The study “Housing Status, Cancer Care, and Associated Outcomes Among US Veterans” by Hannah C. Decker et al. analyzes differences in cancer diagnosis, treatment, and mortality comparing unhoused and housed patients within the Veterans Health Administration (VHA). When comparing the 5% of study participants who were unhoused with the remainder of the cohort who were housed, individuals experiencing homelessness were more likely to be diagnosed with later-stage colon cancer and had longer postoperative hospital stays. Unhoused patients also had higher rates of all-cause mortality 3 months or longer after diagnosis for both lung and colorectal cancers.

There is a large literature that associates homelessness with earlier onset of chronic disease; higher rates of death by overdose, suicide, and homicide; and earlier mortality. The disparities in outcomes related to cancer diagnosis and treatment found in this study offer further evidence of the critical challenges faced by people experiencing homelessness when it comes to health care. At the same time, it is important to acknowledge that the disparities the authors describe are less marked than those found in other studies conducted outside the VHA. In addition, on this study’s other outcome measures related to lung, breast, and colorectal cancer treatment course, surgical outcomes, and overall survival by cancer type, there were no significant differences between patients who were housed and unhoused.

In 2009, the VHA began a multipronged initiative designed to end and prevent homelessness among veterans. The initiative has now spanned over a decade and has included a partnership with the US Department of Housing and Urban Development to fund housing vouchers (housing subsidies) and supportive services needed for unhoused veterans to enter and maintain permanent housing. It also aids with employment and health services. A key pillar of this approach was the concept of housing first, a proven approach that recognizes needs such as food and housing are necessary before people can attend to other needs, such as attending to substance use disorder treatment or employment.

This VHA initiative to prevent and end homelessness led to a 45% reduction in veteran homelessness from 2009 to 2017. This stands in stark contrast to the overall population of people experiencing homelessness in the United States, which decreased by just 14.4% during a similar timeframe. Yet housing provision is not the reason for better oncologic outcomes among unhoused veterans in this study: patients who began the study unhoused were only included in the results if they also ended it unhoused.

What is it about the VHA that facilitates more equal cancer diagnosis and treatment outcomes compared with other health systems? There are 3 main factors to consider. First, insurance is not an access barrier within the VHA. To optimize cancer outcomes, a person must be able to access outpatient primary care for screening and specialty care once a cancer diagnosis is made. The VHA’s ability to provide universal coverage for veterans, including those who are unhoused, eliminates insurance as a barrier. Outside of the VHA system, people experiencing homelessness are most likely to have Medicaid or to be uninsured, both of which equate to more difficulty accessing health care, regardless of housing status. Homelessness raises the access barriers erected by poor insurance to a point of being unsurmountable, thereby contributing to significant disparities in cancer outcomes found in other studies.
Second, the VHA’s longstanding, nationally integrated electronic health record reduces likely outcome disparities when comparing unhoused with housed veterans. The instability of homelessness can often result in an individual seeking care in multiple different locations or being lost to follow-up. By being able to see within a single system what screening has occurred or where someone who has been temporarily lost to follow-up is in their course of oncologic treatment facilitates a level of care coordination that can be otherwise absent but that can be needed when caring for complex illness among people experiencing homelessness.

Third, there have likely been spillover effects from the VHA initiative to prevent and end homelessness—apart from just housing—that have benefitted its unhoused patients. While it has been successful by any standard in the US, the process of finding an unhoused veteran permanent housing can involve months of effort, during which outreach workers interact with veterans while they remain homeless, assisting with coordination of medical care and other needs. As a result, it is probable that many unhoused veterans included in this study were able to benefit from these efforts, even as they remained homeless during diagnosis and treatment.

All of this said, it is important to note that the VHA system is not free of access barriers, most notably in rural areas. It created the Office of Rural Health in 2007 to begin to address this, through interventions such as telemedicine services and the development of several hundred community-based outpatient clinics. However, the cities hardest hit by homelessness are in urban areas with long standing VA hospital systems, which may have contributed to this study’s relatively favorable results.

In addition, low-barrier access to outpatient care cannot completely overcome the challenges faced by VHA patients experiencing homelessness, as is demonstrated in the study’s finding that significantly more unhoused veterans were diagnosed with stage IV colon cancer than their housed counterparts. Screening for colon cancer requires a colonoscopy and related bowel prep, and research by some of the authors of this study has found that physicians are less likely to discuss colonoscopy with patients experiencing homelessness and that patients are more likely to refuse it due to a lack of private bathrooms. Increasing use of and adherence to fecal occult blood testing, temporary access to private bathrooms, and patient navigation to assure follow-through are policy suggestions that may be cost-effective.

Finally, while Decker et al did not find a difference in cancer-related mortality between unhoused and housed veterans for any cancer type, they did find an increase in all-cause mortality at 3 months and longer after diagnosis of lung and colorectal cancers. This finding is not surprising given the abysmal mortality outcomes when comparing unhoused with housed individuals: individuals experiencing homelessness can have up to 25 years shaved off their life expectancy when controlling for other factors. It would seem plausible that the mortality differences in this study were related to these cancer diagnoses in some manner, but given the high risk of early death faced by this population even without a cancer diagnosis, this deserves further study.

In conclusion, the results of this study indicate that in addition to providing housing at comparatively high rates for unhoused veterans, the system’s initiative to prevent and end veteran homelessness has also likely helped reduce important disparities in oncologic care for this population. While the VHA system is not perfect, based on existing research this study shows it outperforms other systems of care. Reducing health care disparities for people experiencing homelessness is essential, and the VHA can serve as an example of what it takes to do so.
Improving Cancer Outcomes Among Unhoused Patients

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