, and the four articles selected were considered the most relevant. This was determined by first reading the article titles; if they appeared to pertain to violence perpetrated by homeless individuals, we proceeded by reading the abstracts followed by the review of the full article to make a final determination on whether they contained relevant information. We eliminated articles on domestic violence leading to homelessness among women, violence toward the homeless, and violence among homeless youths, among other topics.

The literature suggests that, although being homeless in itself is not the cause of aggressive behavior or violence, some common characteristics, (e.g., drug use, substance abuse, mental illness) among homeless individuals make them more susceptible to displaying violent and aggressive behaviors (Swanson et al., 2002). These conditions are seen in higher rates among the homeless population, which influence violent behaviors. Substance abuse is known to be associated with aggressive outbursts or violent behavior (North, Smith, & Spitznagel, 1994). In a quantitative study by Delisi (2000) of 100 formerly homeless inmates and 100 domiciled inmates, the formerly homeless inmates were more likely to be dangerous and more likely to use weapons than the domiciled inmates. They also had significantly more prior arrests than the

**Table 1.** HUD/VASH Provider Demographics

		Frequency	Percent	Valid Percent
Discipline	Nursing (LPN, RN, ARNP)	18	52.9	54.5
	Auxiliary (SW, OT, Diet, Pharm, Psych)	15	44.1	45.5
	Total	33	97.1	100.0
	Missing	1	2.9	
Total		34	100.0	
Age Range	20-29	1	2.9	2.9
	30-39	5	14.7	14.7
	40-49	3	8.8	8.8
	50-59	17	50.0	50.0
	60-69	8	23.5	23.5
	Total	34	100.0	100.0
Education Level	Bachelor's Degree	1	2.9	2.9
	Master's Degree	30	88.2	88.2
	Doctoral Degree	3	8.8	8.8
	Total	34	100.0	100.0
Years of Experience	6-10 yrs	2	5.9	5.9
	11-15 yrs	6	17.6	17.6
	16-20 yrs	2	5.9	5.9
	21+ yrs	24	70.6	70.6
	Total	34	100.0	100.0

other inmates. Per the author, this may have been because of survival instincts acquired while living on the streets, which required them to use weapons to defend themselves (Delisi, 2000). Violent behavior also could be attributed to the need to adapt to an environment where they feel that violence is a means of survival (Anderson, 1996). Nonetheless, this violent behavior is not uncommon.

If home health care workers do not feel safe, they will limit the amount of time spent completing the patient assessment, education, and visit(s) or lessen the frequency of visits, which may have a negative impact on patient outcomes (Brillhart, Kruse, & Heard, 2004; Campbell et al., 2013; Campbell et al., 2015; Kendra, Weiker, Simon, Grant, & Shullick, 1996). A study by Kendra and colleagues (1996) found that 68% of homecare workers would cut short a visit with a consumer if they felt unsafe in the home (Kendra et al., 1996). Participants also stated that they wrapped up their visits “as soon as possible.” Kendra and colleagues proposed that, when visits were wrapped up “as soon as possible,” the quality of patient encounter and care was compromised (Arnetz & Arnetz, 2000; Galinsky et al., 2010).

**Pilot Study**

In 2015 through 2016, a pilot study was conducted within the North Florida/South Georgia Veterans Health System (NF/SGVHS) HUD/VASH program to assess the prevalence of patient perpetrated violence against federal health care providers serving the homeless or previously homeless population. This pilot was a cross-sectional study that surveyed HUD/VASH providers to develop a baseline understanding of the frequency and prevalence of patient perpetrated violence and reporting of such incidents in relationship to the form of violence and aggression in non-institutional setting. Through use of a systematic literature review, theoretical framework, and focus groups, the researchers developed a survey composed of 37 items. For survey develop-

**Table 2.** Most Recent Form of Abuse

	Frequency	Percent	Valid Percent
Valid None of any kind	3	8.8	8.8
Verbal	23	67.6	67.6
Physical	1	2.9	2.9
Sexual	7	20.6	20.6
Total	34	100.0	100.0

ment and validation, please refer to Campbell et al. (2015). The survey requested quantitative responses regarding the most recent encounter of patient perpetrated violence and aggression. A qualitative question allowed respondents to expand upon any question within the survey. It also gathered information regarding provider demographics and professional information (see table 1).

The sample included all federal employee home care providers within the NF/SGVHS HUD/VASH program. Recruitment criteria for sampled staff within this group were (1) staff employed by the VHA whose job description included at least a .5 full-time equivalent (FTE) of routine non-institutional care services and (2) who were present at the mandatory all-staff meeting held on August 12, 2015. Before survey dissemination, an in-person five-minute introduction was conducted to explain the study and survey, privacy and anonymity assurances, and informed consent form. By completing the survey, participants agreed to the written informed consent distributed to them. The study received approval from the University of Florida affiliated Institutional Review Board and VA Research and Development Committees.

Out of an estimated sampling frame of 66 potential respondents, 35 completed surveys were returned. The response rate of this sample, estimated due to estimated sample frame, was 53%. Within this pilot study, descriptive statistics for the sample included 35 responses representing the disciplines of nursing and auxiliary services (see table 1). Provider characteristics of this sub-sample showed that the overwhelming majority of respondents had a master's degree (85.7%) with most respondents between the ages of 40–49 (31.4 %). Much of respondents had 6–10 years of work related experience.

Within this sub-sample, 88.5% of respondents ( $n=31$ ) reported experiencing patient violence or aggression while providing clinical health care in a non-institutional care setting. The most frequent form of abuse *in the most recent episode* was verbal abuse (80.0%), followed by sexual abuse (8.6%). One respondent indicated experiencing physical abuse of a nonsexual nature as their most recent form of patient perpetrated violence (see table 2).

Four respondents of the total who experienced violence or aggression did not fully complete the survey to reveal if they had reported their most recently experienced incident. Of the 35 respondents who did complete this element of the survey, 34.3% indicated that they had reported this most recent incident, while 54.3% indicated that they did not. Most respondents had experienced verbal abuse (88.6%), and only four respondents (11.4%) had not experienced any episodes of verbal abuse over the past 12-month period. Of those who experienced verbal abuse, 19 did not report this occurrence, and 11 respondents did report the incident. Physical abuse, experienced by six respondents (17.1%), was reported by four respondents, whereas two did not report this incident. Sexual abuse or violence, experienced by 40% of respondents within this sub-sample ( $n=14$ ) is closely split regarding reporting; six respondents did not report this form of abuse, and 7 respondents did report the abuse (see table 3).

**Table 3.** Report Made

		Frequency	Percent	Valid Percent
Valid	No	22	64.7	71.0
	Yes	9	26.5	29.0
	Total	31	91.2	100.0
Missin System		3	8.8	
g Total		34	100.0	

**Discussion and Implications**

While prior studies have identified a gap in the literature regarding the prevalence of patient perpetrated violence in non-institutional health care settings (Campbell, 2016), the results of this pilot study support the findings of existing literature that patient perpetrated violence remains largely unreported specifically in the field of providing health care services to homeless veterans. Filling the existing gap in the literature, this study supports the assertion that unreported workplace violence extends into non-institutional health care settings and offers information on the prevalence of this issue and demonstrates the impact on health care providers serving homeless or recently homeless veterans. This pilot study found a concerning 70% of federal providers have been exposed to at least one form of patient violence or aggression in the past 12 months. Furthermore, 54% of these incidents remain unreported.

With a greater focus on providing services to veterans outside traditional institutional care settings and with the goal of eradicating homelessness among veterans, focusing on barriers to access is indeed warranted. While workplace violence is a well explored phenomenon, exploration of patient perpetrated violence in other health care settings remains in its infancy. The study of patient perpetrated violence in non-institutional health care settings, among the homeless veteran population, is particularly nascent. The National Institute of Occupational Safety and Health (NIOSH) and the Occupational Safety and Health Administration (OSHA) have defined guidelines for workplace violence prevention and response protocols in health care organizations, with evidence that “an integrated organizational perspective” is required. They advise incorporating explicit workplace violence monitoring tools, differentiated training for staff, and a predetermined response protocol (Leather, Beale, Lawrence, Brady & Cox, 1999). The VHA is making great strides toward achieving the NIOSH and OSHA guidelines; however, the results of this review and pilot study suggest that more work is needed.

The direction of the VA to bring health care to the veteran in his/her home and community is likely to be an increasing trend. Thus, addressing the problem of keeping personnel safe is essential considering that home visits are not exclusive to clinical staff (e.g., RN, occupational therapy, or physical therapy). For example, the increasing reliance on telehealth as a form of health care delivery means other nonclinical staff or contractors (e.g., telehealth technicians, IT staff, etc.) who set up equipment at veterans’ homes may not be equipped to handle violent incidents. Thus, the issue of safety is larger than a patient and health care provider relationship. Additionally, the issue extends to veterans who are dually eligible for Medicare Part B benefits because home health care agencies and providers are also at-risk for patient perpetrated violence and aggression. Future work is needed, with a focus on understanding the current prevention mechanisms and training available to keep employees safe and to identify unique requirements that employees servicing the health care needs of this particular veteran population may have.

## **Conclusion**

Considering presidential and congressional efforts calling for health care access solutions and the eradication of homelessness by 2015, providing health services to previously homeless individuals has challenges. Results of this study are consistent with previous studies among other non-institutional health care providers and suggest that incident reporting of patient perpetrated violence among HUD/VASH providers is grossly under-reported. Additionally, with prevalence of patient perpetrated violence and abuse being greater than 88%, recent study results suggest further research is warranted. Future studies should focus on how serving the health care needs of previously homeless veterans may have an impact on the role that health care providers play as they travel to veterans' homes. This article helps us to consider the important question of remote workplace safety and the role that employee safety plays as a contributor or barrier to health care access, as described by Fortney and colleagues (2011). We need to consider what kinds of access solutions might be used to deliver care (e.g., telehealth) that can keep employees safe while serving the needs of previously homeless veterans. This topic and article are timely, as the Department of Labor through the Occupational Safety and Health Administration (OSHA) recently released proposed rules entitled "Prevention of Workplace Violence in Healthcare and Social Assistance" regarding potential standards needed to safeguard health care and social assistance employees. OSHA is seeking input on the magnitude and nature of workplace violence in the health care field, calling into question the effectiveness of interventions and mechanisms currently in place to stop such violence.

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