

The Home Improvements and Structural Alterations Program: Overview and Future Implications

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Background: The Veterans Health Administration (VHA) Home Improvements and Structural Alterations (HISA) program provides home modifications that allow veterans to continue living independently and safely in their homes. This program has been administered by individual VHA facilities and Veterans Integrated Service Networks (VISNs). This article outlines HISA program resources and provides information for how to use them effectively.

Methods: Veterans who participated in the HISA program, VHA administrators, and VHA clinicians were identified from a directed convenience sample of select VHA medical facilities and interviewed. Ten facilities from among identified high and low HISA program prescribing facilities were selected. Variable geographic representation and a focus on rural veterans were considered in facility selection. Interviews were reviewed, coded, and categorized into the following areas: education about the HISA program, the contracting process, use of telehealth, interaction between VHA clinical care and the Prosthetics and Sensory Aid Service, marketing

of the program, program funding, and revising the application process. Interviews obtained concerns and recommendations regarding the HISA program in these areas.

Results: Interviews noted deficits in VHA employee knowledge about the HISA program and their effective communication with veterans. Respondents indicated concern over the process for moving through the provision of the needed home modification. Telehealth was identified as a possible means of expanding program reach, though barriers were noted. Interviews noted the need for increased program funding for veterans with and without service-connected disabilities. Respondents called for increased dissemination of information about the HISA program on various accessible platforms and overall process standardization to increase equitable access.

Conclusions: The HISA program is a valuable resource for veterans seeking to remain safely in their homes despite disability or age-related functional changes. Program structure should be improved to allow greater access, and regularly reviewed to ensure efficient use of resources.

The Veterans Health Administration (VHA) Home Improvements and Structural Alterations (HISA) program is a primary means through which veterans can obtain home modifications necessary to continue safe and independent living in their home, including fall risk reduction and accessibility to essential parts of the home. However, not all eligible veterans who may benefit from this program participate, for a variety of reasons.¹⁻⁶ Historically, the HISA program has been administered in a decentralized and nonstandardized fashion dictated by the organizational structure of each US Department of Veterans Affairs (VA) medical center (VAMC) within a certain region or Veterans Integrated Service Network (VISN). Previous research found differential access to the HISA program by younger veterans, women, minorities, veterans with certain disability types, and veterans living in rural vs urban settings. These disparities in access and use of benefits conferred by the HISA program suggests an area of unmet need, which may improve veterans' health care outcomes and reduce costs associated with their care.²⁻⁸

The purpose of this article is to provide information to improve equitable provision

and effective eligible use of resources available through the HISA program in a more generalizable manner by providing insight to highlight common program process deficiencies and care provision gaps relevant to VAMCs nationwide. This information can be used to inform the VA Physical Medicine and Rehabilitation (PM&R) and Prosthetic and Sensory Aid Service (PSAS) national policy initiatives, as well as hiring practices, clinic organization, specific care provision, and administrative goals and metrics at each VISN and at the VA Healthcare System level.

METHODS

Veterans who participated in the HISA program, VHA administrators, and VHA clinicians from select VAMCs were identified and interviewed to better understand what helps increase access to the program, barriers to access, and how existing program components and processes impact use of the service. These interviews were taken from a directed convenience sample of selected VAMCs. To obtain this directed convenience sample, 167 VAMCs that participated in the HISA program were categorized as facilities that provided either a

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TABLE. HISA Program Improvement Recommendations

Recommendation
Educate Primary Care, Geriatrics, Home Based Primary Care, Caregiver Support Program, Blind Rehabilitation Services staff about program
Provide PSAS and PM&R staff more detailed HISA program education so they can connect veterans to correct individuals within HISA program
Establish routine standard work processes to ensure PSAS and PM&R staff are aware of HISA program regulations and policy updates
Provide educational materials to supervisors to disseminate to stakeholders and veterans regularly
Ensure clinicians are familiar with funding available to veterans enrolled in HISA program
Provide veterans with telehealth equipment to connect them to virtual services
Educate veterans on documenting home needs, including photographs and measurements
Inform veterans about the full costs of home modifications and ongoing maintenance
Additional funding for rural veterans and/or specific funding for travel expenses
Exception to the lower funding cap for veterans without service connection

Abbreviations: HISA, Home Improvements and Structural Alterations; PM&R, Physical Medicine and Rehabilitation; PSAS, Prosthetic and Sensory Aid Service.

high or low number of HISA program prescriptions based on data from 2010 to 2018. Ten facilities from the top quartiles and 10 from the bottom quartiles of prescribing locations were selected. This facility selection was driven by the proportion of rural veterans served by each facility, favoring those serving a greater proportion of rural veterans, as well geographic location, with the aim of avoiding overrepresentation of any specific region. The convenience sample included 45 individuals (20 VHA employees and 25 veterans) across 22 states from the Northeast, West, South, and Midwest US Census regions.

INTERVIEW PROCESS

Interviews underwent a coding process. The development of topical themes followed a systematic, 2-phase approach. Initially, researchers analyzed responses to semistructured interview questions addressing specific aspects of the HISA program, such as program awareness and accessibility. These responses naturally clustered into preliminary categories based on the interview guide structure. For example, responses related to program discovery

formed a marketing-related category, while recommendations about program implementation contributed to a training and development category.

Following this initial categorization, the research team conducted a more rigorous coding process. A team of 3 researchers systematically reviewed assigned interview transcripts to extract practical recommendations for the guide. The researchers first identified relevant responses individually and then convened during group meetings to discuss and finalize selections. This second phase refined the preliminary categorization while maintaining alignment with the original interview structure.

This approach allowed the team to preserve the practical utility of participant feedback while ensuring methodological rigor in the analysis process. Resulting themes reflect both the structured nature of the original inquiry and the practical recommendations identified for improving the HISA program. Information on the following areas were collected: education about the HISA program, the contracting process, use of telehealth, interaction between VHA clinical care and the PSAS, marketing of the program, program funding, and revising the application process.

RESULTS

Interview respondents provided several recommendations for improving the HISA program (Table). Regarding training and education, respondents noted deficiencies in VHA employee communication about the HISA program to veterans. Some employees did not know details or were unaware the HISA program existed. Additionally, a lack of knowledge about HISA program alternatives, including other available programs for obtaining home modifications or other durable medical equipment alternatives (eg, provision of a portable ramp rather than construction of a permanent one), was apparent. It was strongly recommended to provide additional education to effectively disseminate knowledge about the HISA program. Specifically, VHA employees, especially those in Primary Care, Geriatrics, Home Based Primary Care, the Caregiver Support Program, and Blind Rehabilitation Services, require greater awareness of the program and its processes.

PSAS and PM&R professionals, including physicians, nurse practitioners, physician assistants, and physical and occupational therapists, would be expected to have some knowledge of the HISA program, and therefore be more likely to connect a veteran with it. However, they may lack specific details about the program such as correct contact persons in the other service (PSAS or PM&R, respectively), facility-specific processes, such as how to enter a HISA consultation within the veteran's electronic health record, how the entered consultation would progress through the system and avoid cancellation, and what should routinely be done to avoid HISA consultation cancellation, such as referral to Occupational Therapy for a functional assessment so appropriate durable medical equipment can be trialed with the veteran prior to proceeding with more costly and time-consuming home modifications.

In addition, there is no routine standard work process to ensure that PM&R staff are aware of updates in HISA program regulations and policy. Further recommendations in this area include having supervisory employees in PSAS and PM&R work both individually and together to develop effective information dissemination methods for key stakeholders. These include targeted in-services (ie, educational trainings often scheduled and conducted during recurring meetings), whether face-to-face or virtually in real time, or recorded, that occur on an ongoing and regular basis with sister services such as Primary Care, Geriatrics, Home Based Primary Care, the Caregiver Support Program, and Blind Rehabilitation Services (eg, the facility Vision Impairment Services Team coordinator). Regularly updated educational materials should be provided to veterans and VHA adjacent stakeholders such as Veteran Service Organizations and Veteran County Service Officers, via a variety of platforms.

Successfully navigating the provision of home modifications via the HISA program involves identifying a contractor to perform the home modification and obtaining service and construction plan pricing. A key barrier in this area is that veterans and VHA clinicians perceive the funds available through HISA as insufficient,

regardless of whether they have service-connected status or not. Service connection refers to designation of ≥ 1 medical conditions determined to be related to military service and thus eligible to receive VHA care.⁹ Service-connected veterans receive a lifetime maximum award of \$6800 from HISA while veterans without service connection receive a lifetime maximum award of \$2000.^{1,2}

Rural veterans face a greater challenge than urban veterans, as there are fewer contractors located nearby. Thus, providing higher funding for rural veterans, or specific funding such as for travel expenses, would be especially helpful to find a willing contractor to perform home medications.¹ The current requirement of working with a licensed contractor was also a barrier, especially for smaller jobs, and could result in VHA employees (including clinicians) feeling pressured to become overly involved to assist veterans to move through the process.

To that point, respondents requested resources such as a regularly updated list of licensed contractors in the area, especially those familiar with working with the HISA program, be provided to veterans and their assisting groups. In addition, respondents asked that VHA take on greater responsibility and liability with regard to contractors accessing HISA funding, such as not releasing final payment until VHA approved the completed home modification. On the other hand, respondents also expressed concerns about the length of time associated with HISA program payment and noted it should be sped up to allow contractors who participate to receive payment sooner, which many believed would increase the number of contractors willing to take on this work.

The role of telehealth was noted as a great facilitator of increased access to care, especially following the COVID-19 pandemic. Telehealth modalities adapted for the HISA program could help increase access to the program and improve processing speed. Barriers include lack of appropriate veteran telehealth equipment and poor understanding of information needed to move the process forward. Recommendations included providing veterans tablets

to connect to virtual services, and developing information on home measurements needed, assistance in obtaining and sending photographs, and detailed information on successfully using telehealth for the HISA application process. Of note, some clinicians, representing home-based primary care, prosthetics services, geriatrics, rehabilitation therapy, mobile clinic, and the telehealth division, and including both clinical staff (eg, occupational therapists) and nonclinical staff (eg, prosthetics representatives and administrative personnel), have found patients expressed comparable satisfaction with the process whether face-to-face or via telehealth.

The essential relationship between PSAS and PM&R regarding the HISA program was a key finding. Both services are integral to helping veterans successfully obtain home modifications via the HISA program.^{1,2} Barriers include insufficient communication and a lack of clearly defined points of contact for each service, poorly defined roles, and inefficiencies because 2 services are involved in navigating the process. Recommendations therefore include addressing these issues, such as adopting a case management or liaison model between the services to better manage the process.

Respondents indicated that insufficient program funding was a concern. Veterans living in poorer quality housing, such as older homes, often require more expensive home modifications, necessitating greater out-of-pocket expenses. Veterans and VHA employees advocated for the creation of an exception to the lower funding cap for veterans without service connection in cases of financial hardship. Overall, the funding limits for both service-connected veterans and those without service connection were thought to be insufficient, especially as the COVID-19 pandemic increased the cost of construction materials.

Respondents also noted that veterans would benefit from clear messaging that receiving HISA funds does not impact eligibility for other VA benefits and services. Veterans must understand that home modifications work must be approved by VHA before being started and should be aware that if their disability rating increases so

that they become eligible for the higher level service-connected benefits, they would then become eligible for the higher maximum benefit. Respondents recommended veterans should receive assistance in understanding the full costs of the home modification and ongoing maintenance, and the HISA research team recommended that the National Program develop a fact sheet that can be used to advise veterans.

Respondents consistently indicated that information about the HISA program was not disseminated effectively to key internal and external stakeholders, and opportunities to highlight the program on VHA websites, brochures throughout VHA facilities, and other outlets such as direct mailing should be used. Veterans who have used the program are overwhelmingly older (mean age 71 years), White, and male, suggesting missed opportunities and unmet need for underrepresented groups. Therefore, targeted marketing interventions would especially benefit these groups.

Respondents also noted inefficiencies throughout the HISA program application process and advocated for changes such as national standard operating procedures (SOPs) to guide navigation through the HISA process. The national SOPs could include home evaluation prior to HISA application submission, clearly identified points of contact for the HISA program in PSAS and PM&R, and standardized documentation.

FUTURE DIRECTIONS

Information from respondents provided several avenues for future studies. Recommendations were obtained from each of the 7 broad topical areas: training and educational needs, potential, contracting challenges and opportunities, telehealth as a conduit to facilitate the availability of the HISA program, PSAS, and clinical services collaboration, marketing, need for increased funding, and revision of the application process. Input from stakeholders can help direct efficient use of resources to guide future studies for the greatest impact and highlight current and future priorities. Easy areas of intervention indicated by respondents include creating a national standard work process regard-

ing the HISA program with standardized educational materials for key stakeholders, revised at regular intervals, and readily available on national websites. A pre- and postimplementation survey could help provide quantifiable information about the benefits of such an intervention.

CONCLUSIONS

A qualitative analysis of interviews with veterans and VHA clinicians provides evidence of potential barriers for the HISA program. Addressing these barriers could allow HISA to better meet the VHA goal of providing home modifications that allow veterans to live safely and independently in their homes. There is a need for ongoing review and assessment of the program to ensure optimization and efficient use of resources across the spectrum of veteran needs.

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Ethics and consent

This article is part of a series of deliverables and was created with approval from the Institutional Review Board at University of Florida and VA Research and Development Service at the North Florida/South Georgia Veterans Health System, in Gainesville. Consent of participants is not applicable.

References

1. Semeah LM, Ahrentzen S, Jia H, et al. The Home Improvements and Structural Alterations Benefits Program: veterans with disabilities and home accessibility. *J Disabil Policy Stud.* 2017;28:43-51. doi:10.1177/1044207317696275
2. Semeah LM, Wang X, Cowper Ripley DC, et al. Improving health through a home modification service for veterans. In: Fiedler BA, ed. *Three Facets of Public Health and Paths to Improvements.* 2020:381-416. doi:10.1016/B978-0-12-819008-1.00014-6
3. Semeah LM, Ganesh SP, Wang X, et al. Home modification and health services utilization by rural and urban veterans with disabilities. *Housing Policy Debate.* 2021;31:862-874. doi:10.1080/10511482.2020.1858923
4. Semeah LM, Orozco T, Wang X, et al. Home modifications for rural veterans with disabilities. *Fed Pract.* 2021;38:300-310. doi:10.12788/fp.0153
5. Semeah LM, Orozco T, Wang X, et al. Predictors of county-level home modification use across the US. *Fed Pract.* 2022;39:274-280. doi:10.12788/fp.0279
6. Semeah LM, Orozco T, Wang X, et al. Rural and urban home modification program users: a comparative study. *HERD.* 2023;16:223-235. doi:10.1177/19375867221142627
7. US Department of Veterans Affairs. Home Improvements and Structural Alterations (HISA) benefits program: final rule. *Fed Regist.* 2014;79:71658-71663.
8. US Department of Veterans Affairs. Home Improvement and Structural Alterations (HISA): increase in the limit for home improvement and structural alterations (HISA)-VA: final regulations. *Fed Regist.* 1993;58:25565.
9. US Department of Veterans Affairs. Eligibility for VA disability benefits. Updated April 25, 2025. Accessed April 1, 2026. <https://www.va.gov/disability/eligibility>