The Successful Incorporation of GPD into Coordinated Entry Systems (CES)

Grant and Per Diem (GPD) National Provider Call

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March 12, 2018 at 3pm EST/12pm PST
Webinar Format

• The webinar will last approximately 60 minutes.
• The VANTs line will be muted due to the high number of callers.
• Questions can be submitted using the Chat function.
Agenda

1. VA Homeless Programs and CES
2. CES Background
3. GPD and CES
4. GPD Liaison Perspective
5. GPD Grantee Perspective
6. Q and A
VA HOMELESS NATIONAL PROGRAM LEADS CES STATEMENT
Department of Veterans Affairs

Memorandum

Date: OCT 17 2017

From: VA Medical Center Participation in the Continuums of Care Coordinated Entry System (VAHQ#7844648)

Subject: Network Director (10N1-23)

To: Deputy Under Secretary for Health for Operations and Management (10N)

The purpose of this memorandum is to issue guidance regarding the roles and responsibilities of the Department of Veterans Affairs (VA) VA medical centers (VAMC) homeless programs in each of their local Continuums of Care (CoC) and the CoC’s coordinated entry systems. VA’s Federal partner, the Department of Housing and Urban Development (HUD), requires that all communities develop and operate a coordinated entry system (CES) for all homeless individuals, including Veterans. CES is a critical element in our continued efforts to end Veteran homelessness because it ensures coordination of community-wide services for Veterans experiencing homelessness, system-wide awareness of the availability of housing and services, and easy access to and appropriate prioritization for these resources by Veterans who are in critical need. VA’s participation is essential to the success of this national effort. There are several key components to a fully-developed CES: case conferencing, Needs Lists (BNL), assessment tools, and data sharing.

The CoC framework is designed to promote a community-wide commitment to the goal of ending homelessness, including Veteran homelessness, making local VA support and participation essential to the CoC process. The Veterans Health Administration (VHA) Homeless Program Office requires all VAMC homeless programs to be fully engaged with each of their local CoCs and actively collaborate in their collective plans to end Veteran Homelessness.

Community case conferencing is one key element essential to an efficient coordinated entry process. Each VAMC’s homeless program team is required to actively participate in person or through conference calls in the case conferencing meetings taking place amongst the community partners within their local CoCs. Specifically, each VAMC homeless program team is required to assign at least one staff person to consistently attend the CoC case conferencing meetings and act as a bridge of communication between the CoC providers and the VHA homeless program.

Coordinated Entry Implementation Assessment Worksheet

VHA Homeless Programs

Category 1: VA Partnership with Continuum of Care (CoC) Boards and Board Activities

The CoC framework is designed to promote community-wide commitment to the goal of ending homelessness, including Veteran homelessness, making local VA support and participation essential to the CoC process. The Veterans Health Administration (VHA) Homeless Program Office (HPO) requires all VA Medical Centers’ (VAMC) homeless programs to be fully engaged with each of their local CoCs, which means at a minimum, participating in a formal decision-making body on decisions that impact Veteran homelessness. Per VA Legal Counsel, VHA employees are legally permitted to participate in and serve on CoC boards. Approval for participation in this capacity should be granted by the facility’s medical center leadership or designee. Recusal from CoC board decision-making processes is only required if the employee has an outside position with, or interest in, a local organization seeking Housing and Urban Development (HUD) funding. Otherwise, employees are permitted and encouraged to participate fully in their role as a CoC board member. In fact, HUD regulations encourage participation by other Federal organizations on local CoCs, including incorporating their input into establishing priorities for funding projects in the geographic area.

VAMCs with multiple CoCs should select “Partial” as the assessment response when they have met the requirements with some, but not all, of the CoCs within their catchment area.

Does your VAMC have a least one staff member who is assigned to actively collaborate with each CoC in the VAMC catchment area in their collective plans to end Veteran Homelessness? This is required.

Yes [ ]
No [ ]
Partial [ ]

This Point of Contact (POC) should be actively involved in the community planning process and be well-versed in the local goals being pursued, the Federal Criteria and Readmissions for Ending Homelessness Among Veterans (https://www.usich.gov/tools-for-action/criteria-ending-veteran-homelessness), and local VA homeless program performance expectations. This POC should have decision-making authority as it relates to the VA’s ability to coordinate housing and services for homeless Veterans with the continuum of care and other key partners, and assumes responsibility for communicating CoC goals and priorities to local VA leadership. VAMCs with multiple CoCs may assign different staff for each CoC at their discretion.
Overview of DUSHOM Memo

• **Background:**
  • HUD requires all communities develop and operate a Coordinated Entry System (CES) for all homeless individuals, including Veterans.
  • CES is a critical element in our work to end Veteran homelessness.
  • VA’s participation in their local CES is essential to this national effort.
  • The DUSHOM memo outlines the expectations for VAMC participation.

• **Purpose of the guidance:**
  • Establish the roles and responsibilities of VAMCS in each of their CoCs and the CoC’s CES.
  • Establish expectations on VAMC’s participation in several key components of a fully-developed CES: case conferencing, by-name-lists, assessment tools, dedication of VA resources, and data sharing.
Policy

- Engagement and active collaboration with CoC on their collective plans to end Veteran Homelessness
- Community Case Conferencing Participation
- By-Name-List Participation
- Utilization of Assessment Tool
- Dedication of VA Resources to CES
- Data Sharing
Why Coordinated Entry?

Without CES

With CES

Connect with Housing & Supports
Navigate
Assess

Image: Chris Ko, United Way of Greater Los Angeles
<table>
<thead>
<tr>
<th>Event</th>
<th>Year</th>
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<tbody>
<tr>
<td>HEARTH Act 2009 Amends McKinney-Vento Act</td>
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<td>2011 HEARTH Defining “Homelessness” Final Rule</td>
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<td>HUD Prioritization Notice 2014</td>
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<td>2012 CoC Program Interim Rule</td>
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<td>2012 ESG Program Interim Rule</td>
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<td>2015 Coordinated Entry Policy Brief</td>
<td>2015</td>
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<td>2017 CES Additional Requirement s Memo (January 2017)</td>
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<td>CoCs must have Coordinated Entry by January 23, 2018</td>
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<td>2010 USICH Releases “Opening Doors”</td>
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<td>2011 SSVF Begins</td>
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<td>2013 Veteran Boot Camps</td>
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<td>2014 VA 25 Cities</td>
<td>2014</td>
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<td>2014 Mayor’s Challenge Launched</td>
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<td>2014 SSVF Surge (P1)</td>
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<td>2015 Federal Criteria and Benchmarks</td>
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<td>2015 Com Solutions’ Functional Zero</td>
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<td>2015 Vets@Home TA</td>
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<td>2017 Updates to Federal Criteria and Benchmarks and Opening Doors</td>
<td>2017</td>
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<td>2017 VA, HUD, USICH Community Planning Survey</td>
<td>2017</td>
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Components of Coordinated Entry

- Access
- Assessment
- Prioritization
- Referral
**Coordinated Entry System in Context**

- **Diversion**
  - Household avoid homelessness

- **Targeted Prevention**

- **Coordinated Entry**
  - Temporary Shelter
  - Street Outreach

- **Rapid Re-housing**
  - Transitional Housing

- **Market Rate Housing**
  - Community-Based Housing, Services and Supports, e.g. Public Housing, vouchers,

- **Permanent Supportive Housing**

Source: HUD
What We Have Learned

- **Integration takes openness and time.**
  - We have to be open to new perspectives.
  - Sometimes we are at different paces and speeds; we need to recognize this.
  - Past history does not define our future.
  - We need each other.
  - We need to be curious and simultaneously take on the role of teacher and also learner.
- **We don’t have all of the answers but need to be committed to learning together.**
  - Self-Learning
  - Organizational Learning
  - Community Learning
  - System Learning
GPD and CES
Background and Change Process

Planning for Change

1994 GPD Program Begins

Preparining for Change

Spring 2016 Providers can Request Change of Scope-Bridge Housing

Implementing Change

December 23, 2016 GPD NOFA Released

October 1, 2017 New Models Begin

24 Years of Work

5 Months into the Change Process
1. Why is CES Important
2. Expectations Around GPD and CES
3. Encouragement
Coordinated Entry System in Context

Coordinated Entry

Diversion
Targeted Prevention

Temporary Shelter
Street Outreach
Service Centers/ Drop-In Centers

Bridge Housing

Rapid Re-housing
Transitional Housing

Households avoid homelessness

GPD TIP, Low-Demand, Clinical Treatment, Service-Intensive, Hospital to Housing

Market Rate Housing
Community-Based Housing, Services and Supports, e.g. Public Housing, vouchers, Permanent Supportive Housing
COMMUNITY COLLABORATION
(VA GPD LIAISON, SSVF GRANTEE & GPD GRANTEE)

Lori Bowley, MSW, LCSW
Grant and Per Diem Liaison
VHA Northern California Health Care System
Where Does GPD Fit?
Works Within a Community Plan

- Short term placement with supportive services
- Matching available resources to demand
- “No wrong door”
  - CES, Inpatient, Jail/Prison, outside of county, streets
- Rapid, efficient engagement and Housing First
- Participates in the community Continuum of Care (CoC)
- Participates in the Coordinated Entry System & Assessment
- Veteran Leadership Committee
- BNL
  - Regular case conferences to collectively review and plan interventions
Overview: How did we got started?

- Initially we worked in Silos
- VA Requirements
  - GPD (CoC & HMIS)
  - SSVF (Gap Analysis, HMIS)
- Veteran Leadership Committee
Building Relationships

- Veteran Leadership Committee
- Continuum of Care Collaboration
- Coordinated Entry System
- By Name List
  - HUD VASH, GPD, CoC, SSVF
Combining efforts

- Referring Veterans to GPD
  - Temporary housing in a structured environment

- Referring to SSVF
  - Move in assistance
  - Prevention assistance

- Combining efforts accessing community resources for Vets

- By Name List (BNL)
  - Avoid duplication of services
Role of Collaborating Partners

• GPD working with SSVF
  • Coordinate services for Veterans
  • Links and/or follows up with Housing Intervention
  • Supports SSVF with efforts to house Veterans

• VA
  • Monitor Care of Veterans
  • Foster collaboration and coordination between Grantees

• SSVF
  • Assist Veteran with housing search (as needed)
  • Assist Veteran with housing application process
  • Assist Veteran with rental subsidy and/or move in assistance
Important Take-Aways

• Reach out to VAMC Homeless Staff, VA Liaison and GPD Grantee

• Communication between CoC, Vet Leadership, CES & BNL

• Allow input from all collaborating partners to foster relationship building

• Tap into partners to access additional community resources

• Remember it is all about the Veterans!
ST. VINCENT DE PAUL CARES
MICHAEL RAPOSA, CEO
Current Veteran Programs:

- **Grant and Per Diem (single occupancy)**
  - 25 Bridge Housing beds
  - 15 Low Demand beds
  - 10 Hospital-to-Housing beds

- **HCHV Emergency Shelter**
  - 20 beds (double occupancy)

- **Supportive Services for Veteran Families**
  - $7,100,000 (covering 4 counties)
Grant and Per Diem

- **100% Housing First**
  - Zero barriers to entry
  - Complete flexibility for intakes

- **100% Housing Focused**
  - Offer of permanent housing at entry and often

- **Referrals from Coordinated Entry System**
  - Ceased being the default discharge plan for homeless at medical center (no side door)
Grant and Per Diem

• **Veteran Choice:**
  • Center of every decision
  • Sometimes they choose ‘no’ to shelter/GPD (over being doubled-up, etc.)
  • Most are choosing the fastest path to housing!
Grant and Per Diem

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<th>FROM:</th>
<th>TO:</th>
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<tbody>
<tr>
<td>50 “Service Intensive” Beds</td>
<td>25 – Bridge</td>
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<tr>
<td></td>
<td>15 – Low Demand</td>
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<tr>
<td></td>
<td>10 – Hospital To Housing</td>
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<td>(still in the process of making full transition)</td>
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<th>FY 2016</th>
<th>FY 2017</th>
<th>Difference</th>
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<td>120</td>
<td>158</td>
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<tr>
<td># Positive Discharges</td>
<td>51</td>
<td>87</td>
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<td>Average Length of Stay</td>
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<td>170 days</td>
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<tr>
<td>Occupancy Rate</td>
<td>96%</td>
<td>92%</td>
<td>- 4%</td>
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Grant and Per Diem

<table>
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<tr>
<th>FY 2018 YTD Data</th>
<th>Bridge</th>
<th>Low Demand</th>
<th>Hospital To Home</th>
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<td># Unduplicated Clients</td>
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<td>44</td>
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<td># Positive Discharges</td>
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<tr>
<td>Occupancy Rate</td>
<td>82%</td>
<td>123%</td>
<td>-36%</td>
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Lessons Learned:

• Housing First attitude and action works

• Fear of major occupancy rate reduction is unfounded

• CES coordination and collaboration is critical
Questions?