

Facing the Digital Divide: Increasing Video Visits Among Veterans Experiencing Homelessness

Alyson Prince, DNP¹

Ynez Sabio, MSN¹

Leah Effron, MSN¹

Maren Abromowitz, MSN¹

Liesl Reyes, PharmD¹

Phillip Chen, MD¹

Christine Willinger, MD, MPH¹

Diamond Ng, MD¹

¹Veterans Administration Greater Los Angeles Healthcare System, Los Angeles, California

²UCLA Department of Family Medicine, Los Angeles, California

³UCLA Fielding School of Public Health, Los Angeles, California

Julia Darnell, PharmD¹

Kristin Kopelson, DNP, MS¹

Peter Capone-Newton, MD, MPH¹

Brianna Cowan, MD¹

Katharine Borthwick, MD¹

Cleo Penamon, PharmD¹

Lillian Gelberg, MD, MSPH^{1,2,3}

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THE INNOVATION

The COVID-19 pandemic increased the need for telemedicine in primary care and subsequently widened the gap of technology inequity among vulnerable populations.¹ In response, an interdisciplinary team of primary care clinicians implemented a quality improvement project to increase video visits for veterans experiencing homelessness (VEH). Our project addressed patient and clinician technology barriers, utilized Veterans Administration (VA)-sponsored telehealth programs to bridge access to care for VEH, and highlighted an interprofessional team approach that strengthened telemedicine practice during the COVID-19 pandemic and beyond.

WHO & WHERE

In 2020, Los Angeles had 66,433 people experiencing homelessness, including 3,902 veterans.² The national VA Homeless Patient Aligned Care Teams (HPACTs) are community-based outpatient “medical homes” that provide comprehensive, individualized care to VEH. The VA Greater Los Angeles, home of the largest HPACT, serves more than 3,000 patients per year (mean age 56 years; 95% male; 46% Black, 28% White; and 26% other race/ethnicity).³

HOW

The VA’s COVID-19 response aligned with national initiatives to prioritize video visits over telephone visits when conducting telemedicine.

Conflicts of interest: authors report none.

Corresponding author

Alyson Prince, DNP
VA Greater Los Angeles Healthcare System
11301 Wilshire Blvd
Los Angeles, CA 90073
alyson.prince@va.gov

We anticipated unique challenges achieving this national goal in our VEH population. Our team conducted an evidence-based literature review on the impact of telemedicine amidst the COVID-19 pandemic,^{4,6} identified current HPACT video visit rates and obtained clinic leadership endorsement for our project. After in-depth staff interviews, we identified the primary organizational barrier was a lack of a standardized process for scheduling and conducting video visits. Delays in video visit care led VEH and clinicians to opt for telephone visits.

Our project aimed to increase the percentage of video visits among telehealth visits to 10% within 16 weeks (**Supplemental Figure 1**). The primary process change was the implementation of a flowchart (**Supplemental Figure 2**) that detailed a standardized workflow for video visits. This new workflow promoted an efficient clinician experience. Additionally, our team utilized existing VA programs such as the Digital Divide Consult, which connects VEH to technology support and devices. Clinic social workers, peer support specialists, case managers, and mental health clinicians assisted VEH with obtaining and using their devices for an effective video visit patient experience. Ensuring that our homeless program affiliates had a VA-provided iPad on-site further reduced video visit no-show rates. Lastly, we reinforced staff participation during monthly meetings, conducted live demonstrations of VA-supported video visit applications, and shared successful strategies from video champions.

The proportion of video visits among telehealth visits doubled from baseline by the conclusion of the 16-week intervention period (December 2020: 4.8% vs April 2021: 10.3%, $P < 0.001$). Post-intervention rates continued to increase during the following month (4.8% vs 12.9%, $P < 0.001$). Video visit uptake differed by age (19% of patients aged <60 years vs 10% aged ≥60 years, $P < 0.001$) and housing status (19% of patients in long-term supportive housing vs 12% in other settings, $P < 0.001$), but did not differ by sex, race/ethnicity, or documented diagnosis of serious mental illness.

LEARNING

The COVID-19 pandemic highlighted the need to address the digital divide for disadvantaged populations accessing health care. We found that standardized video visit workflows, sustained education, and maximizing resources available at the VA proved essential to increasing video visit use. We recommend future studies exploring the impact of programs providing persons experiencing homelessness with digital access devices and identifying factors affecting differential video visit use in emergency shelter, transitional, and permanent housing program participants.

 [Supplemental data, including acknowledgments, references, etc.](#)

Key words: veteran; homelessness; telemedicine; telehealth; COVID-19; video visit; primary care

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