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Intake Case Managers' Perspectives on Rural Veteran Homelessness

Amanda Eun Jee Webreck
Walden University

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Walden University

College of Social and Behavioral Sciences

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Amanda Allen Webreck

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Review Committee

Dr. Tina Jaeckle, Committee Chairperson, Human Services Faculty

Dr. Kristin Ballard, Committee Member, Human Services Faculty

Dr. Jan Ivery, University Reviewer, Human Services Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Walden University

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Abstract

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by

Amanda Allen Webreck

MA, Capella University, 2011

BS, University of North Carolina at Wilmington, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Human Services

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Abstract

Homeless research has focused on the service-directed approach, but few qualitative studies have focused on the critical and sensitive nature of the intake process. Staff in rural and remote communities struggle to refer services and mainstream resources to homeless veterans. The purpose of this case study was to explore case managers' perspectives on intake procedures in rural Pennsylvania communities. Lewin's force field analysis was used as a theoretical basis to examine the rationale for behaviors and forces that impact an individual's state. Six case managers and 1 supervisor were selected for face-to-face interviews based on their experience, job duties, and length of time involved in homeless services. The themes that emerged from coding analysis included coordinated entry, paperwork length and redundancy, geographical barriers including transportation and employment services, identification and outreach, and case management staff. Findings may be used to improve assessment techniques and critical time intervention strategies to reduce the length of homelessness for rural veterans.

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Dedication

I dedicate this dissertation to my family and friends. I want to thank my husband, Russell, for being an instrumental figure in helping me complete this journey. I know it has been a challenging process, but I appreciate your dedication and unwavering support to my personal and professional goals. You provided a light in a dark, uneasy path and allowed me the freedom to explore and gain my confidence again. I would also like to thank my children, Rori and Lana, for being so patient and supportive throughout “mommy’s school nights.” I hope I can make you proud!

I would also like to take a moment to mention how grateful I am to my parents, Gerald and Sandra, for their encouragement to continue my dreams. Being a single mother and pursuing my academic goals was a new and frightening adventure, but I cannot explain how much I admire your willingness to help out when I needed a break or someone to read my work. Your support and endless love have provided a strong foundation for me to help others in this world and make a difference in someone’s life.

To my siblings and family...I love you all and appreciate your kind words and encouragement throughout this process! The bond that we carry with each other has offered me countless memories and a world where I know the meaning of love. Thank you!

Finally, I would like to extend my admiration and gratitude to my two best friends, Taryn and Brooke. Even though you entered my life for different reasons, I love how you have complemented my journey in so many ways. We may have miles between us, but your friendship means the world to me.

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Table of Contents

Chapter 1: Introduction to the Study.....	1
Background.....	2
Problem Statement.....	3
Research Question.....	7
Possible Types and Sources of Information or Data.....	7
Theoretical Foundation.....	8
Nature of the Study.....	10
Definitions.....	11
Assumptions.....	13
Delimitations.....	13
Limitations.....	14
Significance of the Study.....	14
Summary and Transition.....	16
Chapter 2: Literature Review.....	17
Literature Search Strategy.....	18
Theoretical Foundation.....	19
History of Veteran Homelessness.....	22
Civil War.....	23
Vietnam War.....	24
Iraq & Afghanistan War.....	25
Fundamental Barriers for Homeless Veterans.....	26

Effectiveness of Case Management	27
Intake Assessment Tools and Strategies	31
Challenges With Screening Techniques	33
Geographical Barriers	35
Summary and Conclusion	36
Chapter 3: Research Method.....	38
Research Design.....	40
Role of the Researcher	41
Methodology.....	42
Participant Selection Logic.....	42
Instrumentation	43
Interview	43
Secondary Data	44
Data Analysis Plan.....	44
Issues of Trustworthiness.....	45
Credibility	45
Transferability.....	46
Dependability	46
Confirmability.....	47
Ethical Procedures	47
Summary	48
Chapter 4: Results.....	49

Setting	49
Demographics	49
Data Collection	50
Data Analysis	51
Evidence of Trustworthiness.....	52
Credibility	52
Transferability.....	52
Dependability	53
Confirmability.....	54
Results.....	54
Coordinated Entry System	55
Paperwork Length and Redundancy	58
Geographic Barriers: Transportation and Employment.....	60
Identification and Outreach.....	63
Case Management Staff	66
Steps Moving Forward.....	69
Chapter 5: Discussion, Conclusions, and Recommendations Introduction	73
Interpretation of the Findings.....	73
Theoretical Framework.....	78
Limitations of the Study.....	79
Recommendations.....	80
Conclusion	81

References.....	84
Appendix A: Homelessness Interview and Protocol	107
Appendix B: Letter of Cooperation from a Research Partner.....	110
Appendix C: Confidentiality Form	112

Chapter 1: Introduction to the Study

The housing crisis in Pennsylvania has created a movement to reassess the current intake procedures that housing providers use when assessing homeless veterans (Pennsylvania Coordinated Entry Committee, 2018). Organizations are training frontline staff to implement emergency based services as a form of early intervention techniques to reduce the number of homeless veterans in the state of Pennsylvania (Burt, McDonald, Montgomery, Pearson, & the Urban Institute, 2005; National Alliance to End Homelessness, 2015). However, case managers are faced with a complex and constantly evolving population. Homeless providers are dealing with a challenging environment to offer rapid assessment, shelter diversion services, and implement crisis intervention techniques (SAMHSA Homeless Families Coordinating Center, 2005; United States Interagency Council on Homelessness, 2018). Equally important, case managers are focusing on improving housing stability in rural communities for homeless veterans while also addressing mental health concerns, substance abuse, employment and training opportunities, and the income status of the individual or family (Byrne, Treglia, Culhane, Kuhn, & Kane, 2015; Castro, Kintzle, & Hassan, 2014; Caruso, 2007).

Nonprofit organizations and community-based homeless providers are now seeking diversion and shelter programs that coordinate services to the homeless veteran population (Alexander, Krablin, & Silver, 2017). The U.S. Department of Veterans Affairs (2016) announced a public announcement in November of 2009 to end veteran homelessness across the country within 5 years. The proposed goal appeared to be an ambitious response to eliminate a national housing crisis in a short period of time. To

meet state and federal needs, rural communities have opted to combat veteran homelessness through local initiatives that focus on improving entry services and intake procedures (The Pennsylvania Department of Community and Economic Development, 2019; The U.S. Department of Veterans Affairs, 2017).

Case managers are faced with improving their local practices to focus on multiple generations of homeless veterans. Evaluating the existing structures in community-based practices can be challenging because a centralized and uniform process may not exist in rural and remote areas (Housing Alliance of Pennsylvania, 2017. Pennsylvania communities are attempting to reevaluate their current structure to improve early assessment techniques, reduce the length of homelessness, and improve outcomes for homeless veterans engaging in community-based services (Veterans Multi-Service Center, 2013). The purpose of the current study was to examine the initial intake process in rural and remote areas in Pennsylvania to identify best practices and barriers for homeless veterans.

Background

Case management is one the most important stages of the housing process for homeless veterans engaging in services (Cunningham, Calsyn, Burger, Morse, & Klinkenberg, 2007). The initial assessment process can illustrate disparities among homeless providers based on experience, location, and forms (The U.S. Department of Housing & Urban Development (HUD) Exchange, 2015). Disparities can be further exacerbated by a lack of proper intervention techniques, questions, referrals, and case management services that can potentially hinder the outcomes and housing stability for

homeless individuals or families engaging in services (Jost, Levitt, Hannigan, Barbosa, & Matuza, 2014). The U.S. Department of Veterans Affairs (VA, 2014) explained that veterans residing in rural and remote areas struggle to access VA-related services, which can create multiple barriers to their housing stability. Case managers offer services to mitigate barriers such as poor financial skills, poor coping skills, severe trauma, substance abuse, mental illness, violence, victimization, and other factors that hinder homeless veterans, especially in rural areas, when transitioning from military to civilian life (Elbogen, Sullivan, Wolfe, Wagner, & Beckham, 2013). However, little research has been done to explore the intake process from the case manager's perspective (Henwood, Padgett, & Nguyen, 2011; Vinton, Crook, & LeMaster, 2003). Case managers can provide knowledge regarding prevention techniques and case management skills to enhance a homeless veteran's chances to reside in permanent housing in a rural community (Basu, Kee, Buchanan, & Sadowski, 2012; Montgomery, Fargo, Byrne, Kane, & Culhane, 2013). This study was conducted to explore best practices in rural communities that serve homeless veterans in Pennsylvania and evaluate the specific assessment tools that are used. Findings may provide information that is beneficial to homeless service providers, veteran affiliated organizations, and community members.

Problem Statement

Case managers are challenged with the current homeless population due to the complex and vulnerable situations that surround their housing instability. Rural homeless veterans remain a hidden epidemic because many individuals are living with friends or family, in vehicles, or in substandard housing (National Advisory Committee on Rural

Health & Human Services, 2014). Often this leads to a misrepresentation or an undercounted subpopulation in the homeless population, which provides an unclear image of veterans' homeless plight, especially in rural communities. Many rural homeless veterans remain invisible to social programs and policy leaders. According to Diana T. Meyers and Associates (2016), an estimated 278 homeless veterans were identified in Pennsylvania in 2015. These statistics remained steady with 277 homeless veterans being identified in 2014 (Diana T. Meyers and Associates, 2016). Of those veteran homeless individuals, 116 were in emergency shelters, 114 were in transitional housing units, and 45 were unsheltered in 2015 (Diana T. Meyers and Associates, 2016). These individual categories have shown a small fluctuation since 2014 with the implementation of programs like Supportive Services for Veteran for Families and Rapid Re-Housing Programs (Byrne, Treglia, Culhane, Kuhn, & Kane, 2015). Shifts in 2014 showed that there were an estimated 139 homeless veterans in emergency shelters and 109 in transitional housing units, and 23 were unsheltered (Diana T. Meyers and Associates, 2016). Traditionally, homeless programs and services have focused on an urban context (National Advisory Committee on Rural Health & Human Services, 2014). Rural homelessness, however, can differ due to the unique needs of this population and the difficulty to engage rural communities when the problems are understated.

Homeless veterans have difficulty accessing mainstream resources as a result of criminal backgrounds, mental health instability, addiction, trauma, health issues, and other variables (Corporation for Supportive Housing, 2015). According to the National Advisory Committee on Rural Health & Human Services (2014), rural veterans continue

to battle access to basic needs such as healthcare due to issues surrounding homelessness. Research suggests that it is difficult to include homeless veterans in current studies due to inconsistent or non-utilization of services by veterans, a limited number of homeless veteran researchers, and a lack of incentive for human service providers to capture necessary statistics since many may be faith based or small organizations (National Advisory Committee on Rural Health & Human Services, 2014).

Federal funding for homeless programs in rural areas are at an all-time low. Feldhaus and Slone (2015) indicated that in 2008, only 9.3% of HUD's funding was awarded to communities that met HUD's definition of rural. Community-based service providers are aware that veterans are among the homeless, but few programs cater to those in rural areas who lack access to mainstream resources (Driscoll, 2006; Edens, Kaspro, Tsai, & Rosenheck, 2011). Revisions within the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act have created an aggressive approach to better understand rural homelessness (Feldhaus & Slone, 2015).

Improving veterans' access to local-level resources has become a priority for a wide range of federal, state, and local programs (Byrne et al., 2015). However, case managers are struggling to identify resources for homeless veterans in rural and remote areas due to the lack of local, specific needs assessments that reflect the complex barriers and services that this growing population requires (Kopelman, Huber, Kopelman, Sarrazin, & Hall, 2006; Vinton et al., 2003). In addition, veterans in rural areas face barriers such as medical and behavioral health care, lack of affordable housing, and few transportation options (Robertson, Harris, Fritz, Noftsinger, & Fischer, 2007).

The difficulty surrounding cost-effective strategies has also hindered case managers working with veterans (Basu et al., 2012; de Vet et al., 2013). The initial screening and intake process is a crucial period, not only as a program requirement but also as an early opportunity to help a household gain a stronger housing plan (HUD Exchange, 2009). The case management assessment is the foundation that guides both the veteran and the case manager throughout the monthly goal setting process. However, many of these assessment forms lack a standardized approach or rely on the staff's interpretation of the policies, which can create program delivery variations (Fuller, 2007). Lengthy assessment forms can also hinder the ongoing dialogue that is imperative between case managers and veterans (Fuller, 2007). Improved assessment strategies are needed to identify risk factors surrounding homeless individuals including veterans at individual and community levels (Flanagan & Briggs, 2015).

New housing initiatives have pushed for a uniform and centralized assessment process, but little is known about how these tools and resources are being used (The Corporation for Supportive Housing (CSH), 2015). In addition, case managers are questioning whether these practices are effectively matching the individual's needs with housing interventions (CSH, 2015). Rural and remote homeless case managers struggle to house homeless veterans due to concerns with overcapacity facilities, long waiting lists, and eligibility requirements (PA Housing Choices, 2015; United Way of the Laurel Highlands, 2015). To properly allocate scarce resources and funding, further examination of the initial screening process is needed.

I found little research with a focus on comprehensive case management for rural case managers during the initial assessment process and the ongoing community barriers that hinder service delivery. Case management requires multifaceted approaches because outreach, identification, and engagement are involved to reduce the risks associated with homelessness (HUD Exchange, 2009). Jost et al. (2014) emphasized that improved intervention and coordination models are needed to enhance case management relationships in homeless services. An innovative approach through the Supportive Services for Veteran Families (SSVF) has begun to target rural and tribal areas that are focused on improving permanent housing options for veteran families (Southcott & Albanese, 2014). SSVF's crisis intervention and rapid rehousing services have reduced the length of time for veterans on the street or in shelters since the implementation 3 years ago (Southcott & Albanese, 2014). Evaluating the triage system within rural housing communities could offer insight into barriers or issues impeding housing stability for veterans across Pennsylvania.

Research Question

How do intake case managers describe the assessment process when engaging in community-based homeless services with veterans in rural or frontier areas of Pennsylvania?

Data Collection

I collected data from participants through interviews and other sources such as reports, point in time counts, annual performance reports (APRs), logs, and training materials. The case study approach guided the exploration of multiple data sources to

ensure an explicit data collection process (see Yin, 1984). I recruited participants from a sample of human service organizations that currently operate the Supportive Services for Veteran Families program in their rural or remote community in Pennsylvania. Interview questions focused on participants' experiences with the intake process, barriers, improving access to services, and individualized techniques. This approach ensured validity for the study (see Yin, 2003). The goal of data analysis is to identify trends or patterns that demonstrate certain results as a product of the data (Henwood, Padgett, Smith, & Tiderington, 2012). The data were collected using semistructured interviews, assessment forms, housing action plans, database systems, referral process for mainstream resources, client outcome reports, and service document forms that can aid in the development of the assessment process. A multiple case study approach was intended to enhance understanding of the assessment process from a holistic and richer perspective because real-life experiences were addressed. The results were compared after the centralized themes were identified. The cases were also cross-case examined to offer a comparative theoretical framework (see Baškarada, 2014).

Theoretical Foundation

Lewin's (1933) force field analysis provide the theoretical basis to examine behaviors and forces that impact an individual's state. Lewin argued that behaviors arise from psychological forces in a person's life span and that behavioral changes also arise from changes to these forces (Cartwright, 1952). To fully comprehend a person's circumstance and predict a person's behavior, Lewin (1943) argued that it is necessary to take into account both perceptual and psychological environments that can construct an

individual's life space. These factors are relevant to a person and are needed to organize behavior, goals, needs, desires, intentions, cognitive processes, and other factors related to a person's system (Burnes & Cooke, 2013).

Lewin's theory has become a highly sophisticated framework used by researchers and change management practitioners (Swanson & Creed, 2014). The analysis of organizational case examples offered a unique framework to understand the complex nature of homelessness and the social interactions that can influence the outcomes (see Lewin, 1943). Enabling factors such as external pressure, clarity of change objective, leadership, and additional skills are evaluated (Swanson & Creed, 2014). Other constraining forces were evaluated such as management style, weak system, number of staff, and communication of change (see Swanson & Creed, 2014).

Exploring the principles that guide force field analysis was helpful to address and monitor successful strategies for outcomes attached with intensive case management services. This method requires defining community barriers and the change that is hoped to be achieved (Cartwright, 1952). Lewin (1943) suggested identifying driving and restraining forces that support or resist these changes while also developing comprehensive strategies to develop a sense of equilibrium. The force field analysis also requires further evaluation into unintended consequences that may emerge from altering those equilibrium forces such as new alliances or increased resistances (Swanson & Creed, 2014).

Lewin's (1943) theory was used to improve social policy and service delivery regarding case managers' perceptions of the initial intake process for homeless veterans.

Specific considerations were taken into account such as clarification of this segment of veterans being ineligible for VA-related benefits, suggesting that they were other than dishonorably discharged or lacked adequate active duty time. Factors such as these are critical to the predisposing, enabling, or needs-based categories that impact the streamlined approach toward service utilization and access (Song, Han, Lee, Kim, Kim, Ryu, & Kim, 2009). This theory was used to explain the multifaceted issues surrounding rural veteran homelessness in Pennsylvania because it provided a lens that focuses on the nature of this social problem and offers a holistic perspective on the assessment process.

Nature of the Study

I conducted a multiple case study to explore the complex issues surrounding homeless rural veterans in Pennsylvania and the barriers to accessing mainstream resources. This design allowed me to evaluate the complex factors surrounding homeless rural veterans in Pennsylvania and their unique challenges in rural communities, especially if they are ineligible for VA benefits. Vohra (2014) noted that case studies are applicable when attempting to evaluate twin purposes such as detailing a rich description of a population and strengthening the patterns of findings. Improved understanding of the case managers' role and the decision-making process from the intake case managers' perspective may be used to enhance the service delivery approach and how assessment procedures are handled.

Definitions

Doubling up: An individual or family living in a housing unit with extended family, friends, and other nonrelatives due to economic hardship, earning no more than 125% of the federal poverty level (National Alliance to End Homelessness, 2010).

Homeless:

1. Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution;
2. individuals and families who will imminently lose their primary nighttime residence;
3. unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or
4. individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member (HUD, 2011).

The HEARTH Act of 2009 amended the McKinney-Vento Act, which revised HUD's existing definition of homeless and the various programs that it affected. The Shelter Plus Care Program (24 CFR 582), the Supportive Housing Program (24 CFR

583), and the Emergency Solutions Grants Program (24 CFR Part 576) incorporated the revised homeless definition into the Consolidated Plan regulation (24 CFR Part 91) (HUD, 2011).

Household: All persons as identified by the veteran, together present for services, and who identify themselves as being part of the same household (Department of Veterans Affairs, 2015).

Permanent housing: Community-based housing without a designated length of stay where an individual or family has a lease in accord with state and federal law that is renewable and terminable only for cause. Examples of permanent housing include, but are not limited to, a house or apartment with a month-to-month or annual lease term, or home ownership (SSVF, 2015).

Rural: A rural county (HUD, 2013) that

1. Has no part of it within an area designated as a standard metropolitan statistical area by the Office of Management and Budget; or
2. is within an area designated as a metropolitan statistical area or considered as part of a metropolitan statistical area and at least 75% of its population is located on U.S. Census blocks classified as nonurban; or
3. is located in a state that has a population density of less than 30 persons per square mile (as reported in the most recent decennial census), and of which at least 1.25% of the total acreage of such state is under federal jurisdiction, provided that no metropolitan city in such state is the sole beneficiary of the grant amounts awarded under this part.

Veteran: A person who served in the active military, naval, or air service, and who was discharged or released in conditions other than dishonorable. The period of service must include service in active duty for purposes other than training (SSVF, 2015).

Assumptions

This study was based on the following assumptions: (a) the data collected from the evaluation and assessment forms were accurate and the participants were truthful within their answers, (b) each intake session was documented accurately between the case manager and the participant, and (c) the previous knowledge of any chronic nature of homelessness did not bias any of the results because all of the information had been previously documented through the PA Homeless Management Information System.

Delimitations

The sample was delimited to homeless veterans who met the Supportive Services for Veteran Families definition of a veteran. The sample was further delimited to males and females who engaged in community-based homeless services in rural areas in Pennsylvania. Individuals who were identified in the management system more than once were noted and only used once in the study. All of the participants who engaged in an initial intake assessment were studied including those who no longer received preventative or rapid re-housing services through Supportive Services for Veteran Families. Finally, all archival data were limited to the past 6 years, or from the initiation of the grant.

Limitations

The limitations that were related to the archival nature of this data included the following: (a) I had no control over the intake participant selection process, (b) only homeless veterans who enrolled in services through the Supportive Services for Veteran Families programs were studied, (c) the length of the initial intake process varied from one organization to the next due to the lack of a centralized process and the internal structures that existed, and (d) not all of the participants who were interviewed were receiving services after the initial intake process through Supportive Services for Veteran Families program.

Significance of the Study

The purpose of this qualitative multiple case study was to explore rural veteran homelessness and to understand the perceptions of case managers' regarding the inconsistency of the intake processes and barriers that exist for homeless veterans in rural communities. Interviews with the case managers' offered a new perspective on the complex and dynamic relationship that exists between staff and veterans in rural communities. Services in rural communities tend to cover a large geographic area because veterans may lack transportation and costs can hinder their ability to access resources (Feldhaus & Slone, 2015). Barriers to effectively serving this population continue to exist, including shortage of qualified staff, large caseloads, inflexibility of available resources, barriers to employment, shortage of available service programs and providers, and a lack of safe and affordable housing in rural communities (Jones, Zur, & Rosenbaum, n.d.; National Advisory Committee on Rural Health & Human Services,

2014). Furthermore, the interviews with case managers addressed the issues surrounding a noncentralized assessment process for incoming veterans.

Researchers had not explored the barriers for rural veterans and the lack of prevention-based services focused on reducing the length of homelessness in these communities. Through analysis of secondary data and interviews with frontline staff such as case managers, I examined the current infrastructure in rural communities and the factors hindering homeless veteran stability. Findings may be used to develop tailored services for this special population that encourage interagency collaboration, individualized service planning, and flexible services (see de Vet., van Lujtelaar, Brilleslijper-Kater, Vanderplasschen, Beijersbergen, & Wolf, 2013; Metraux, Clegg, Daigh, Culhane, & Kane, 2013; Montgomery et. al, 2013; National Advisory Committee on Rural Health & Human Services, 2014;).

In addition, these findings may help to improve case management practices and assessment techniques to mainstream referral processes and housing program entry (Molinari, Brown, Frahm, Schinka, & Casey, 2013). Creating a more thorough evaluation of these processes may also reduce the length of time in emergency shelters or transitional housing, and address underlying problems for homeless veterans (Cunningham, Calsyn, Burger, Morse, & Klinkenberg, 2007; Dinnen, Kane, & Joan, 2014; Henwood et al., 2011). Findings from this study may also be beneficial to other service providers working with this complex group (see Feldhaus & Slone, 2015; Stergiopoulos, Gozdzik, Misir, Skosireva, Connelly, Sarang, & McKenzie, 2015).

Summary and Transition

The complex nature of veteran homelessness has become a prevalent issue throughout rural communities in Pennsylvania. Research has indicated that the initial assessment process may require a more extensive evaluation to identify and meet the ongoing needs of rural veterans. Programs such as the Supportive Services for Veteran Families (SSVF) offer a focal point to explore the intervention techniques that occur at the community level. The existing literature revealed gaps in program evaluation and screening techniques. In Chapter 2, I review the existing literature on veteran homelessness and the current barriers that hinder veterans. I also examine the role of the case manager and the impact it has on program outcomes for homeless veterans.

Chapter 2: Literature Review

Current political and social initiatives have addressed the factors surrounding homelessness for veterans in the United States (Edens et al., 2011; Montgomery et al., 2013; Montgomery, Fargo, Kane & Culhane, 2014). Many of these studies have addressed the variables and barriers that exist for this growing population (Elbogen et al., 2013; Tsai, Rosenheck, & Kaspro, 2013). However, little research has been done to explore the initial assessment process on veteran homeless providers within rural communities that may lack a centralized intake procedure (National Alliance to End Homelessness, 2015). Researchers have evaluated the variables surrounding the at-risk identifiers and ongoing programs and services targeting homeless veterans (Montgomery et al., 2014; Shinn, Greer, Bainbridge, Kwon, & Zuiderveen, 2013). Despite the research on this social phenomenon, no research had examined the perceptions of rural veteran homelessness and the critical stages surrounding the intake process through the lens of a case manager. Improving the delivery of intake services and early intervention techniques has been a focal point for social policy leaders, frontline staff, and advocates in recent years (Fargo, Munley, Byrne, Montgomery, & Culhane, 2013). The case manager could offer a frontline perspective on the barriers, questions, experiences, and time-sensitive issues that homeless veterans in rural communities are facing.

I evaluated the types of services that may be needed to assist this challenging population to develop a stronger assessment tool, continuum of care, and wraparound treatment program including mental health services, social services, and individualized programs in rural areas. The intake stage offers an opportunity to develop a specified

action plan and individualized services for homeless veterans enrolling into housing programs. In this qualitative study, I explored the current assessment process across rural and remote areas in Pennsylvania along with the strategies that guide both the case manager and the veteran to a defined housing plan. A small group of intake case managers in rural communities across Pennsylvania offered their perspectives on the experiences, barriers, risks, and strategies needed to improve the initial assessment process for homeless veterans. All case managers were selected based on work experience, job duties, and rural location. Case managers who perform the initial intake service and coordinate program referrals and eligibility were eligible to participate. Face-to-face interviews were conducted to evaluate current procedures, forms, policies, referrals, and other time-sensitive matters related to the intake process.

Chapter 2 addresses the barriers that can hinder a successful outcome. I review the framework to describe an action plan to ensure a successful assessment process for homeless veterans in rural communities. I also describe the theoretical framework that guided this study and the role case managers have in the intervention strategies with homeless veterans.

Literature Search Strategy

To support this research, I reviewed empirical and nonempirical literature. I used the Walden University Library as my primary source to search for literature, but I also used web-based sources. Databases included PsycArticles, PsycINFO, SocINDEX, Academic Search Complete, ERIC, Health and Psychosocial Instruments, Dissertation, and ProQuest Dissertation & Theses. I also used websites hosted by HUD HRE, Veteran

Affairs, National Alliance to End Homelessness, Housing Alliance of PA, and Pennsylvania Department of Human Services. In addition, I used the Google Scholar search engine. The key words I used in the searches were *homelessness, rural, remote, veterans, barriers, assessment, intake, community, organizations, nonprofits, supportive services, case managers, ineligible for VA benefits, and mainstream resources*.

Searches yielded over 1,000 options from which I selected 110 articles relevant to my study. I ensured that sources were peer reviewed, primary documents and scientific materials. Given the focus of this study, selected articles addressed potential barriers to the assessment process, especially those with factors related to outcomes, utilization, assessment techniques, case management strategies, and other variables that may influence services. Furthermore, I evaluated the types of services that may be needed to assist this challenging population to develop a stronger assessment tool, continuum of care, and wraparound treatment program in rural areas. A few articles were published in the early 1940s, but these were necessary to provide a theoretical perspective on systematic barriers and driving forces in communities.

Theoretical Foundation

Lewin's force field analysis theory provided the conceptual framework for this study. Lewin (1933) offered a rationale for behaviors and forces that can impact an individual's state. Due to the complex nature of veteran homelessness, a theory such as the force field analysis was needed to analyze the problem, the restraining forces, and the driving forces involved in this type of social problem. Lewin argued that behaviors arise from psychological forces in a person's life span and that behavioral changes also arise

from changes to these forces (Cartwright, 1952). According to the force field analysis theory, driving forces can propel change both externally and internally within a situation or organization (Lewin, 1947).

Lewin developed the force field analysis theory as a means to free Gestalt psychology from an outdated positivist perspective (Swanson & Creed, 2014). Lewin attempted to mathematize field theory through an evidence-based approach (Bargal, 2006; Burnes & Cooke, 2013; Lewin, 1936; Swanson & Creed, 2014). Lewin's unique theory offers an opportunity to evaluate change through the complex nature of social interactions, new ideas, and programs that can be a catalyst for groundbreaking developments. The force field analysis theory has become a widely popular tool among practitioners to provide different perspectives from multiple organizations within the field of study, while aiding an open discussion forum among providers (Swanson & Creed, 2014). Forces such as the number of staff, skill levels, management styles, leadership skills, weak systems, and communication of change were instrumental variables when evaluating the intake process for homeless veterans within rural community-based housing services. Although many researchers focused on restraining forces, both restraining and driving forces impact the ability of an organization to reach a state of quasi-equilibrium (French & Bell, 2013; Phillips & Oswick, 2012). The force field analysis theory has been used in multiple studies that focused on identifying the driving and restraining forces in health care programs, social work, and cognitive activity (Bargal, 2006; Baulcomb, 2003; Kruglanski, Bélanger, Chen, Köpetz, Pierro, & Mannetti, 2012).

The underlying concepts of the force field analysis theory were reiterated by Phillips (2013), who evaluated the attitudes of U.S. police supervisors regarding the utilization of volunteers in policing. Phillips studied the factors surrounding the forces that drive or restrain the sense of equilibrium within police organizations. The attitudes of police supervisors from the FBI National Academy were evaluated from across the United States to examine the factors that may encourage volunteers within police organizations (Phillips, 2013). Phillips concluded that the participants viewed volunteers as outsiders within a police organization. The study revealed that aggressive policing was a strong restraining force with scores as high as a 3.0 on a 4.0 scale (Phillips, 2013). Phillips encouraged use of volunteers from a supervisor standpoint to increase the acceptance from police officers and others under their administration.

Fernandez, Bustamante, Combs, and Martinez-Garcia (2015) also used force field analysis theory to explore the perspectives of Latino/a secondary principals from suburban school districts regarding career advancements and experiences. Internal and external drivers were explored to examine factors such as passion, drive, determination, family support, mentoring, questioning leadership abilities, doubt, and gender bias in hiring (Fernandez et al., 2015). The results revealed that perceptions of resistance to change reflected an ongoing lack of support for the recruitment and promotion of Latino/a administrators in both predominately White and African American school districts throughout suburban areas (Fernandez et al., 2015).

Force field analysis theory was applicable for the current study to examine barriers such as unemployment, substance abuse history, mental health issues, physical

disabilities, limited social networks, and extreme poverty for homeless veterans (see Metraux et al., 2013; Montgomery et al., 2013). Recent studies revealed that interventions such as intensive case management approaches in conjunction with housing or alone have shown positive outcomes including improvement of psychiatric symptoms, decrease in substance abuse, and reduction in-patient services (Stergiopoulos et al., 2015). Intensive case management strategies have been shown to be instrumental in improving services for homeless veterans (Mohamed, 2015). The current study addressed case managers' perspectives regarding the intake process that occurs at a critical time for intervention services.

History of Veteran Homelessness

Homelessness veterans are often referred to as vagrants, vagabonds, bums, beggars, indigents, tramps, underclass, and homeless (Long March Home, 2015). Many of these labels date back centuries, but the context and nature of these terms is not well understood (Long March Home, 2015). Homelessness is not a new phenomenon for veterans as it dates back to the colonial era. In the wake of the Revolutionary War, vagabonds were claimed to be on the rise in urban areas and created mass concern among political leaders (Coalition for the Homeless, 2003). Many vagabonds accounted for the rising number of homeless veterans during that era due to the lack of pensions and injury compensation granted by the Constitutional Congress of 1776 (Long March Home, 2015).

Civil War

After the Civil War, a significant increase in homelessness occurred across the United States (Coalition for the Homeless, 2003). Unemployment skyrocketed after the Civil War due to the growing number of individuals who were no longer self-employed, such as farmers and merchants who were seeking employment in the industrialized North (DePastino, 2003). Wage earners had to face the uncertainty of the market to survive. As the homeless became more visible, the United States attempted to use vagrancy laws to isolate small communities and shield themselves from the moral decay of homelessness (Beirer & Ocobock, 2008). The aftermath of the Civil War initiated further discussion regarding a soldier's home and prompted answers from politicians regarding the care of veterans after their discharge date (Trout, 2011).

The war caused countless displacements for many rural veterans and households, which eventually led to the succeeding economic recession (Coalition for the Homeless, 2003). The Depression set in and created a wave of demobilized soldiers and out-of-work laborers who were forced to travel on the railroad to find employment in urban areas (Beirer & Ocobock, 2008; Coalition for the Homeless, 2003). The *hobo nation* from many rural areas continued to wander from city to city in hopes of locating work that did not exist (Rubin, 2007). In Pennsylvania, Massachusetts, and Illinois, an estimated two thirds of the vagrants during the Depression were veterans (Beirer & Ocobock, 2008).

The expansion of transportation systems created a newfound issue in the United States. Masses of individuals began to travel across the country in hopes of finding improved work conditions and increased employment opportunities. Urban crowding and

vagrancy arrests began to soar as a result (Beirer & Ocobock, 2008). The poor were struggling to find relief from the constant wandering. Many opted to settle in refuge within small outskirt areas. Farmers, local-townsmen, and the police struggled with vagrants in Pennsylvania cities like Harrisburg, Altoona, and Fulton (Beirer & Ocobock, 2008).

Vietnam War

The Vietnam War veterans offered a unique glimpse into the severe psychological injuries that could hinder military personnel. Shay (1999) noted that a common stereotype emerged indicating hair-trigger anger, violence tendencies, antisocial behavior, alcohol and drug abuse, paranoia, suicidality, and compulsive roaming. These types of characteristics were also common in Civil War veterans, but little data existed to draw comparisons between the two military eras (Shay, 1999). During the 1980's, surveys emerged, which evaluated the number of Vietnam homeless veterans. The initial data suggested high numbers of Vietnam veterans that were homeless or were significantly higher at risk of becoming homeless due to readjustment problems (Rosenheck, Gallup, & Leda, 1991).

The homeless population continued to grow throughout the United States during 1991 due to the involvement in the Gulf War. Homeless service providers in concentrated areas like New York reported serving significant numbers of Desert Storm veterans (Coalition for the Homeless, 2003). Little to no response was given prior to this time by federal legislation. During the Reagan Administration, homelessness remained an issue but required no federal intervention at the time (National Coalition for the Homeless,

2006). By 1983 to 1993, drastic shifts began to appear on the social forefront regarding homelessness and social policies. The Stewart B. McKinney Homeless Assistance Act prioritized research and funding for homeless programs that were designed to address intervention policies (Marcus, 2006). In the years that followed, the public outcry began and advocates demanded an increase of policies that acknowledged the severity surrounding the homeless epidemic. Billions of dollars were spent in the late 80's and early 90's to continue research efforts and services, however, social concern began to wane. The general public halted their ongoing discontent on the homeless plight, which created a ripple effect with decreasing funding and media coverage (Marcus, 2006).

Iraq & Afghanistan War

The Iraq and Afghanistan War statistics continue to not bode well for decreasing the risks of homelessness amongst returning veterans. As troops return home from Iraq and Afghanistan, current studies depict a younger generation of homeless veterans, who are female and head of households (National Alliance to End Homelessness, 2015). Repeated deployments, traumatic brain injuries, physical, and mental health issues have created a concerning environment for advocates. According to Tooth, the director of Veterans Affairs for Lancaster County, PA (2007), "We're going to be having a tsunami of them eventually because the mental health toll from this war is enormous."

Recent statistics have illustrated a shift within the homeless population. Hosek and Wadsworth (2013) reported that about 1 in 150 veterans were homeless and that veterans were more likely than nonveterans to enter the homeless system. In January 2014, an estimated 49,933 homeless veterans throughout the United States were

identified in the Point in Time Count, which roughly accounts for 8.6% of the total homeless population (National Alliance to End Homelessness, 2015). This number has shown a significant decrease from 2009, which estimated 67.4% of the veteran population was without proper housing (National Alliance to End Homelessness, 2015). While, these numbers show continued progress on the forefront, veterans are at an increased risk of experiencing homelessness due to low socioeconomic status, mental health disorders, and a history of substance abuse (National Alliance to End Homelessness, 2015).

Fundamental Barriers for Homeless Veterans

Each generation faces unique barriers, which is at the forefront of program development. Molinari and colleagues (2013) stated that “homelessness was a dehumanizing condition that called for a respectful response from VA staff liaisons and housing intervention providers honoring the veterans’ prior service to their country” (pg. 496). At-risk characteristics are commonly identified as veterans begin to engage within community based homeless services. However, these types of demographics can be complicated to pinpoint since today’s veterans face additional barriers due to extensive deployment stints, Post-Traumatic Stress Disorders (PTSD), traumatic brain injuries (TBI), sexual trauma, lack of social supports, criminal justice involvement, money management issues, and difficulty transitioning to civilian life (Edens, Kaspro, Tsai & Rosenheck, 2011; Elbogen, Sullivan, Wolfe, Wagner & Beckham, 2013; Metraux, Clegg, Daigh, Calhane, Kane, 2013). Personality differences play another instrumental role in the unique variables and contributors that impact veteran homelessness (Montgomery,

Fargo, Kane & Culhane, 2014). A relationship was also identified between potential homelessness and financial literacy amongst returning Iraq and Afghanistan veterans (Elbogen, Sullivan, Wolfe, Wagner, & Beckham, 2013). This poses a unique factor since many organizations may not emphasize the financial education of their consumers. Montgomery and colleagues (2014) indicated that the unique barriers and lack of utilization amongst veterans requires an assessment instrument to better meet the needs of this dynamic population (Shinn, Greer, Bainbridge, Kwon, & Zuiderveen, 2013).

Effectiveness of Case Management

Case management has become an intricate piece to many health care and social service providers who serve the homeless population. Many case managers today take on multiple roles to meet the ongoing demands within the field. However, case management can range from intake assessments, referrals to external organization, action plan development/individual service plans, monitoring, and client advocacy (National Health Care for the Homeless (HCH) Council, 2016). Multiple positive effects have been shown to reduce homelessness, increase housing stability, and improve the quality of life (National HCH Council, 2016; Stergiopoulos et. al, 2015).

Researchers have long examined the complex nature of homelessness (Kline, Callahan, Butler, St. Hill, Losonczy, & Smelson, 2009; Lipsky, 1980). The phenomena is usually coupled with variables that hinder the stability of their livelihood. Studies have shown that once an individual obtains housing, their quality of life improves (Lam and Rosenheck, 2000). However, a large portion of the homeless veteran population face unique barriers such as unemployment, substance abuse history, mental health issues,

physical disabilities, limited social networks, and extreme poverty (Metraux et. al, 2013; Montgomery et. al, 2013). These types of barriers as illustrated may create an increasingly difficult environment for social workers and policy makers to overcome.

Recent policy shifts have encouraged agencies to revise their strategies through new initiatives such as The Homeless Emergency and Rapid Transition to Housing Act. This revision of the McKinney-Vento Act of 2009 has modernized and attempted to accommodate these growing needs and barriers of the homeless population (Berg, 2013). These recent shifts have stepped away from previous approaches that required homeless individuals to show housing readiness through emergency shelters and transitional housing programs before placement into permanent housing. An alternative option has been suggested for homeless individuals including rapidly rehousing veterans through the housing first model, which provides supportive and flexible housing resources to avoid recurrent bouts of homelessness (de Vet et. al, 2013). Innovative programs like the Emergency Solutions Grant Rapid Rehousing program and the Supportive Services for Veteran Families have emphasized the role of case management within services.

Four popular models of case management have been widely used with the homeless population. The standard case management (SCM), intensive case management (ICM), assertive community treatment (ACM), and the critical time intervention (CTI) have all grown popularity amongst homeless providers for multiple reasons, which we will explore in more detail (de Vet et. al, 2013; National HCH Council, 2016). Each of these models have distinct functions and target various subpopulations.

The standard case management approach focuses on a coordinated service delivery with the primary goal to provide ongoing supportive care for those homeless individuals (de Vet et. al, 2013). This technique requires case managers to have 35+ caseloads, low intensity and minimal contact with client, and is a slight grade above program referrals (National HCH Council, 2016).

Indicative of the name, intensive case management is geared toward the homeless population that requires further intensive services in order to address their needs (de Vet et. al, 2013). The intensive case management approach on the other hand has been utilized with homeless families and those suffering from substance abuse and severe mental illnesses. Stergiopoulos and colleagues (2015) noted that recent reviews of interventions have shown that the intensive case management approach in conjunction or alone with housing has shown positive outcomes including improvement of psychiatric symptoms, decrease of substance abuse, and reduced in-patient services. Case managers have reduced caseloads, frequent contact, and prioritize the neediest service individuals through the comprehensive approach (de Vet et. al, 2013). Mohamed (2015) noted in 2004, the VA Strategic Mental Health Plan focused on an intensive case management program for seriously mentally ill veterans in small, underserved rural areas. The study suggested that intensive case management was a strong choice for veterans that resided in some of the most remote areas including geographically rural locations since intensive case managers were able to increase house visits and ongoing contact to alleviate some of the barriers (Mohamed, 2015). Many housing first approaches are coupling their services with intensive case management to provide a less costly intervention that is able to serve

a broader population of the mentally ill homeless population compared to those that may require intensive service with the assertive community treatment (Stergiopoulos et. al, 2015). Intensive case management differs from other counterparts such as the assertive community treatment (ACT) in that it does not require a multidisciplinary team or shared caseloads across multiple case managers (Mohamed, 2013). This offers a flexible and natural extension of clinical case management (Mohamed, 2013).

The assertive community treatment (ACT) shares some common variables with the intensive case management strategy. For example, ACT also targets a comprehensive approach for the homeless population that requires the greatest prioritization of service needs. However, a multidisciplinary team of experts work together alongside the case manager to provide 24/7 supportive care to the homeless individual (de Vet et. al, 2013). Razali & Hashim (2015) noted that ACT can be labor intensive and costly to administer due to the constant level of monitoring that needs to take place. This a higher grade of case manager compared to intensive due to the fact that it ranges an estimated 15 person caseload, but requires a multidisciplinary team including clinical providers with a client-centered approach (Finnerty, Manuel, Tochtermann, Stellato, Fraser, Reber, & Miracle, 2015).

Finally, the critical time intervention (CTI) model is a time-sensitive intervention technique that aims to enhance the continuity of care between service providers and strengthening the client's networking system (de Vet et. al, 2013). The CTI approach focuses on direct moments that may be instrumental within an individual's situation. For example, if an individual is transitioning into subsidized housing, the case manager may

opt to utilize CTI has an approach to offer a smooth move. The critical time intervention encourages clients to develop independent living skills and support networks that can eventually help strengthen the individual's goal to remain in placement after the transition (Tomita, Lukens, & Herman, 2014). CTI has been known to break down in multiple phases or stages to align with the time-sensitive approach. CTI workers also provide individualized and detailed arrangements that are critical for long-term community survival, including mobilizing family support and CTI workers provide individualized and detailed arrangements that are critical for long-term community survival including mobilizing family support (Herman, & Mandiberg, 2010; Tomita, Lukens, & Herman, 2014).

Intake Assessment Tools and Strategies

Homeless programs today are shifting toward a coordinated assessment approach (National Alliance to End Homelessness, 2013). Coordinated assessment is defined to mean a centralized or coordinated process designed to coordinate a program participant's intake, assessment, and provision of referrals (National Alliance to End Homelessness, 2013). The Department of Housing and Urban Development (2012) defined

A centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment too (*CoC Interim Rule, Section 578.3*).

Coordinated assessments are ideal since a cohesive entry form is developed to reduce the number of program referrals that are inappropriate, avoid redundant questions and paperwork along with receiving program information that can reduce the crisis situation (National Alliance to End Homelessness, 2015). However, this is challenging for rural communities since power struggles may be present or lack resources to accommodate this need. A consistent process offers multiple benefits that provide a standardized tool, enhanced reporting and data collection techniques, and staff training (National Alliance to End Homelessness, 2013).

The intake stage offers an early opportunity to set the tone and individualized service plan for the incoming homeless veteran. However, in many communities like outlying and rural areas, a formal process may not be cohesive across a particular state. For instance, Pennsylvania has had multiple discussions to review the concept of coordinated entry but had yet to agree on a particular start date. In this case, homeless veterans that are engaging in community based services may see multiple intake forms and processes across the state of Pennsylvania. These variations may create a not uniformed approach to homeless service entry and case management services.

The intake process usually entails screening, assessment, referral, and verification. The intake, itself, may or may not result in program admission (HUD Exchange, 2013). This is a critical moment for the intake case manager and homeless veteran to receive services, referrals or deny further services due to eligibility. The intake case manager's level of authority and role carry a tremendous weight on the outcomes. Case managers vary on their process, questions, contact (phone vs. face to face), and data

collection techniques. Exploring this process in more detail will provide a strong catalyst for improved intake assessments and program outcomes throughout rural areas.

Challenges With Screening Techniques

Case managers and program supervisors are being challenged with meeting the ongoing demands and outcomes of housing programs for homeless veterans. Molinari and colleagues (2013) added that sharp differences exist between older and younger homeless veterans. Generational issues are apparent when determining client based approaches, for example, the older veterans have less social support, greater employment challenges, more significant health care needs, and perhaps more motivation to change (Molinari et. al, 2013). The role of the case manager has evolved causing many frontline staff to feel the effects of consumers disengaging from services or a lack of efficient program services aimed to assist their clients (Cunningham et. al, 2007; Dinnen, Kane & Joan, 2014; Henwood, Padgett & Nguyen, 2011).

Emergency shelter services are seeing a rise in immediate need, but are struggling to adequately serve the homeless population with the recent shift in national funding (National Alliance to End Homelessness, 2012). Diversion programs are emerging as the newfound strategy aimed to improve program outcomes and competing for grant funding (National Alliance to End Homelessness, 2011). Assessing for homeless programs can be challenging though since strict eligibility requirements can prohibit entry into many needed services such as rapid rehousing or permanent supportive housing (National Alliance to End Homelessness, 2012). Assessment tools are being used to identify vulnerabilities and prioritizing target subpopulations such as mental health and/or

substance abuse (Brown et. al, 2015; Tolomiczenko, Sota & Goering, 2000).

Cunningham (2009) noted that the data also demonstrates that some families may have higher needs than others and this speaks volumes to the importance of targeting housing and service interventions based on an assessment of need (with the most intensive interventions going to those families with the highest needs). The extent that these assessment tools focus on rural needs has yet to be seen.

The number of homeless staff can also play a pivotal role in the program outcomes. Jones, Zur & Rosenbaum (n.d.) added that staffing patterns and caseloads can vary depending upon location for homeless based services. Rural areas and those located in the south were subject to lower behavioral health and enabling services due to staffing (Jones, Zur & Rosenbaum, n.d.). Other issues such as low pay, high rates of burnout and turnover, limited time for supervision, and multiple staff training needs were identified as potential reasons that maintaining staff can be troublesome in the homeless field (Olivet, McGraw, Grandin, and Bassuk, 2010). Case managers are also challenged with direct services that require frequent contact with a consumer, while also engaging clients that require maintaining appropriate boundaries, monitoring the safety of clients and themselves, and coping with the stress of “witnessing” the traumatic life experiences of the consumers’ serve (Olivet, McGraw, Grandin, and Bassuk, 2010; Fisk et al., 1999).

The length of the housing program and flexibility design have been shown to be key elements when evaluating intervention techniques (Archard & Murphy, 2015). Person-centered approaches have been noted as being a successful practical option to identify individualized needs and providing wrap around services (Archard & Murphy,

2015). However, not all homeless based programs are focused with this agenda in mind, but rather target outcome goals and consumer data needs. In addition, developing a rapport with consumers continues to be a struggle for some providers, but this could be in relation to staff lacking the appropriate training to commit to this level of effort, motivation, and involvement with the consumer (Archard & Murphy, 2015; O'Toole, Johnson, Aiello, Kane, & Pape, 2016).

Geographical Barriers

A growing number of programs are developed with case studies and research backing urban homeless populations (Crouch & Parrish, 2015; Fuehrlein, Ralevski, O'Brien, Jane, Arias, & Petrakis, 2014; Krausz et al, 2013; Ku, Fields, Santana, Wasserman, Borman & Scott, 2014). Rural housing issues tend to be underscored and overlooked when developing programs that effectively cater to co-occurring populations and those with complex barriers (Jones, Reupert, Sutton & Maybery, 2014). Henwood, Cabassa, Craig, & Padgett (2013) indicated that in order to overcome geographical barriers in rural areas that innovative technology systems including telehealth will need to be developed to compensate. Team structures have also required extensive modifications to adapt to weekly in-person home visits and minimizing travel to specific case managers (Henwood et al, 2013).

The lack of attention drawn to the multitude of issues surrounding rural homeless veterans has created a serious concern for many advocates (Adler, Pritchett, Kauth & Mott, 2015). Rural veterans face increased risks such as a lack of transportation to mental health and healthcare services, lack of affordable housing, and little choices of healthcare

providers in their area (Adler, Pritchett, Kauth & Mott, 2015). Rural veterans differ from their urban counterparts since the local Veteran Affairs system may be countless miles away from their residence. Rural residents continue to be “at-risk” for becoming homeless since they remain in substandard, overcrowded, and/or cost-burdened housing (National Alliance to End Homelessness, 2010). Cutting edge programs like Pathways in Vermont has identified an ongoing need to assess the rural plight, but a lack of research continues to emerge regarding the assessment process and services offered in rural communities across the country (Stefancic et al., 2013).

Summary and Conclusion

In Chapter 2, I reviewed the literature that was associated to my study. I detailed the areas that were related with the themes and variables that impacted veteran homelessness including the assessment process, the historical context, the case management techniques, assessment tools and strategies, and the barriers that can hinder a veteran from accessing resources. These variables were highlighted in more detailed and dissected to understand the non-homogenous dynamics in rural areas that can impact service delivery and access to programs. Evaluating the organizational and structural environments offered insight into the infrastructures that can impact the practices and delivery outcomes in rural communities.

In Chapter 3, I present the research design and rationale along with geographical sample and location that guided the study. The data collection and procedures for recruitment and participation are also detailed. I also highlight the various measures that

were taken to ensure credibility and ethical standards towards all the human participants involved in the study.

Chapter 3: Research Method

In Chapter 3, I discuss the research design, research questions, geographical location, ethical standards, and case studies that guided the study. I conducted a qualitative study that focused on case managers' perspectives in rural areas regarding the assessment process and barriers that homeless veterans face when engaging in community-based services. I evaluated the assessment process in community-based homeless programs throughout the state of Pennsylvania and the strategies that guided case managers used in providing services for homeless veterans. I evaluated factors including assessment forms, intake procedures, supportive service referrals, case management strategies, length of program stay, life skill coaching, and barrier identifications. My initial intention was to conduct interviews with the case managers' from various rural locations in Pennsylvania. I expanded my data collection to include secondary data from the Homeless Management Information System database, intake forms, and Point in Time Count Survey. I assumed that the forms and data were accurate.

Although primary data were essential to my study, I was aware that data collection may pose challenges due to the unique population being studied. Many of the organizations across rural Pennsylvania lack a centralized intake form, which creates challenges when studying the impact they have on homeless veterans. Secondary data were collected to alleviate some of these barriers and improve the overall quality of the study.

The secondary data had been compiled by the Homeless Management Information System, which all homeless providers are required to use by the Department of

Community and Economic Development (DCED) to store and report data. I also evaluated intake forms on an individual level from each organization. Although these forms may vary across the United States, they offered a unique perspective into the best practices and challenges that each rural homeless community may be facing and their assessment techniques upon intake.

Disadvantages in using secondary data exist in a study, especially if the previous researcher did not share the current researcher's interests in data collection. This lack of alignment could result in valuable data being missed and the study failing to answer the research questions (McKnight & McKnight, 2011). However, secondary data can be a strong supplement to a study and can create cost-effective solutions (McKnight & McKnight, 2011). Cheng and Phillips (2014) added that the analyses of secondary data offers a cost-effective means to a set of data that already exists and addresses new research questions or provides a new perspective on an assessment of the primary results from an original study. The Homeless Management Information System contains a statewide database and is mandated to report specific collections of data for veterans who are engaging in homeless services throughout the state of Pennsylvania. Annual reports are provided to local agencies and organizations throughout fiscal years. Furthermore, each organization is ranked based on their outcomes and data collection methods.

To reduce errors and limitations, I focused my study on case managers who had direct access to homeless funds through HUD or state allocated funding. I also used a large sample from community agencies across the state of Pennsylvania. In addition, I focused my data collection on enrollment from 2009 to 2015. I assumed that homeless

veterans addressed in this study were not accessing other homeless services (double dipping) at the same time.

Research Design

In this study, I evaluated the role of the assessment process in rural community-based homeless programs. The sample population was recruited from the Diana T. Meyers and Associates, who currently has overseen the strategic planning and the Continuum Care process of Pennsylvania since 1997. The community-based homeless providers currently operate programmatic services through the Homeless Assistance Program, Emergency Solutions Grant, emergency shelters, transitional housing, Permanent Supportive Housing model (disabilities, chronic, youth based), domestic violence shelters, shelter plus care, rapid rehousing, supportive housing and Supportive Services for Veteran Families. Case managers were interviewed to assess their current intake procedures and the decision-making process that they use to determine appropriate services. A collection of intake forms was also examined to identify common themes and procedures throughout the state of Pennsylvania. Other forms of secondary data included case notes, reports, point-in-time counts, annual performance reports, logs, training materials, and other pertinent information.

A qualitative case study research design was used to conduct this study. This design helped to facilitate further discussion surrounding the phenomenon of homelessness and the use of a various data sources (see Baxter & Hamilton, 2008). In addition, the case study design allowed multiple perspectives to be identified and appreciated.

Research Question

How do intake case managers describe the assessment process when engaging in community-based homeless services with veterans in rural or frontier areas of Pennsylvania?

Role of the Researcher

I was the sole researcher in this study who was responsible for data collection, evaluation, and analysis. A risk of researcher bias existed, so I used various strategies to reduce the threats to the best of my knowledge. The trustworthiness and validity of the data were crucial to this study. Therefore, certain procedures were used, which are described later in this chapter along with protocols that ensured the confidentiality and informed consents of the participants.

I collected data from multiple rural community-based homeless providers across Pennsylvania. My role as a homeless assistance case manager did not interfere or jeopardize my role as a researcher. To protect the integrity of this study, I used voluntary participation and informed consent. Also, I did not include any participants who may have been associated with my caseload. All participant names, locations, and identifying indicators were replaced with pseudonyms to ensure confidentiality of all personal information. Furthermore, all data collection materials were password protected on a personal computer. I also offered participants the convenience of exiting from the study at any point in time.

Due to my close professional relationship with the study topic, I developed and followed strict protocols and procedures when conducting interviews. I limited

information regarding my professional association with the study topic to the participants. The trustworthiness of this study was considered in the procedures that were implemented.

Methodology

Participant Selection Logic

I invited any willing rural homeless based organization or intake case manager across the state of Pennsylvania to participate. However, only six organizations/intake case managers were selected to represent the rural community-based homeless programs. Each intake case manager was required to be affiliated with the intake process in a rural community in Pennsylvania. The participants were also required to have received homeless funding from a HUD or state-affiliated entity. I used a purposeful sampling technique to select information rich cases that would enhance the data set to answer the research question.

I added further selection criteria to identify the most appropriate participants. These participants needed to have rich experience with case management techniques and involvement with veteran homelessness. The following criteria were identified prior to the implementation of the study: (a) Participants needed to have at least 2 years of full-time case management experience to ensure rich and detailed responses to the questions asked; (b) participants were also required to have had direct contact with homeless veterans during the intake process (individuals who were transferred cases after the initial intake process were not considered); and (c) participants must have served a rural community in Pennsylvania. Diana T. Meyers and Associates and the Department of

Community and Economic Development assisted in identifying potential participants given this inclusion criteria.

Instrumentation

Data collection including primary data from interviews and secondary data.

Interview

Oral interviews were conducted using a semistructured approach. Participants were interviewed with this technique to allow more probing questions and detailed responses. The interview questions were predetermined, and the approach offered flexibility if further detail or additional questions were needed throughout the interviews. The interview protocol involved an open-ended approach and focused on intake questions, barriers, case management styles, referral processes, program delivery, time frames, training processes, and other key factors to the intake process and program outcomes.

I contacted each individual case manager to schedule an interview after the selection process. An e-mail was sent to confirm the scheduled time and date for each participant. A formal letter of participation was also sent and signed by each intake case manager (see Appendix A). I also requested approval from the Walden University institutional review board (). All interviews were conducted face to face and in English. Each interview was recorded, but transcription was conducted by a third party. The interview protocol included a semistructured approach that offered flexibility for detailed responses and additional questions (Appendix C). Finally, all participants were given consent forms and provided necessary approval for the interviews (Appendix D).

Secondary Data

Intake informs were collected from participating organizations. Forms were analyzed and central themes were identified along with questions that related to the intake process for that community. A cross comparison was conducted and an analysis was also added to the study. Additional secondary data were collected including reports, point-in-time counts, annual performance reports, logs, training materials, and other pertinent information. Some of this information was collected through the use of the Homeless Management Information System and the individual organizations.

Data Analysis Plan

For this portion of the study, I used a two-pronged approach. First, I separated the interview and secondary data into two different categories. I analyzed all the interviews and later coded them into categories. Common themes were identified throughout this process, which occurred during the coding process. The same was done for all of the secondary data; however, a content analysis was used to code these data. This was a lengthy process because each document was evaluated and identified by organization, purpose, and other unique identifiers. To minimize errors and reduce bias, I asked a third party to transcribe the interviews to provide reliability and validity to the findings. In addition, all interviewees received a copy of the transcript for their review.

Then, after all the information had been compiled and coded, it was then my responsibility to cross-analyze the data. Evaluating all of the information from six organizations offered an opportunity to pinpoint common themes and discrepancies amongst the various rural organizations/case managers that were studied. The rich data

offered through both the interviews and the secondary data including interview forms, techniques, logs, and annual progress reports offered a strong catalyst for discussion. Using Kurt Lewin's Force Field Analysis, as a theoretical guide, allowed the researcher to focus on a rationale for the behaviors and actions of an individual's state and decision making process. The interpretation of these findings will later be discussed.

Issues of Trustworthiness

Credibility

This researcher was aware that the study may have minimal impact by the lack of full disclosure from the interviewees. Due to the nature of the study, some interviewees may still have concerns disclosing all barriers that exist within the work environment and the intake process when engaging with homeless veterans. With this knowledge, the researcher continued to implement multiple techniques to improve the trustworthiness of the study. Yin (2013) stated that credibility is demonstrated within the certainty of the information collected and the accuracy that is portrayed by the researcher. The overall purpose of qualitative research is to describe or understand the phenomena of interest from the participants' perspective, in this case the case managers' are the only ones who can legitimately judge the credibility of the results (Farrelly, 2012). Qualitative research asks the researcher to validate how well the research investigates what it intends to form of internal validity (Farrelly, 2012).

The use of triangulation was used to compare the data from the interviews and the secondary data including intake forms, reports, training documents, and annual progress reports. I also compared the information with the SSVF grant contract supervisor that had

direct contact with the documents and can verify the process. Their responses to the creditability of the study was imperative to ensure that all information was to the best of their knowledge.

The use of multiple case studies offers a rich, descriptive opportunity to gather information on the topic. In this case, I offered a detailed explanation to both the intake case managers and also the organization that were participating in the interview questions and how it related to the research. This offered a clear understanding of the intended goals. In addition, the use of direct quotations was another way to validate that the findings within the study were transferable. Multiple quotations were given throughout the findings to further solidify the opinions and results.

Transferability

Farrelly (2012) stated that transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. In this case, it would be the role of the researcher to offer a detailed description of the research and the assumptions that were essential to the completion of it (Farrelly, 2012).

Dependability

Dependability emphasizes the need for the research to account for the ever changing context within which the research occurs (Farrelly, 2012). In this case, it would be the constantly evolving homeless field and the complex nature of the veteran homeless population. In addition, any changes that occur that effect the way the researcher approaches this study will also need to be identified.

Confirmability

Farrelly (2012) indicated that confirmability refers to the degree to which the results could be confirmed by others. The researcher will discuss the process in which the data is checked and rechecked throughout the study. In addition, the researcher will also indicate any negative findings and how that contradicts the original thought process within the study.

Ethical Procedures

After discussing the study's purpose to all those willing participants, informed consents were dispersed and collected. All participants signed that they were voluntarily participating in the study and that every intent to ensure confidentiality would be taken into precautions. The risks and benefits were also thoroughly reviewed with participants in case questions or concerns were noted. The consent form also disclosed that the use of pseudonyms would be used to further conceal identifying factors including organizations and intake case managers' names. In addition, all participants were offered the opportunity to withdraw from the study at any point in time. All research participants were adults over the age of 18. Any identifying information was locked in a safe and electronically password protected.

I understand that my study would not be approved without the final consent from the Walden University's Institutional Review Board (IRB). Once, approval was obtained, an application was submitted to the IRB for approval. At which time, all data collection will commence once the final approval has been received.

Summary

Chapter 3 identified the research design and framework for the study including the role of the researcher, data collection, and data analysis techniques. It was discussed that the use of a multiple case study would guide this research by allowing a rich, descriptive analysis of the intake process that rural community case managers are utilizing and identifying barriers when engaging with homeless veterans. The participants were pooled from organizations across Pennsylvania, who currently serve rural areas and have direct access to HUD or state related homeless funding. Each participant also directly engage in the intake process with homeless veterans in rural community housing programs. This chapter discusses the core themes surrounding the research questions and the data collection techniques. The risks and benefits were also addressed along with ethical considerations to ensure trustworthiness within the study.

Chapter 4: Results

The purpose of this qualitative study was to examine the case managers' perspectives on the assessment process that community-based homeless programs face in rural or frontier areas of Pennsylvania. I used the following research question to guide how case managers evaluated the current triage assessment system for veterans engaging in homeless services: How do intake case managers describe the assessment process when engaging in community-based homeless services with veterans in rural or frontier areas of Pennsylvania? This chapter includes a discussion of the setting, demographics, data collection, data analysis, evidence of trustworthiness, and the results of the interviews.

Setting

I conducted individual interviews with case managers who consented to participate in the study. The case managers who shared information had key roles in the initial assessment, referral, and programmatic process for incoming homeless veterans in housing intake services. To the best of my knowledge, there were no personal or organizational influences that impacted the participants or their experience at the time of the study, which would have affected the interpretation of study results.

Demographics

Individual e-mails and phone calls were used to communicate with Supportive Services for Veteran Families (SSVF) homeless providers in the Pennsylvania Continuum of Care (CoC) to avoid a potential conflict of interest in my professional role. Each of the participants in the study was a homeless case manager with direct knowledge of the intake process in a rural community in Pennsylvania and who had received funding

from a HUD or state-affiliated entity. The participants had at least 2 years full-time case management experience to ensure rich and detailed responses to the interview questions asked. Participants were also required to have had direct contact with homeless veterans during the intake process. I e-mailed ten agencies that operate over a 12-county region offering homeless services to rural or frontier veterans in their communities. I offered interested case managers the opportunity to schedule a face-to-face interview. Seven case managers agreed to participate in the study. All of the participants served rural or frontier communities throughout Pennsylvania. The location of the interviews was chosen by the participants, and each one opted to hold the session in his or her individual agency. The participants were male and female.

Data Collection

Data collection involved face-to-face interviews with six case managers and one supervisor that provided homeless services for veterans in rural and frontier areas in Pennsylvania. The interviews were conducted from November 2017 to March 2018. The interviews provided an opportunity to explore the statewide shifts occurring in Pennsylvania's intake process since the coordinated entry system began in January 2018. Each interview was conducted at the assigned agency by the case manager's choice. I traveled approximately two hours one way to each county to meet with each participant. At the beginning of each interview, I reviewed the consent and confidentiality form and provided further explanation if needed to clarify benefits or risks involved. Each of the participants signed an informed consent form. To triangulate the information provided by the case managers, I conducted an individual interview with the grant supervisor who

oversees the contract for the Supportive Services for Veteran Families (SSVF) grant for a region of Pennsylvania Continuum of Care to verify the accuracy of the intake process.

The data were collected using handwritten notes and audio recordings on a digital recorder. Recordings were transferred to my personal computer, which is password protected. Failure to provide a correct password in three tries locks out the computer for over an hour. The recordings were transcribed by a third-party who also completed a nondisclosure agreement. During the interviews, some of the case managers answered multiple questions during a particular response. As a result, some questions varied slightly during the interview, and some interviews varied ranging from 45 minutes to an hour.

Data Analysis

After all the data were collected, they were imported into an Excel spreadsheet and grouped into responses based on overarching themes. Repeated words were identified, which created a pattern in the responses from the case managers. Data were then transferred into NVivo and analyzed for a more precise evaluation. The themes that emerged from the respondents included transportation, housing first, coordinated entry, employment, affordable housing, criminal backgrounds, and landlords. Other apparent themes were identified throughout some of the responses including redundant paperwork and being unable to serve or having to identify additional resources for military personnel that do not meet the Veteran Affairs definition of a veteran. Depending on the additional funding sources within their county, some case managers were able to use Emergency Solutions Grant funding to prioritize military personnel who did not meet the VA's

definition of a veteran due to lack of active duty time, national guard, reservists, or discharge status.

Evidence of Trustworthiness

Credibility

Cope (2014) argued that to support credibility in a qualitative study, the researcher should demonstrate engagement, methods of observation, and audit trails within the study. I used triangulation to compare data from the interviews with the case managers and the overseeing grant supervisor who developed and implemented the intake process. Papautsky, Crandall, Grome, and Greenberg (2015) noted that triangulation refers to the investigation of complex problems through the use of multiple sources including but not limited to data, methods, investigators, or theories. Credibility was achieved through the perspectives and responses of the case managers in the study. A qualitative study is considered credible if the descriptions of human experience are immediately recognized by individuals who share the same experience (Cope, 2014; Sandelowski, 1986). The purposeful sampling of the participants added further credibility to the study because the participants were within the field (see Farrelly, 2013). In this case, the case managers represented the rural community-based homeless programs that interact with homeless veterans on a daily basis. A detailed data collection and analysis process was also instrumental in ensuring credibility in the study (see Yin, 2013).

Transferability

No adjustments were needed for transferability as described in Chapter 3. Rich descriptions and findings provide a strong foundation for others to relate and eventually

develop ongoing themes (Yin, 2013). Similar questions could be applied to case managers across the country and the study could be repeated with other housing providers. Examining the case managers' perspectives provided an opportunity to identify the barriers that homeless veterans face.

Dependability

Case managers across multiple counties were included in this study to ensure credibility and dependability (see Cope, 2014; Yin, 2013). The interview process transpired over a 5-month period, which coincided with the statewide shift to a coordinated entry system for the state of Pennsylvania. Although the data collected from the case managers offered a rich description of phenomenon, some of the responses after January 23, 2018, relayed ongoing themes regarding coordinated entry. All of the respondents indicated a need for a centralized system.

I used a credible data collection and analysis process including the use of NVivo, which aided in the dependability of the data analysis (see Yin, 2013). The use of semistructured questions provided a means to obtain detailed responses to probing questions. I used multiple steps to reinforce the information that I was receiving from the respondents including recalling, evaluating, and responding to presented answers. For example, if I did not fully understand the concepts that a respondent detailed, I followed up with an additional question seeking further clarification. Eliminating ethical concerns and having a strong knowledge of the topic aided in the dependability in the study (see Yin, 2013).

Confirmability

Farrelly (2013) indicated that confirmability refers to the degree to which the results can be confirmed by others. In the current study, I was able to ensure through the use of NVivo that a reliable data analysis system was used. I used handwritten notes and a third-party transcriptionist to ensure a clear and accurate account of the respondents' answers. The respondents had the opportunity to review the transcripts to ensure that nothing was missing or inaccurate. The coding techniques were reviewed on multiple occasions to ensure a thorough process. I asked each of the respondents at the end of the interview if there was anything they wished to add before commencing their session. This offered an opportunity for respondents to add their opinions or thoughts that had not been discussed during the question period.

Results

The research study addressed the perceptions of frontline staff who had daily interactions with homeless veterans. I posed the following question to explore the assessment process for homeless veteran in rural communities: How do intake case managers describe the assessment process when engaging in community-based homeless services with veterans in rural or frontier areas of Pennsylvania? The respondents' answers were categorized into six overarching themes that highlighted the complex nature of homelessness and the ambiguity surrounding the intake process. The six themes provided insight into the intake process and the nature of barriers for veterans in rural communities. The first theme was the role of the coordinated entry system. The second theme was the need to evaluate the redundancy and paperwork case managers were being

asked to complete during the intake process. The third theme was the geographical barriers that hinder housing, transportation, and employment-based services in rural communities. The fourth theme was the challenges surrounding the identification of homeless households in rural area. The fifth theme was outreach techniques. The sixth theme was the importance of client-case manager relationships and staffing related dynamics.

Coordinated Entry System

I had informed the case managers of the recent shift in the assessment process for the state of Pennsylvania during this interview process. The statewide implementation of the Coordinated Entry System was launched on January 2018 (Pennsylvania Continuums of Care, 2018). HUD released a Coordinated Entry Policy Brief, which indicated that the coordinated entry process helps communities prioritize assistance based on the household's vulnerability and severity of needs with the ultimate goal that those needing services the most are prioritized in a timely manner (Pennsylvania Continuums of Care, 2018). All of the case managers identified that their current participant list was pulled from the coordinated entry system and that they are anticipating additional housing programs to follow suit. As a result, many of these agencies have begun to incorporate the coordinated entry system into their daily housing practices.

Coordinated entry has allowed us to use a 'no wrong door policy' that helps us screen for all [internal] programs. We use one application and divvy to all departments, which includes medical, transportation, and weatherization. One of the major assets of coordinated entry is that it allows us to look at the whole case

and screen for multiple services. By utilizing a teamwork approach, it has been a more effective way to streamline resources (Participant 1, personal communication, November 9, 2017).

Communities have established coordinated entry as a means to connect households to the appropriate support and housing program, in order to, end their homelessness permanently. While, this may seem to be a simplistic task, case managers/frontline staff in rural areas have reflected and identified recommendations, as the system moves forward through the implantation stages.

The coordinated entry system is not designed for rural areas. It actually has hindered us from serving whether it is veterans or other homeless in a rapid rehousing fashion (Participant 5, personal communication, December 28, 2017).

Five of the case managers identified a barrier with the prioritization scale since the scoring is grounded on the homeless veteran's self-declaration within the assessment process. One example was posed about the subjectivity of the responses during the assessment process despite alternative information from referring agencies or resources regarding the case.

Let's say that the consumer all of a sudden says [when answering one of the vulnerability questions], 'No. My hygiene is great. I don't have a problem with that.' The case manager cannot interject and say, 'Well, this might be an area that we need to explore' (Participant 7, personal communication, February 8, 2018).

Failing to respond or answering incorrectly out of fear or misunderstanding with the question can prioritize the household within the inappropriate housing option or

identify the necessary resources to stabilize the household moving forward. All access sites and coordinated entry locations focus on avoiding steering any of the participants throughout the overall question process, in order to provide a non-skewed image of the barriers that the participant is facing upon intake.

It's hard to determine that because a lot of the times, they're not going to be honest with you. I mean, they are going to admit they have a mental health issue. They are not going to admit that they have a drug issue. Some will, but most of the time they don't. So, it's just play it by ear and hopefully maybe they will open up later on. We can always go back in and redo it if needed (Participant 3, November 9, 2017).

The prioritization scale that is used for communities when utilizing coordinated entry ranks households based off of the level of need and vulnerability score. Another Case Manager that had firsthand experience with the que when asked about the development of her perception stated

I guess some of the scoring has been surprising to us, some of the people that we think would rank higher, don't (Participant 6, March 2, 2018).

However, two could not identify a specific reason as to why they felt the scoring was not fitting to the housing outcome. All of the respondents noted that the new coordinated entry system has changed the overall framework of the assessment process that homeless advocates are engaging within. In addition, it has forced communities to reevaluate their current process and scrutinize implementation inconsistencies.

Paperwork Length and Redundancy

The responses to the research question examined the relevant state of the length of paperwork and redundancy found in the screening process. Four out of the seven case managers addressed concerns with the overwhelming amount of redundant paperwork from both internal agency requirements and from a state/federal perspective.

Four different assessment tools in there [process] that ask all the same kind of questions. There's housing programs through so many different places, but no two places have the same screening or assessment tools (Participant 4, December 28, 2017).

Staff admitted that the length of time to complete the assessment can vary, depending upon the family size. The number of individuals within a household can increase the complex nature of the intake process, in order to capture necessary documentation and services for each household member. The same information is requested in multiple databases both from internal organizations along with information that is needed to comply for state and federal systems.

A single adult [intake] that took roughly a half hour, but a family with four kids took close to two hours (Participant, 4, December 28, 2017).

Family size was a reoccurring theme with many of the case managers and impacted the amount of paperwork that had to be completed to verify program eligibility. The length and complexity of the application itself is a significant hurdle.

Usually if it's one individual, it's manageable. But, if it's a family, where there are usually three or four members, all those papers get done all over again and most of

them for each individual in the family. It can literally be, probably, 100 pages or more (Participant 5, December 28, 2017).

Homeless individuals had difficulty maintaining appointments for intakes and would reportedly get discouraged to the point of leaving if they felt the process was too long or cumbersome. One example was in reference to the reassessment process that was needed to verify continued eligibility.

There's quarterly certifications that have to be done on every single person to make sure they still meet eligibility requirements (Participant 4, December 28, 2018).

Each of these packets whether it is the initial assessment forms or the reassessment forms can vary in appearance and by agency level. The case managers indicated that this can be problematic, especially since one of the performance measures for the U.S. Department of Housing & Urban Development (HUD) (2015) seeks to reduce the length of homelessness to 30 days. While, many Continuum of Care (CoC) have made systematic changes to reach these goals, some case managers continue to express concern over the tedious process of the Coordinated Entry System (CES).

You are going through all this list, you have somebody that walked through your door, who is completely homeless and needs help immediately. In the process, you do all the paperwork and put them in the system and then you have to go through this tedious process, which takes days, if not weeks before you get back to the person and it's not reducing that time in homelessness (Participant 5, personal communication, December 28, 2017).

Case managers identified that the process can be delayed even longer, if the veterans fail to have proper documentation. In which case, many of the case managers identified that the eligibility process requires documentation such as a DD-214, income verification, and other forms to verify continued services.

The norm is that they [homeless veterans] don't have everything they need for documentation (Participant 5, personal communication, December 28, 2017).

The process to obtain a DD-214 can also be challenging despite being red flagged as 'literally homeless'. Interviewees mentioned that some homeless people would be sent out for more information and would not return. The overly-time consuming and wheel spinning requirements can pose significant delays to engage in homeless programmatic services.

I think there is a process we put on as 'homeless' or something that's supposed to prioritize it, but you are still at the mercy of whoever is doing it (Participant 5, personal communication, December 28, 2017).

All of the case managers expressed a need to simplify the process and develop uniform documents that can be used across federal, state, and local housing programs to reduce redundancy and overcome bureaucratic red tape requirements, while also streamlining the assessment process. Lack of case managers or adequately trained staff can exasperate these barriers and will be reviewed in a later section.

Geographic Barriers: Transportation and Employment

All of the respondents were serving homeless veterans in rural based communities throughout the state of Pennsylvania. Each of the case managers identified that the rural

nature of their location has created ongoing barriers for the incoming veterans including transportation and employment.

To expect somebody to be able to travel two and half hours, if there is a bed available—First off, they typically don't want to relocate that far. Second of all, there is no transportation to get them there even if they did want to (Participant 5, December 28, 2017).

A majority of the respondents noted that their individual counties were attempting to alleviate some of the transportation issues by examining local options to overcome this barrier but all addressed funding as a reoccurring theme that may halt their options, especially if crossing county boundaries. All of the case managers added that if a veteran is unable to come to the local agency for an intake, they can travel or transport a veteran if circumstances required. However, three case managers identified that their agency is operating in multiple counties with limited staff.

The geographic isolation has created issues in employment options. One of the case managers indicated

Employment has always been a barrier for many of them. Part of it is, the employment, it goes back to transportation too. Because, unlike in urban areas where there is public transportation that you can go from where you live to where you work, it's basically non-existent [in rural areas] (Participant 5, December 28, 2017).

It is apparent that transportation in rural communities is one of the biggest barriers since it poses issues of accessibility that is not just restricted to the physical movement and access between locations, but includes barriers surrounding the social, economic, and

political context for the households to move into self-sufficiency. A second case manager added

There's just not a lot of jobs around here. It's very limited. A lot of the times we have the homeless coming in and they have a criminal record or of course, they don't have a photo ID or lack transportation to get to certain places. It's just a lot of barriers (Participant 3, November 9, 2017).

Other case managers have added that many of the core factories or businesses in their rural communities have shut down or outsourced. Four case managers indicated that labor markets in their rural counties can be challenging for multiple reasons including background checks, mismatch of skill level and job opportunities, transportation, resources like childcare options, and pay levels. These shortages have created barriers within rural areas and have forced many job seeking applicants to travel distances for decent paying employment and good work conditions. However, the perpetuating cycle of transportation continues to be echoed throughout all of the respondents since safe and affordable housing are scattered and dispersed from available job sites. Many of the homeless veterans lack a vehicle or access to a driver's license for multiple reasons – which has prompted many to rely on the inadequate or nonexistent transportation system in their rural community. Three case managers indicated that their transportation issues were slowly being resolved through county funding and efforts, but the remaining respondents continued to cite that their area was still problematic to maintain ongoing transportation resources.

Two case managers indicated a concern with employment options in rural areas including temporary or seasonal positions. They argued that this particular employment barrier exacerbated a disrupted work history causing many employers to overlook their resumes. They further added that many of their participants are not eligible for unemployment benefits after their temporary or seasonal work has ceased since they failed to obtain the necessary work hours to gain compensation. As a result, it has created ongoing barriers within their work history and with obtaining substantial income to gain self-sufficiency within their housing goals.

Identification and Outreach

Another barrier that was identified by all the respondents (in some form) was that the proper homeless identification and outreach services were challenging in rural regions. These case managers reported that rural homelessness tends to conflict with the common HUD definition. One case manager described their challenges with the identification process

They might stay on the street or they might be so darn cold that they sleep in someone's house or on the porch [for a night] and they might work for two or three days and then they will get kicked out. That's really hard when you are trying to assess a person because you know they are not meeting that definition of literally homeless, but you know they are not stable either. They are couch-hopping and that is really hard--I think nationally for folks to grasp that they are still homeless (Participant 8, February 8, 2018).

Problems defining, locating, and engaging rural homeless populations are apparent and require a sense of flexibility, especially since there are far fewer shelters compared to urban areas. In which case many of the individuals experiencing homelessness are less likely to live on the street or in a shelter, one case manager further explained this theory

It's hard to say, you just don't fit the national criteria. I think that's always going to be a barrier in these parts. It's not like if you're going to Pittsburgh or go to Philadelphia and you're tripping over people or in New York. It's completely different, but it's the same. There isn't any shelters or if they are, they are faith-based or privately funded, you do one thing wrong, you can't go back. Where are you going to go? That's huge and we can't change the way we assess that because it is what it is, but is definitely a barrier in these parts (Participant 7, February 8, 2018).

Couch surfing or hopping is relatively common in rural areas due to the unpredictable nature of the weather and safety from harmful elements. Certain socioeconomic statuses were also noted from multiple case managers to have a higher vulnerability of not meeting the definition of homelessness but lack stable and consistent housing such as youth and the mentally ill. While, couch surfing provides a temporary resource from the streets, three case managers indicated a concern with the nature of it since poor family or social relationships can deteriorate causing the temporary housing to falter and resort in no alternative options but to enter emergency shelters or the streets.

Another barrier that was addressed from all the case managers was the inconsistency of the definition and documentation required to serve veterans or military personnel with certain funding streams. The Supportive Services for Veteran Families requires at least an ‘other than honorable’ discharge from the military along with a DD-214. However, multiple case managers indicated that a large portion of their population do not have access to their DD-214 and require assistance applying for a new copy. A few case manager argued that they were at the mercy of agencies to provide that documentation—which still may take a week or two causing a gap within services for these potentially eligible individuals. Furthermore, all of the case managers noted that a growing number of incoming individuals do not qualify for veteran services since they lacked a certain discharge status, served in National Guard or Reserves, active duty time, etc. Many of the respondents identified this growing number of military personnel falling through the gaps of services and are utilizing Emergency Solutions Grant (ESG) to prioritize these veterans. However, they were mindful that not all rural communities utilize ESG funds in the same capacity or have availability.

All of the case managers agreed that outreach is an ongoing barrier for these veterans. One case manager identified that the rural nature of the location again hinders the outreach to these individuals since many residents reside in remote areas and do not readily access centralized sites. As a result, many of the veterans may opt to utilize diversion techniques such as asking a friend for money, selling medication, engaging in illegal activities, or couch surfing for temporary fixes to their unstable housing situation. Another case manager added that this population is highly transient and can be difficult to

locate if immediate services are not provided. For example, government phones have a limited amount of minutes, which can be challenging in awaiting multiple agency phone calls.

Case Management Staff

Another identified barrier was the need for well-trained case management staff to meet the unique needs of the homeless population. All of the respondents acknowledged (in some form) that case management was instrumental to the effectiveness of their services and resources. Despite each of their caseloads varying in size, the level of care for each of their veterans was imperative to their success according to the responses. All six case managers along with one supervisor echoed that current caseloads possess a large portion of chronic and intensive based needs for their consumers due to barriers such as mental health, substance abuse, unemployment, criminal justice involvement, educational limitations, transportation, and disabilities. One case manager noted

These are the neediest of folks, too, and it's really hard even if you got five and you're one person. Sometimes, you might have all the five that have the highest needs. Sometimes that is an issue but we definitely offer guidance and give our services to help fill that gap (Participant 8, personal communication, February 8, 2018).

The complex and persistent health and addiction based services needed was identified with all individuals through the use of engagement and strategic planning. All of the case managers, as well, noted that client-centered referrals were necessary to identify services within a broader system. Two of the case managers noted that their

partnerships with the outside community was necessary to implementing a well-managed system. However, all case managers (in some form) identified that these interventions had to be contextually analyzed to ensure that the service era, age, culture, sexual orientation, and other factors were reviewed to mainstream applicable resources to the consumer.

Another issue addressed was that high staff turnover can be problematic and poorly misunderstood. Specialized training, supervision, and implementation efforts can be not only costly, but also personally invested within an agency. One case manager added

We do have turnover, which again is an opportunity for new jobs, but at the same time, it can impact the number of staff and may create larger caseloads at times.

We attempt to combat that through building capacity within our departments and fill those gaps with alternative resources like AmeriCorps folks (Participant 1, personal communication, November 9, 2017).

With these high levels of investment, agencies can be facing burnout with staff or negative effects such as lack of rapport between personnel and consumers. Another case manager added that building rapport with a homeless veteran can be difficult to ‘break the ice’ and build that connection.

I think it’s more about building the relationship and the rapport that you’re going to help each other, to help a client and hope it works, and sometimes, it does and sometimes, it doesn’t. People [case managers] are overwhelmed over worked and sometimes, probably underpaid. I always keep saying this, but in a perfect world

scenario or the grand scheme of things, to try to remove yourself from that, meaning case managers or other agencies, and just do what's best for the client. Sometimes, it's just hard. There are barriers and you just don't understand why they aren't housed and they still have drug and alcohol issues. But, I think it's a philosophy of understanding it and just trying to get past that and be like, 'let's just work with this individual together and have a common outcome or goal' (Participant 8, personal communication, February 8, 2018).

This process can take a bit of time and effort on behalf of the case manager to establish a level of trust with the consumer. One supervisor further added that if staff leave prematurely it can affect internal and organizational structures along with the consistency and outcome for the consumers.

There's always room for improvement. There's change in staff so there's always that learning curve that happens and that's multiplied across our seven counties that run these programs. Just when you have a county going well, maybe there's a change of staff and you've got to get someone up to speed again (Participant 2, personal communication, November 9, 2017).

In addition, all of the respondents noted that the current program, the Supportive Services for Veteran Families, incorporates a checks and balance model to corroborate best strategies to meet the needs and eligibility for their consumers. Many of the case managers noted that the funding is not what keeps them in the field, but the ongoing lure of wanting to help others in need. However, none of the respondents noted any additional concerns with staff turnover related to the geographical area or limitations.

Steps Moving Forward

The interview process allowed multiple opportunities for the respondents to offer their insights on the assessment process based upon their experiences and daily interactions with homeless veterans. Six case managers indicated that further research needed to be done to examine the unique needs of homeless residing in rural communities. Many suggested that while some of the programs are instrumental to reducing homelessness, they fail to incorporate barriers that rural communities face within their daily implementation.

I think our model is unique and the capacity and getting other entities in local communities involved and the train of thought. I feel that's unique, which fosters a lot of other relationships and I think it's just getting someone to maybe understand a different way of doing things (Participant 7, February 8, 2018).

Efforts to end rural homelessness are challenging due to barriers such as isolation, lack of awareness, and lack of resources. Developing helpful initiatives that encourage community collaboration and partnerships is essential within rural communities.

I have been at regional meetings and I'll have someone say something to me that we've been doing this forever like years and years and year, maybe even a decade. It's something so simple to me, like 'oh'. Then, you realize you were fortunate and we have the things we need to do our jobs and some other agencies don't. There's many differences, as far as barriers or what they face in the communities. I'm sure we have a lot of the same barriers because there's not a lot of service providers out there in rural communities. It's just really getting

everyone on the same page (Participant 8, personal communication, February 8, 2018)

All case managers encouraged that ongoing conversations needed to occur whether regionally or at a state level. Discussions could field potential new program designs, barriers, and collaborative partnerships that foster new relationships amongst entities.

In addition, all six case managers also agreed that frontline staff should be part of roundtable discussions when addressing potential programmatic or legislative amendments. Future relationships that incorporate these changes might impact various facets of service quality that are not typically adopted within programmatic guidelines or design models. Most of the respondents added that many housing programs are designed with urban areas in mind and fail to engage case managers in rural communities when identifying potential barriers for their homeless population. Rural areas face unique structural issues such as transportation, employment opportunities, lack of resources, competition of funding, limited staff, multiple county coverage, and poor access to services. Evaluating the designs of assessment processes, vulnerability of needs, definition of homelessness and other core factors with the perspective of rural communities in mind may be a necessary change to incorporate the unique landscape of rural homelessness.

All case managers would prefer to see a more cohesive and uniform assessment process that can be carried across all housing programs. Despite the efforts of the Coordinated Entry System, many housing programs still vary in their documentation and questions that case managers are required to ask. One suggestion was that local, state, and

federal programs utilize the same database and documentation to verify eligibility within case files. Case managers believed that a reduction in redundant paperwork from both the internal agency and federal/state requirements would help reduce the length of time in homelessness, reduce the chances of repeat questions on multiple forms, alleviate staff burnout, and provide a consistent streamlined approach to housing those in need.

Other suggestions that were discussed throughout the interviews contained unique and innovative solutions to their rural community barriers. These recommendations required flexible and inventive uses of funding resources such as transportation options that could alleviate or minimize some of the strains their communities are facing. Discussions prompted needs for employment transportation funding opportunities that could alleviate time restrictions and geographical barriers. Even if a homeless veteran can locate work in an outlying town, it can be challenging--if even plausible-- for them to access public transportation to and from work. Many of the public transportation routes have hours that may not accommodate the individual's work schedule or consist of extensive travel time. Other areas of concern addressed needs to increase outreach or mobility capabilities to those outlying areas with consumers that do not have easy access to agency supports or resources. Improving relationships with emergency shelters to reduce county boundary restrictions and other barriers which limit access to these resources was identified in multiple conversations. Even developing resources that could access services across the state would be beneficial as individuals may attempt to relocate back to certain areas that they have resources and supports within.

Finally, all of the respondents identified that training opportunities for case managers was crucial to improve and manage the intensive level of care that homeless veterans were seeking in rural communities. Specialized training that focuses on community referrals, resources, diversion tactics, community outreach, case management problem solving, and other conflict resolutions were all referred to in some capacity. As agencies continue to increase caseloads and level of care to meet the demanding needs, case managers are seeking ongoing support to reduce turnover, improve job satisfaction, and distinguish the need to be heard when addressing issues that veterans in rural communities are facing and unique solutions that could be utilized.

Chapter 5: Discussion, Conclusions, and Recommendations Introduction

The purpose of this case study was to explore case managers' initial intake process in rural and remote areas in Pennsylvania to identify best practices and barriers for homeless veterans. Lewin's force field analysis was used to examine the behaviors and forces that impact an individual's state (Burnes & Cooke, 2013). Six case managers and one supervisor from rural communities were selected for face-to-face interviews based on their experience, job duties, and length of time involved in homeless services (see Braaksma, Klingenberg, & Veldman, 2013; Yin, 2013). The range of case managers consisted of senior to entry level, but each manager had a rich experience of frontline homeless case management and assessment services. The research addressed the needs of the rural homeless population and the strategies being used across the continuum of care. The case managers were interviewed to identify unseen and overlooked issues in the rural context of this social issue. Rural agencies are struggling with limited funding, insufficient resources, and boundary wars when providing homeless services; therefore, their insight provided a unique perspective regarding the barriers for homeless veterans (see Braaksma et al., 2013; Yin, 2013). A qualitative case study design was chosen to provide a better understanding of the intake process. Face-to-face interviews facilitated a powerful and rich conversation to explore participants' perceptions of the internal and systematic barriers faced by homeless veterans (see Yin, 2013).

Interpretation of the Findings

The purpose of this qualitative study was to provide unique perspectives on how case managers are handling assessments in rural areas to meet the needs of their homeless

population, and to explore barriers and best practices. Previous research focused on urban populations and provided little information on rural homelessness. The lack of research created a misconception of homelessness that does not exist in rural communities (HUD Exchange, 2010). This misconception was echoed by all interviewed case managers in the current study (Schiff, Schiff, Turner, & Bernard, 2015). The geographic isolation in rural areas was an ongoing concern for employment and transportation reasons. Two case managers reported that economic downturn and seasonal conditions are co-occurring factors that impact their homeless population's employability. In addition, many of the mainstream agencies are not well-versed regarding the barriers and lack of supportive services that impact the stability of the homeless population (Poremski, Woodhall-Melnik, Lemieux, & Stergiopoulos, 2016). Further training and resources may be needed to improve educational outreach with these employment agencies, while also cultivating new discussions surrounding coordination of services (Tanekenov, Fitzpatrick, & Johnsen, 2018).

One barrier involved the identification and outreach process. All of the case managers reported that the identification process and outreach services in rural homeless areas can be challenging. Many argued that the identification and outreach process tends to conflict with the common HUD definition because couch surfing is a common characteristic in this geographical area. HUD focuses on those who are homeless and in many cases leaves out those who are doubled up, staying with family or friends in overcrowded situations, or couch surfing (National Coalition for the Homeless, 2016). Although many reports indicated a decrease in homeless numbers, these studies may not

have provided a full tally of those who are in permanent housing due to the definition of homelessness (National Coalition for the Homeless, 2016). The standardized Point in Time Count is used by HUD as a tool to predict the amount of federal homeless funding each state should receive. Obtaining adequate funding can be challenging for rural communities that are aware of their homeless population but do not meet the federal definition (National Public Radio, 2016).

Other identification issues involved the definition and eligibility of the term *veteran*. Programs such as SSVF can only assist veterans who meet the Department of Veteran Affairs' (2016) definition of homelessness:

a person who served in the active military, naval, or air service, and who was discharged or released there from under conditions other than dishonorable. Note that the period of service must include service in active duty for purposes other than training/ (p. 6).

Many of the individuals seeking homeless services may fall between the cracks of this definition including those who are dishonorably or medically discharged, enlisted as a reservist, or fail to meet the adequate time of active duty requirements. Failure to meet these definitions or eligibility criteria prompts referrals to alternative programs. Multiple case managers in the current study indicated that they supported those with military experience by using alternate funding sources including Emergency Solutions Grant.

All six case managers and the supervisor stated that current caseloads present considerable chronic and intensive-based needs for their consumers due to barriers such as mental health, substance abuse, unemployment, criminal justice involvement,

educational limitations, transportation, and disabilities (Byrne et al., 2015; Edens et al., 2011; Fargo et al., 2013). Co-occurring disorders have been found to be an increasing risk predictor of those with housing instability issues along with other barriers such as those that transcend physical disabilities, mental health, and/or substance abuse fields (Byrne et al., 2015; Elbogen et al., 2013). This has created a challenging environment for caseworkers. Barriers have prompted agencies to evaluate the current caseload levels due to the intensive nature of their population, as a means to avoid burnout. Cross-training occurs across rural communities to stretch federal and state funding. Three case managers disclosed that they complete data entry for their various programs. Two other case managers noted that they operate multiple other programs besides their duties with SSVF such as ESG, Permanent Supportive Housing, Rapid Re-Housing, and life skill components. Some individuals identified an ongoing concern with staff turnover and burnout rates for this field (see Vinton et al., 2003).

All case managers identified that these interventions had to be contextually analyzed to ensure that the service era, age, culture, sexual orientation, and other factors were reviewed to mainstream applicable resources for the consumer. Characteristics surrounding the service era indicated the specialized barriers and needs of the incoming homeless population (see Metraux et al., 2013). Many of the case managers were mindful that generational differences and war experiences impacted behaviors, disabilities, and motivation to seek homeless services. These case managers understood the importance of cohort studies and agreed that younger generations of Operation Enduring Freedom (OEF)—Operation Iraqi Freedom (OIF) serving veterans were at a higher risk of

homelessness due to increased barriers and behavioral health diagnosis categories such as substance abuse, psychotic disorders, and personality disorders (see Bryne et al., 2015; Elbogen et al., 2013; Kline et al., 2009; Metraux et al., 2013). Other case managers added that socioeconomic statuses were further predictors of the likelihood of self-sufficiency and relapses in homeless veterans (see Hosek & Wadsworth, 2013; Mertraux et al., 2013).

Four case managers added that complex documentation and record-keeping requirements added increased levels of accountability and pressure for many case managers to meet federal standards. All case managers had concerns regarding the increasing level of paper documentation in both internal and external databases and files. Several of the case managers added that many of the incoming homeless veterans lack basic documentation including identification cards, DD-214's, or income documentation, which delay their program entry. Recommendations from case managers included simplifying documentation across federal and state funding streams. One case manager noted that simplifying required documentation can help mainstream services and reduce the time in homelessness (see HUD Exchange, 2014).

The recent launch of the coordinated entry system in Pennsylvania has left many of the providers straddling two evolving systems. All of the interviewed case managers indicated that they had begun implementing coordinated entry services and operating off of their community queue list. The coordinated entry system was designed to coordinate and manage access and provide assessment, prioritization, and referrals to housing providers and services within a 33 county region (Pennsylvania Continuums of Care (CoC), 2018). In the past, uncoordinated services have been found to be fragmented,

duplicated, confusing, and inefficient within the overall service arrangement and implementation (Pennsylvania CoC, 2018). The convenience of a centralized service helps alleviate some of the identified barriers including transportation costs and the confusion of multiple locations (de Vet et al., 2013). Five of the case managers identified the prioritization scale prompted concern because it relied heavily on self-identification and declaration. Henwood et al. (2011) stated that disagreements between consumers' and case manager's perceptions of needs have been addressed on multiple occasion because either party may feel the other is not fully disclosing their limitations or strengths in certain areas. Suggestions to improve these limitations involve the use of specialized training such as motivational interviewing and further research to evaluate the effectiveness of service planning techniques (Henwood et al., 2011; HUD Exchange, 2009; Jost et al., 2014).

Theoretical Framework

Lewin's force field analysis provided the theoretical basis for examining the behaviors and forces that impact an individual's state. According to force field analysis, behaviors arise from psychological forces in a person's life and behavioral changes arise from changes to these forces (Cartwright, 1952; Lewin, G.W., 1943; Lewin, K., 1943). Lewin identified a resistance to a change as a force, like inertia that is preventing the disruption of an old equilibrium (Burnes & Cooke, 2013). In the current study, multiple case managers identified a concern with the use of the new coordinated entry system despite the research that this may evoke positive changes to reducing the number of homeless individuals within the system. Several case managers identified multiple

concerns with the system, but noted that an established need existed such as a prioritizing those with a higher level of vulnerabilities.

Studies focusing on organizations indicated that there is a constant inertia or resistance to new changes that affect individual habits and group norms (Cunningham & Kempling, 2009; Swanson & Creed, 2014). Despite initial reluctance to embrace a systematic change, all service providers have transitioned to a coordinated entry process throughout the state of Pennsylvania (if they opted to maintain state or federal funding). Additional steering groups were developed to begin the change process (Cunningham & Kempling, 2009). A few of the interviewed case managers were part of a coordinated entry system from inception and assisted with the authority and responsibility of implementing systematic changes within their organizations (see Burnes & Cooke, 2013). All of the case managers articulated a need for further improved outcomes for rural homeless veterans. These case managers encouraged further discussions among CoCs and other coalitions to examine strategies surrounding rural communities and improved techniques to overcome assessment and programmatic barriers.

Limitations of the Study

The identified limitations throughout the study consisted of slight variations regarding the sample population. The participants were selected based on work-related qualifications rather than other demographics that might have been considered, including race, gender, and religion, to provide a more comprehensive participant pool. Veterans were not able to be interviewed due to the sensitive population; therefore, I included case managers who worked closely with incoming veterans seeking homeless services. The

purpose of the study was to explore the perceptions of frontline staff who had direct contact with veterans engaging in homeless services (Yin, 2013). Another limitation may include the geographical limitation of Pennsylvania. The results were limited to the geographic region in the Continuum of Care to ensure that a conflict of interest was avoided (Yin, 2013). Thus, sample size could be argued as a potential limit within the study. The findings within the study were analyzed through interpretations and as a result, researcher bias may be argued. However, the findings were identified, minimized, reduced, and controlled to the best of the researcher's ability through various steps including ongoing discussions with the IRB and other oversight including the committee chair (Trafimow, 2014; Yin, 2013).

Recommendations

This study afforded the opportunity for frontline staff to voice their concerns and potential feedback on programmatic designs along with assessment procedures for homeless veterans. Based on the results of this study, a few specific recommendations were identified for future research. One of the main suggestions surrounded the increasing need for detailed research to occur within rural communities, as a means to identify gaps within services, unique barriers, and best practices. Insufficient available data exists surrounding rural needs of homeless veterans. The unique needs understandably manifests itself differently from urban homelessness, thus, arguing a need to evaluate assessments processes and programmatic designs from a realistic and measurable means within rural communities. In addition, case managers argued that current services are not designed with rural needs. Other recommendations surround the

need for ongoing training. A large proportion of training opportunities focus on data or best practices in urban communities, but lack attention to areas that identify a remote or rural geographical location. This limitation may hinder the applicability to their work, thus, creating a need for customizable training opportunities. It may be beneficial to also increase internal organizational capacity amongst providers since homeless agencies are seeing dramatic cuts to funding sources. As a result, many organizations are reducing staff to consumer ratios, decreasing salaries, or limiting nonessential activities. Exploring opportunities to retain qualified staff and avoid burnout is critical to the overall quality of service provided to homeless veterans. Another reoccurring theme addressed surrounds direct networking amongst service providers to identify and address barriers within their rural communities. Developing committees that provide relevant insight into the operational concerns and request clarified guidance around policies and procedures specifically for rural communities may be essential when addressing federal policies. Other proposals include increasing partnership and utilization amongst existing delivery systems to address the unique needs of homelessness. Strengthening engagement amongst service providers and landlords alike may increase cooperation, collaboration, and improve service planning during the early stages of assessment, thus, reducing the length of time in homelessness and providing a support network to maintain housing.

Conclusion

Communities across the country were making significant efforts to increase access, improve assessment techniques, and reduce the length of time in homelessness for veterans (Applewhite, 1997; Basu, Kee, Buchanan, & Sadowski, 2012; Byrne, Treglia,

Culhane, Kuhn, & Kane, 2015; Diana T. Meyers and Associates, 2016; Edens, Kaspro, Tsai, & Rosenheck, 2011; Henwood, Padgett, & Nguyen, 2011). A majority of studies have focused on the practices utilized in urban communities, but have rarely focused their attention to rural areas and their unique needs throughout the assessment process (Byrne, Treglia, Culhane, Kuhn, & Kane, 2015; Cunningham, Calsyn, Burger, Morse, & Klinkenberg, 2007; HUD Exchange, 2010; Kopelman, Huber, Kopelman, Sarrazin, & Hall, 2006; Montgomery, Fargo, Byrne, Kane, & Culhane, 2013). Throughout this research study, case managers revealed their perspectives on the underlying barriers that affect homeless veterans in rural communities and the various strategies that should be analyzed when completing intake assessments. While, recent policy shifts have redirected the current assessment procedures to encompass coordinated entry, some providers still feel that gaps exist within the eligibility, structural and overall capacity within the system. Existing data has identified multiple mechanisms to overcome some of these barriers (Herman & Mandiberg, 2010; Hosek & Wadsworth, 2013; Jost, Levitt, Hannigan, Barbosa & Matuza, 2014). Agencies throughout Pennsylvania have identified the scope and ongoing need to improve assessment techniques, while also creating a push for improved data and research efforts throughout rural communities. As these communities begin orchestrating multiple, coordinated, communitywide activities to develop strategies to fill these necessary gaps, additional suggestions were also poised. Interviewed case managers' recommended improved research opportunities, ongoing training for staff, direct networking with providers, and improved partnerships and utilization amongst entities, as a means to, assure access to safe and affordable housing

especially in rural communities. Refocusing questions, self-declaration, and concerns around definitions were identified as subjective and at times conflicting with the needs of rural areas. By reevaluating some identified barriers with the needs of rural communities, it can potentially open new doors and be a catalyst of change for homeless veteran providers across the country.

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Appendix A: Homelessness Interview and Protocol

Hello. My name is Amanda Webreck and I'm doing a study on exploring case managers' perspectives on the varying intake procedures in rural Pennsylvania communities. I am a Human Service doctoral student at Walden University where we are interested in evaluating the current structure as a means to improve early assessment techniques, reduce the length of homelessness and improve outcomes for those homeless veterans engaging in community based services in Pennsylvania. I would like to ask you a few questions for this interview, if it is alright with you, from the perspective of a case manager/intake coordinator? The interview will last about 60 minutes at which, I will record this interview to ensure that I am accurately transcribing your thoughts. As a side note, your information will remain confidential. Also, I would like to reiterate that the final decision about participation is your discretion and no weight or disadvantages will be placed on you or your agency by opting not to participate. I had previously sent a copy of the consent and confidentiality forms for this interview, did you have a moment to read those forms and do you need any further explanation on the benefits and risks for you and the community by participating? Do you need me to read any portion of this form to you for clarity? If you would be so kind enough to read the form and sign below and we can make you a copy for your records. Your signed form will be separate from the answers you give me today, so it holds no bearing on your interview responses. Do you have any further questions before we begin? Thank you again for choosing to participate in this study.

[THE FIRST FEW QUESTIONS WILL FOCUS ON THE INITIAL INTAKE PROCESS]

1. Can you please state your name and position title?
2. Can you please describe your current role at the agency?
3. How many years have you worked in the housing/homeless department of this agency?
4. What is the current intake process that an incoming homeless veteran experiences upon walking through your doors?
5. What do you believe are the major assets of your intake process? Any major weaknesses?
6. What type of questions do you feel that your assessment process lacks or hinders a veteran when accessing services?

7. Do you currently have a coordinated entry program? If so, can you explain how that process works?
8. If not, can you please explain in more detail the current assessment process you have in place for incoming veterans?
9. Do you have any current assessment tools that you use? If so, what are they and how do you feel they streamline income veterans into services?
10. Do you have a priority waiting list for veterans?
11. What type of criteria does your assessment process ask and why?
12. Are there any questions that you feel should be added or erased?
13. What type of referral process and determinations are in place to streamline other resources to outside agencies for homeless veterans?
14. Do you have a basic outline of how your assessment process and referrals work in your county?
15. Do you feel there are any areas that gaps or missing when attempting to serve these individuals? If so, what are they? What are some ideas you have to better assist these individuals for your county?
16. What is your current wait time to be enrolled into homeless services for veterans in your county?
17. Are there any portions of the prevention model that you feel should be tweaked or altered to better assist veterans?
18. Are they any portions of the rapid re-housing model that you feel should be tweaked or altered to better assist veterans?
19. Do you have a housing first approach and how has that affected your assessment process?
20. Does your county currently have a triage system for veterans? And how does that currently impact your level of care and services?

[the next few questions focus on your experience involved with the intake process]

21. What has been your overall experience with the current intake process for rural veterans in your community?
22. Do you see any potential areas that need improvement? If so, what are they?
23. What are some best practices that your community currently engages within for homeless rural veterans?
24. What are some of the biggest challenges for homeless rural veterans in your community?
25. What are some ways that your community is attempting to combat with those barriers?
26. As a case manager, what is the hardest task or barrier you are seeing in your day to day interaction with homeless veterans?
27. When you evaluate your current intake process, how do most of your veterans handle the current process from your perspective? Are they okay with length, the types of questions, or the prioritization process that occurs afterwards? Have any mentioned areas that are troublesome to navigate?
28. What is the process for your agency-- when determining a level of care or program referral for a homeless veteran? Is there a specific process or model in place or is it based off of a case manager's/management's "gut feeling"?
29. What is unique about your particular community in reference to how veterans enter the homeless system?
30. Are your community stakeholders and partners receptive to coordinating services for homeless veterans? What are some ways that you partner with these outside agencies?
31. Do you see any areas of community involvement that need improved? What are some best practices?
32. What is unique about your particular community in reference to how veterans enter the homeless system?
33. How long has this particular intake been in place for your agency? Have you had any other models or systems? If so, what prompted the shift?

34. Were you finding that other agencies within your geographical area were utilizing a different assessment process or intake forms?
35. Within your community, do you feel that there are duplicated resources or efforts in reference to engaging homeless veterans into homeless services? Can you please explain in detail your reasoning?
36. What are your perceptions in reference to a coordinated entry system for the state of Pennsylvania?
37. Can you please describe the communication/referral process after the intake assessment with a homeless veteran? What is the general timeframe your agency attempts to achieve?
38. [Time permitting]Please describe a usual day for you, including people and places that you encounter
39. Do you have anything else to add to this interview?

Appendix B: Letter of Cooperation from a Research Partner

Letter of Cooperation from a Research Partner

Agency Name

Address

Date

Dear Amanda Allen Webreck,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Intake Case Managers' Perspectives on Rural Veteran Homelessness: A Multiple Case Study within Community Action Partnership for Butler County. As part of this study, I authorize you to recruit volunteers for data collection via email, letters, or phone calls, member checking procedures which will offer participants to correct errors and challenge what are perceived as wrong interpretations. In addition, it will provide respondents the opportunity to assess adequacy of the data and preliminary results. A dissemination meeting will be conducted via teleconference or webinar to share information regarding the information found within the results. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: to allow the case managers' discretion to identify an appropriate interview setting at their convenience that will suffice for a one to two hour interview session with the intake homeless case manager and supervisor separately at their discretion. During the interview process, only the participant and the student researcher will be present to ensure confidentiality and honesty of the participants. We will assume that only the remote faculty members are supervising the researcher. We reserve the right to withdraw from the study at any time if our circumstances change. However, any data that has already been collected will not be surrendered or prevent the data from being used within the dissertation.

I understand that the student will not be naming our organization in the doctoral project report that is published in Proquest.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
Authorization Official
Contact Information

Appendix C: Confidentiality Form

Name of Signer:

During the course of my activity in collecting data for this research: “Intake Case Managers’ Perspectives on Rural Veteran Homelessness: A Multiple Case Study.” I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant’s name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I’m officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature:**Date:**