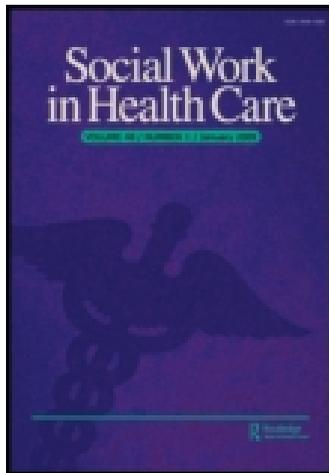


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### Barriers and Facilitators to Veterans Administration Collaboration With Community Providers: The Lodge Project for Homeless Veterans

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# **Barriers and Facilitators to Veterans Administration Collaboration With Community Providers: The Lodge Project for Homeless Veterans**

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*Since 2009, the U.S. Veterans Administration has made concentrated efforts to end homelessness among veterans. As part of these efforts, the Iowa City, Iowa, VA Health Care System in collaboration with local community providers deployed a supportive housing program aimed at homeless veterans. Called the Lodge program, it is intended to serve a Mid-Western mid-size city and its surrounding rural communities. This article presents qualitative findings from a mixed-method, two-year formative evaluation of the Lodge's implementation. Primary barriers to the effectiveness of the Lodge program were regulations hindering cooperation between service programs, followed by problems regarding information sharing and client substance abuse. Facilitators included personal communication and cooperation between individuals within and among service groups. The feasibility of implementing a Lodge program in a more rural community than Iowa City was also discussed.*

**KEYWORDS** *homelessness, veterans, social services, co-operation, rural health, communication, substance abuse*

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## INTRODUCTION

The 2011 Veterans Administration (VA) Point-In-Time (PIT) count, taken on a single night in late January of that year, identified more than 67,000 homeless veterans in the United States (U.S. Department of Housing and Urban Development, 2012). In November of 2009, Secretary of Veterans Affairs Eric K. Shinseki announced that the VA would end homelessness among veterans in five years. Although the current count reflects a 7% decrease in the number of homeless veterans in the past year, the commitment is that “we will not be satisfied until no Veteran has to sleep on the street” (U.S. Department of Veterans Affairs, 2012).

This article presents a case study of the Iowa City Veterans Administration Health Care System (ICVAHCS) collaboration with local community providers to develop a local supportive housing program serving a mid-sized city and its surrounding rural communities. As part of a two-year formative evaluation of the Lodge Project’s effectiveness, we conducted qualitative interviews with community and VA providers of services to homeless veterans to better understand barriers and facilitators to collaboration between institutional stakeholders. In this article we summarize challenges and facilitators encountered in implementing the housing program, as well as primary factors affecting its feasibility in more rural locations.

## BACKGROUND LITERATURE

### Homeless Veterans

The exact number of homeless Veterans in the US is hard to determine, but PIT counts and other research has shown that Veterans form a disproportionate percentage of the homeless population in the United States with homelessness rates among veterans at 1 to 1.4 times higher than non-veterans (Fargo, Metraux, Byrne, Munley, Montgomery, Jones, et al, 2012; Perl, 2009; U.S. Department of Housing and Urban Development, 2012). Examination of homelessness among veterans has found that they share a distinct set of features that set them apart from the general population of homeless in the United States. Homeless male veterans are more likely to suffer from mental health disorders, alcohol abuse, and other health problems than homeless non-veterans (53% vs. 41%). Both male and female veterans are more likely to experience homelessness than males and females in the general population (Fargo et al., 2012; Perl, 2009). Several studies have determined that homeless veterans are generally older than homeless non-veterans, and are more likely to be White (O’Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003; Rosenheck & Koegel, 1993; Winkleby & Fleshin, 1993). As well, compared to non-veterans, veterans are likely to be homeless for more than a year (Tessler, Rosenheck, & Gamache, 2002) and are significantly likely to abuse substances/alcohol, with substance/alcohol

abuse running at approximately 80% among homeless veterans (Balslem, Christensen, Tuepker, & Kansagara 2011). To serve veterans experiencing homelessness the Veterans Health Administration (VHA) supports a number of programs; however, other than the Housing Choice Vouchers offered through the Housing and Urban Development - Veterans Affairs Supported Housing (HUD-VASH) program, a housing-first model offering a low-rent housing option and case management services to homeless veterans, the VHA does not fund permanent supportive housing for veterans in need of it.

### VA Community Collaborations

In the late 1980s Congress provided the VA with funds that would offer case management, outreach, and residential treatment services for mentally ill and homeless veterans, allowing official collaboration between the VA and community agencies (Rosenheck, Frisman, & An-Me, 1994). In this cooperative relationship, case management and community outreach are provided by VA staff, and residential services are provided through contracts with community agencies through the Health Care for Homeless Veterans (HCHV) program. In 1994, Congress passed legislation (Public Law 102-405) mandating that all VA medical centers meet annually with local community agencies to assess the needs of homeless veterans and to develop plans to meet those needs. To implement this law, the VA developed the Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG) program for veterans. Project CHALENG is based on the principle that no single agency can provide the full spectrum of services required to help homeless veterans become productive members of society, and thus collaboration among service providers is a necessity. The goal of Project CHALENG is to enhance coordinated services by bringing the VA together with community agencies and other federal, state, and local governments who provide services to the homeless, to raise awareness of homeless veterans' needs, and to plan to meet those needs.

The VA Grant and Per Diem Program (GPD), under the umbrella of the HCHV program, is offered annually to fund community agencies providing services to homeless veterans. The grants represent collaboration between VA and community providers, with VA homeless outreach social workers serving as liaisons between agencies. Another collaborative program is HUD-VASH, a partnership with HUD where a VA social worker administers section 8 vouchers in partnership with the Public Housing Authority (PHA). Other collaborations with community agencies such as the Compensated Work Therapy program (CWT) focus on employment support for homeless Veterans (<http://www.va.gov/health/cwt/>).

### Introduction to the Lodge Project

Because the known causes of homelessness are both numerous and complex, no single approach will provide a comprehensive solution to the

problem. However, in an effort to address key aspects of the issue locally, the Iowa City VA Health Care System (ICVAHCS) collaborated with the Iowa City homeless shelter (Shelter House) to identify local needs and potential solutions. Iowa City is an urban area (metro area population of 152,586) surrounded by rural, mostly agricultural communities. The ICVAHCS includes the Iowa City Health Care System plus nine community-based outpatient clinics (CBOCs) serving 45,000 veterans, of which 64% are rural. The homeless veteran population served by the ICVAHCS is estimated to be 985.

Local collaboration with Shelter House and the National Alliance of Mental Illness of Johnson County (in which the ICVAHCS is located) resulted in the formation of a Lodge model for permanent housing with priority given to homeless rural veterans in Eastern Iowa. The Lodge program was initially funded through low interest loans and financial assistance from the Johnson County Housing Trust Fund, the City of Iowa City, and other grants submitted by Shelter House. During the implementation phase of the program, funding for trainers and program evaluation was provided by the VA Office of Rural Health. The Lodge, based on the Fairweather Lodge model conceived by George Fairweather in 1963, aims to provide permanent, independent housing for as long as the client chooses. In a Lodge model, homeless individuals live together in a single home without any live-in staff, collaborate in performing household duties and at an income-producing job, work interdependently to maintain medication compliance, and socialize with each other. Nearly 50 Lodges are active across the Midwest and Northeast United States, and research on these facilities shows good psychological outcomes and work performance, high medication compliance, and low recidivism (Coalition for Community Living, 2009).

The Iowa City Lodge project is composed of two Lodge houses, each with capacity to house six participants. Prior to graduating to residential status in the Lodge houses, participants complete three to six months of extensive work and life skills training, and are stabilized on appropriate medications. Currently, one of the residential Lodge houses also serves as the training center, where client training sessions are held during weekdays. Training participants reside at Shelter House while they are completing the training process. Shelter House recently secured a grant for the purchase of another house that will serve as a dedicated training lodge, allowing participants in training to sleep at the Lodge rather than at Shelter House while undergoing the training process. Removing the training program from the Lodge will allow more privacy and autonomy for the graduate occupants and more consistency for the trainees.

Veterans are referred to the Lodge through a number of mechanisms. Most begin as residents of Shelter House and are identified by staff as veterans and thus potentially eligible for Lodge participation. Others are referred to the program by ICVAHCS social workers and the Iowa Veterans Home. To be eligible for the Lodge program, participants must have a serious and

persistent dual-diagnosed mental illness (i.e., schizophrenia, schizoaffective disorder, bi-polar disorder, or major depressive disorder). Participants must be willing to take prescribed medications, not have been suicidal in the past three months, not currently abusing drugs or alcohol, and be willing to work 20 hours a week. As this is not a Housing First program, and employment is an essential element of the Lodge program, veterans with current drug or alcohol problems must be willing to address those problems during the training program.

## METHODOLOGY

### Study Design

This article presents a case study (Yin, 2003) that explores VA and Community Provider collaboration. Here we present qualitative findings from a mixed-method, two-year formative evaluation of the Lodge's implementation, guided by an ethnographically informed approach. Data collection activities included semi-structured in-person interviews and participant observation of VA and community provider meetings and Lodge house activities.

The evaluation was conducted in two phases. In the first year we focused on understanding the process and structure of VA/Community collaborations, in particular examining the roles of the primary individuals involved in this process. We conducted interviews with VA and community providers of homeless services. We also attended the monthly VA social worker support meetings as well as inservices conducted by the social work homeless outreach team, which introduced various services available for homeless veterans. To build rapport with Lodge house staff and participants and to gain familiarity with the Lodge house culture, we held weekly on-site Lodge house meetings with the Lodge house staff. In the course of those meetings, we were also able to assess ongoing communication and collaboration efforts.

In the second year, we continued to investigate the referral process—and the problems with it that had been identified in Year 1. We conducted additional interviews with VA providers and collaborated with the social work homeless outreach team on the development and presentation of a VA inservice on the Lodge project. We continued to hold weekly meetings with Lodge house staff.

### Sample

Purposeful sampling was used to recruit all participants. In year 1 of the project, we conducted semi-structured qualitative interviews with VA and community providers of services to homeless veterans living in the

community. VA providers invited to participate ( $n = 15$ ) were identified by their job title in the Veterans Integrated Service Network (VISN) directory. Community providers ( $n = 14$ ) were identified either by their collaborative work with VA providers, or through local information describing homeless services available in the area. In year 2, we conducted ten additional interviews with VA service providers who were identified by the VA social work homeless outreach team as those who have frequent contact with homeless veterans. We also interviewed individuals who had joined the social work homeless outreach team since year 1 ( $n = 3$ ). All participants received an informed consent document describing the study, and all steps were taken to ensure participant confidentiality and data protection. All phases of this study were approved by the local Institutional Review Board and by the Department of Veterans Affairs Research and Development Committee.

### Research Instrument

An interview guide was developed to address communication and collaboration within the VA and between VA and community providers of homeless services. Questions were tailored to the provider group being interviewed (i.e., VA provider or community provider). The guide included questions related to barriers and facilitators to veteran participation in services provided by the interviewee, as well as awareness of the Lodge program. We also included questions exploring the feasibility of a Lodge program in more rural communities. Interviews were not audio-recorded. Field notes were taken by the interviewer during interviews and after attending meetings and Lodge activities. Typed versions of the notes were later reviewed with interviewees for accuracy.

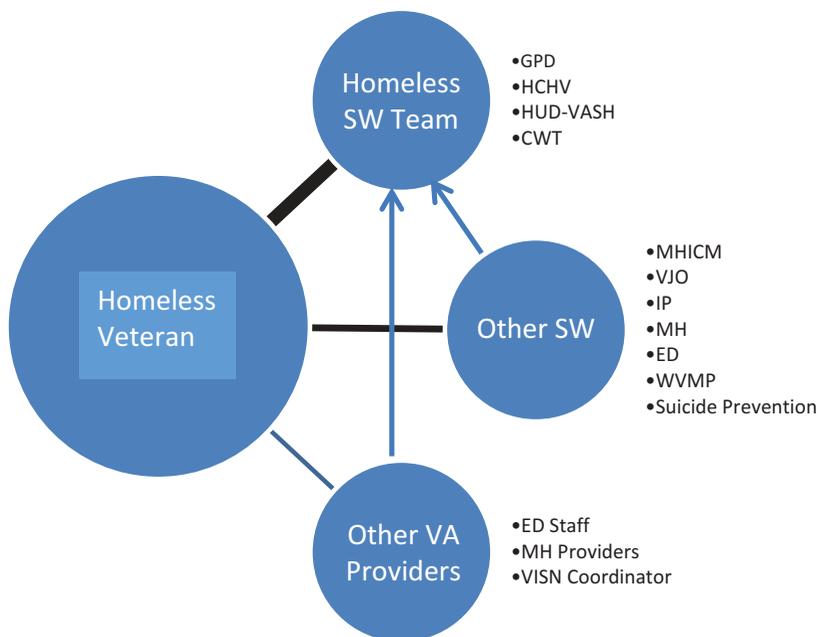
### Analysis

Interview field notes were reviewed by two members of the research team. After reading the field notes, a code book was developed using inductive and deductive codes. These notes were entered into MAXQDA 10, a qualitative data management software program, for data management and content analysis. Segments of the field notes were labeled by thematic content as they appeared in the notes. A portion of the field notes was independently coded by two researchers for agreement. When consensus was reached, the remaining field notes were coded by the researcher who conducted the interviews. The emergence of new themes and sub-codes identified from interviews conducted during year 2 led to revision of the codebook. These changes were tracked in an audit trail. To validate the data, we triangulated interview findings with participant observation of VA and community provider activities and with the literature to confirm consistency of themes.

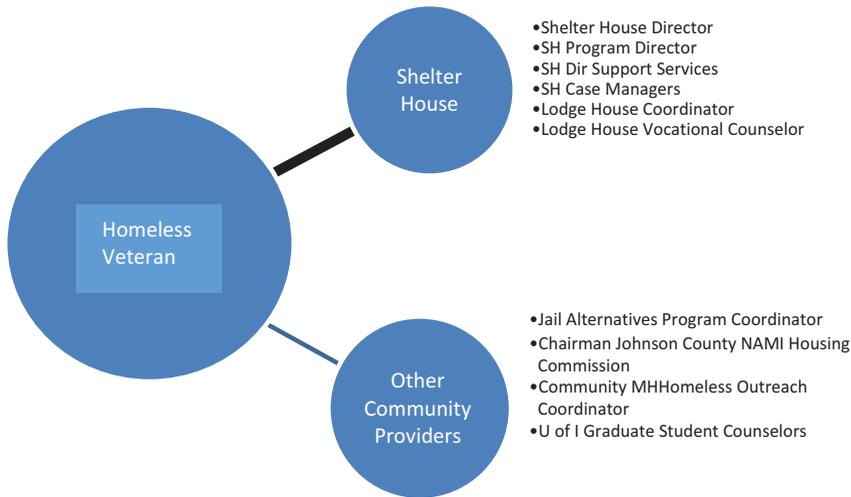
## RESULTS

A total of 39 interviews were completed during the first two years of this project, 25 with VA providers and 14 with community providers of services to homeless veterans. VA providers included the homeless social work team (with members funded by GPD, HCHV, HUD-VASH, CWT), and social workers from Mental Health Intensive Case Management (MHICM), Veterans Justice Outreach (VJO), and inpatient (IP), mental health (MH), emergency department (ED), the Women Veterans Program Manager (WVPM), and the suicide prevention coordinator. We also interviewed other VA providers who serve homeless veterans as a part of their routine service (ED staff, MH providers, and the VISN Homeless Coordinator). Community providers included Shelter House (SH) staff and other local and community providers of services to the local homeless population. Figures 1 and 2 list these providers and illustrate their relationships to veterans and to each other.

Qualitative findings are presented in three major categories: (1) Barriers to collaboration that would inhibit Veteran participation in services provided, (2) Factors that facilitate collaboration and encourage Veteran participation, and (3) Feasibility of a Lodge project in a more rural community.



**FIGURE 1** VA providers interviewed.



**FIGURE 2** Community providers interviewed.

## Barriers to Collaboration

### LACK OF COORDINATION BETWEEN COMMUNITY PROVIDERS AND VA

A key theme identified by our participants was the lack of coordination between community providers and the VA.

One of the barriers consistently identified was the way that regulations hampered access to services and hindered successful collaborations. For instance, regulations can limit the homeless veteran to benefits from only one service program and deny benefits from others. Other VA programs require rigid inclusion criteria, resulting in neglect of some veterans. The eligibility requirements for still other programs are confusing to staff and clients alike. For example, one of the Lodge house residents applied for a HUD-VASH voucher and was told he was ineligible; so it is not clear to the community provider if HUD-VASH will be a resource for the Lodge program participants. A VA homeless outreach social worker commented on this incident and reported that there were some communication and information gaps surrounding the requirements for the HUD-VASH program, especially guidelines regarding payment of the Lodge house's utilities and the manner in which the Lodge program handles this, which does not align with HUD guidelines.

The layers of bureaucracy within the VA also inhibit communication with providers outside of the VA. One community provider mentioned that the multiple forms that are required for most VA services are challenging when trying to provide services for an unstable population. Another community provider noted that the VA system is surprisingly opaque, resulting in many

homeless veterans not knowing about benefits for which they are eligible. The provider explained that veterans find access to services in a variety of ways that fall outside of bureaucratically proscribed processes. This suggests that gaps in services might occur less frequently if services and sources of benefit information were better integrated. For example, most of the veterans go to the VA medical center but not the mental health clinic located off-site, so they are not aware of the support groups and classes available in affiliated facilities.

Information sharing between VA and community providers is also a barrier. Community providers report that they often are unaware of many VA services, and thus are not able to inform veterans who may benefit from these services. For example, the Shelter House staff only recently learned that VA has detox beds and some dental services available for veterans. One provider identified the need for a centralized portal to receive information on new services available to veterans through the VA. Additionally, more than one provider described the difficulty in contacting the VAMC outside normal business hours (8 a.m.–4 p.m.), a time in which many homeless veterans' needs arise.

#### RESTRICTIONS IN THE EXCHANGE OF INFORMATION BETWEEN PROGRAMS

Community providers described the VA's reluctance to release discharge information to Shelter House staff regarding veterans who will be returning to the shelter upon hospital discharge. Since Lodge trainees reside at Shelter House while in the training program, this creates difficulties in follow-up with needed support and care recommendations. Also, Shelter House and the Lodge program have contracted with a non-VA psychiatrist to oversee mental health care for Veterans at Shelter House and in the Lodge program. This has led to obstacles to non-VA physicians for providing care for veterans or collaborating in veteran care. Since all Lodge program participants experience serious mental health problems, immediate and continuous mental health care is essential to the program's success. Thus, continuity of care is impacted by VA restrictions on information sharing between VA and non-VA providers.

#### A CONCENTRATION OF INSTITUTIONAL AUTHORITY AND EXPERTISE IN CERTAIN INDIVIDUAL "CHAMPIONS"

It was found that patients tend to develop relationships with specific providers, and the providing agencies tend to depend on the expertise of one individual service provider. When/if that person leaves, the provider network can fall apart without that individual's information and contacts. This impairs day-to-day decision-making and limits procedural understanding. This was evidenced in our year 2 interviews with new homeless outreach social

workers who lacked the experience and expertise of their predecessors who had held the position for many years.

#### LACK OF AWARENESS OF CRITERIA FOR INCLUSION IN THE LODGE PROGRAM, IN PARTICULAR AMONG VA PROVIDERS

This barrier was mentioned frequently in both years 1 and 2. Despite previous VA inservices related to the Lodge program, and efforts on the part of VA homeless outreach social workers to promote information about this housing option, many providers who work directly with homeless Veterans were either unaware of the Lodge project or were misinformed about its criteria for admission. Awareness of the Lodge's inclusion criteria is very important since it experiences frequent turnover among its participants (many leave the program prior to completion of training) making continuous referrals to the program essential.

#### LIMITED CHRONIC SUBSTANCE ABUSE (SA) ASSESSMENT, TREATMENT, AND LONG-TERM CARE OPTIONS FOR VETERANS

The most common barrier not only to collaboration but to veteran participation in the Lodge project, cited by both VA and community provider interviewees, was veteran substance abuse and its related problems. Substance abuse was the predominant reason Lodge house trainees failed to complete the training program. Shelter House's prohibition of the use of alcohol or illegal substances by its residents limits veterans' engagement with the Lodge program since Lodge program trainees sleep at Shelter House while in Lodge training. Long-term prescription pain medication complicates SA issues and many of the veterans referred to the program reported long-term and ongoing use of opioid pain medication. The availability of drugs and alcohol to Lodge trainees while living at the Shelter House—despite its prohibitions—is also problematic. These problems are often not identified until after a veteran has begun the Lodge training process.

### Facilitating Factors

#### COMMUNICATION AMONG VA HOMELESS SERVICE PROVIDERS

The VA homeless social work team reports regular and frequent communication among team members, both informally and in scheduled meetings. Other VA providers were well aware of who to contact on the homeless team when a veteran experiencing homelessness or near homelessness was identified. Use of the VA's electronic health record, CPRS, for all veteran contacts facilitates communication among VA service providers about veteran needs. The homeless social work outreach team has recently begun using

iPads, which enable immediate onsite communication between a homeless outreach social worker in the field (with a veteran) and an in-house VA provider.

#### VETERANS' CONNECTION TO VA HOMELESS OUTREACH SOCIAL WORKERS

The VA homeless outreach social workers go to the veteran—they do not require the veteran to come to them. This helps build rapport and facilitates referral of the veteran to needed services. VA homeless outreach social workers routinely visit shelters and other venues where homeless persons congregate, such as free lunch programs and known homeless campsites.

#### POSITIVE RELATIONSHIPS BETWEEN VA HOMELESS OUTREACH SOCIAL WORKERS AND SHELTER HOUSE STAFF

Shelter House providers uniformly agreed that communication and collaboration with VA outreach social workers *on an individual level* was good. VA homeless outreach social workers reported regular informal networking with community providers at locations where homeless seek aid, such as free lunch programs, local shelters, and Vet centers.

#### VA SOCIAL WORKER COMMUNICATION: INTERNAL AND EXTERNAL

VA social workers (including the VA homeless social work team) hold regularly scheduled monthly meetings. They also report numerous informal contacts, especially between and among the homeless outreach social workers. Communication with veterans is tracked in CPRS, which enables communication between VA providers. For example, when the ED social worker encounters a veteran in need of homeless services, this information is noted in CPRS and flagged for a consult with the appropriate homeless team member.

Presence at monthly Continuum of Care (COC) meetings is required by HUD for communities to receive funding and to ensure services are not duplicated. These meetings bring together all the community organizations that are providing services to homeless. Although the VA does not receive HUD funds from this participation, their presence at COC meetings can help to leverage funds. COC is administered at the state level but is federally funded with reapplication every three years. As well, VA social workers attend a monthly Recovery in Action meeting which includes all community homeless service providers. Additionally, the VA homeless social work team has an ongoing presence at locations where homeless congregate (shelters, free lunch programs, etc.). The annual CHALENG process brings VA and community providers together yearly.

## Feasibility of a Lodge Project in a More Rural Community

Providers also identified factors that would impact the applicability of the Lodge as a permanent housing solution for rural homeless veterans. These factors follow.

### SUFFICIENT POPULATION OF HOMELESS VETERANS IN NEED OF SERVICES TO SUPPORT THE TRAINING AND LODGE PROGRAMS

Both community and VA providers mentioned the scarcity of services as well as uncertainty about the numbers of homeless veterans residing in areas more rural than Iowa City. VA homeless outreach social workers clearly identified the difficulty in obtaining actual counts in more rural areas, the reluctance of local officials to inform individual social workers of homeless campsites for security reasons, and the uncertainty of how many homeless veterans would be needed to support a Lodge program in a less populated area.

### SUITABLE LOCAL JOB OPPORTUNITIES FOR LODGE PARTICIPANTS

The availability of suitable employment is a key component of the Lodge model. The relative scarcity of employment opportunities in smaller communities poses a challenge identified by nearly all providers interviewed.

### TRANSPORTATION

Transportation services in more rural locations are relatively limited. Thus, transportation to VA health care centers, to places of employment, and to recreational and community activities becomes a more prominent issue when considering the establishment of a Lodge program in a rural area. As mentioned, access to physical and mental health care is essential to the success of the program; especially crucial is immediate access to mental health care, which would pose a distinct challenge in smaller, more rural areas. Although many of the Iowa City Lodge program participants have driver's licenses, many rely on public transportation, which may not be available in outlying areas.

### IMPORTATION OF STAFF FROM MORE URBAN LOCATIONS IF LOCAL STAFF IS UNAVAILABLE

It is likely that skilled staff needed to initiate and manage the Lodge program would have to be brought in from a more urban area. Once the Lodge is up and running, it is possible that some of the initial staff support could be withdrawn. Experience with the Iowa City Lodge program has shown that this could take approximately two years. However, given the turnover

among Lodge participants, it would be necessary that some training staff be available in an ongoing capacity.

#### COMMUNITY BUY-IN

All VA and community providers identified the need for community support of the Lodge program. The high degree of social familiarity often present among members of smaller communities can either more easily stigmatize Lodge participants or strengthen their community support. Community acceptance of individuals with mental health issues and a willingness to support the program and its participants is necessary to prevent Lodge participants from becoming isolated in their community.

#### CONCLUSIONS AND RECOMMENDATIONS

The problem of homelessness among America's veterans is both broad and complex, and requires collaboration among a spectrum of community providers if homelessness is to be ended among this population by 2015. The U.S. Department of Veterans Affairs has stressed this reality: "Still, VA cannot do it alone. Organizations and individuals in communities across the country are integral to providing services to Veterans and spreading the word about the resources VA provides to end and prevent homelessness among Veterans" (2013). The present case study described the collaboration of the Iowa City VA Health Care System and local community providers in developing a Lodge program for homeless veterans with serious mental health problems. Specifically, we assessed the barriers and facilitators to collaboration in establishing the program, and described providers' estimations of the feasibility of implementing a Lodge program in a more rural area. Although barriers and facilitators emerged within the context of implementing the Lodge program, many have broader applicability beyond this case.

During our investigation, themes emerging from both VA and community providers were surprisingly similar. Analysis of the identified barriers to collaborative efforts revealed them to be predominately institutional in nature, that is, practices embedded in organizational structures and relationships that cannot easily be changed. Institutional practices within the VA were found to inhibit communication among VA providers, and institutional norms and policies make working with agencies outside the VA difficult. Each of these barriers, other than chronic substance abuse, was found to in some way impede the flow of information and effort, restricting attempts to create a more organic set of relationships that would enhance the program's effectiveness and vitality. These would be relevant points of concern and possibly pose significant challenges to other programs that depend on

collaborative efforts between VA and community providers, as well as among community providers themselves.

Although many of these barriers are institutional and therefore resistant to change, we found that certain facilitators can be leveraged to improve VA/community collaboration. These facilitators to communication and collaboration were found to be more “individual” in nature; that is, the most effective facilitators were identified as *individuals* who work directly with veterans and in conjunction with community providers. The work of these individual actors often transcended the impediments of institutional cultures and practices. Thus, efforts to strengthen communication and collaboration between the VA and community providers should focus on ways to support and enhance these individual efforts.

Our findings suggest that having a strong, motivated, and unified staff network within the VA working to support homeless veterans creates the necessary communication and workflows to connect veterans to VA and community resources. VA homeless outreach social workers play a key role as they are most often the veteran’s first point of contact, and often find informal opportunities to leverage collaborative relationships established with community social workers while “in the field” in such places as campgrounds, community free lunch programs, and local homeless shelters. Also important are the other VA homeless service providers such as ED staff and primary care providers who coordinate care and access to programs. Without good communication and coordination within the VA itself, processes such as making referrals—an essential facet of the program—break down.

Since high turnover in social service staff and other key positions is normal (and may be universal to social service programs), new employees must be oriented to these positions. To maintain awareness of the Lodge among providers, part of normal orientation, including education on other available social service program, should also include knowledge of the Lodge program and its referral processes. Despite good communication within the VA and among its social service providers, we found that there remains a lack of awareness of the Lodge among VA *health care* providers; this lack of awareness is another factor that affects the number and appropriateness of referrals. A way to ensure that this information is disseminated is the provision of annual inservices to inform health care providers of the Lodge option for homeless veterans. External to the VA, the VA’s presence at community meetings provides a formal mechanism for coordinating effort and an opportunity to build relationships with other individuals and organizations serving homeless veterans. Whether within the VA or among the VA and its social service collaborators, efforts to maintain awareness of the Lodge’s purpose and requirements must be consistent.

Although not an issue pertaining directly to institutional communication or collaboration, the overarching problem of substance abuse was identified in the present study both as an individual and an institutional barrier. This

problem has been identified and investigated in much of the literature on homelessness (Semmelhack, Ende, Farrell, Hazell, & Song, 2010) and discussion of the problem is beyond the scope of this article. However, it is important to note that in this evaluation, substance abuse was the barrier most frequently mentioned by both VA and community providers in preventing successful Veteran participation in the Lodge program. As such, the problem in this context bears further analysis.

This pilot study has shown the Lodge program in Iowa City to be a promising permanent housing model for homeless rural veterans located in an urban area (such as Iowa City), provided the area has sufficient resources to support the program. However, in a further assessment of the Lodge model's viability in a rural setting, the general consensus among both VA and community providers interviewed is that establishment of a Lodge may not be an option in a community more rural than Iowa City, primarily due to difficulty in accessing health care services, transportation requirements, and need for suitable employment for participants.

In summary, the Lodge program as it exists in Iowa City reflects the complexity of the problem of veteran homelessness and perhaps homelessness as a whole: the efforts of no single agency or program can ameliorate the issue. Broadly applied, implementation of collaborative programs requires adequate dissemination of information as well as fluid communication between the various actors involved. An example are the lessons learned in this study, which show that the success of the Lodge depends in great part on collaboration among the VA, the Lodge itself, and other community providers. Identification and analysis of factors that either impede or facilitate this collaboration is a necessary step to enhance the Lodge program's effectiveness. Such an analysis could as well aid other social service programs that share the aim of responding to homelessness, helping them achieve their collective goal of addressing veteran homelessness on a local level.

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