Grant & Per Diem National Program
Operational Grantee Call

May 10, 2022

Recording Link: https://veteransaffairs.webex.com/recordingservice/sites/veteransaffairs/recording/playback/0ebbf3b8b2b9103abf8b00505681a01b

Recording Password: Homeless1!
This call will be recorded

The webinar will last approximately 60 minutes

Please make sure your audio is muted as you enter

Questions can be submitted using the Chat function.

Select the Chat icon on the tool bar at the bottom of the screen.

Select if you would like to send your message to Everyone or to a specific individual. If you select a specific individual, this will send the message privately so no one else in the meeting will see it.
AGENDA

- Announcements
- Per Diem Rate Increase
- Office of Business Oversight (OBO)
  - Omar Ochoa
  - VHA TrainingFinder Real-time Affiliate Integrated Network (TRAIN)
    - Holly Hirsel
    - Angel Wong
- Program Model Snapshots
  - Clinical Treatment
  - Hospital to Housing
- SQUARES POCs in eGMS
Welcome
Melissa Meierdierks, Clinical Program Specialist

Public Health Emergency Declaration
Secretary of HHS extended the declaration for an additional 90-days, effective April 16, 2022

Homeless Veterans Dental Program
New [informational pamphlet](#) on dental care & eligibility to educate Veterans entering GPD programs
• State Home domiciliary rate increased to $52.23
  – Maximum per diem rate authorized, per the waivers under the CARES Act and P.L. 116-315, is $156.69 for transitional housing and $19.59/hr for service centers

• Once the waiver ends, the maximum per diem rate is expected to be $60.06 (115% of the State Home rate)
  – It is possible that the maximum per diem rate could increase again in the fall (typically around November)

• Grantees must incur sufficient allowable costs to support any per diem rate increase
  – New per diem rate modifications are to be submitted through eGMS; instructions available on the GPD Provider Website, under “Per Diem Rate Request Resources”
VA’s Office of Business Oversight

Omar A. Ochoa
Senior Auditor
• Federal Contractors:
  – Trilogy, BDO, RMA & Associates

• Upcoming Fiscal Reviews:
  – Community Extended Nuclear Transitional Residence Ex-offenders, Inc. (Centre) – June 6-8, 2022
  – Fifth Street Renaissance – June 6-8, 2022
  – Gateway Foundation, Inc. – June 6-8, 2022
  – Good Samaritan Shelter – June 20-22, 2022
  – Handup Community Resource Center – June 20-22, 2022
  – Maryland Center for Veterans Education and Training, Inc. – June 20-22, 2022

• SF-425’s were due on 1/31/2022
  – 98% received as of 5/3/2022
  – ***NEW*** SF-425 Fillable Form Link: https://forms.office.com/r/JNSVnng5q8
  – Please Submit the SF-425 and Supporting Documentation to GPD425@va.gov with the grantees’ FAIN in the subject line.

• OBO Annual Training – How to Prepare for a GPD Review
  – July 18-19, 2022
  – Topics
    • Financial system requirements for organizations receiving Federal grant funds
    • Segregation of Duties/Internal Controls
    • Importance for reconciling the general ledger to the SF-425
    • Best practices for tracking and allocating costs and reviewing general ledger categories
    • Document Retention
    • Recommendation Implementation Verification (RIV) Process
    • Notice of Indebtedness (NOI) Process
VHA TRAIN for Non-VA learners

Holly Hirsel
Angel Wong
TRAIN is a national learning network that provides training opportunities for those who protect and improve the public’s health. It is a (mostly) free public service from the Public Health Foundation (PHF).

The network is comprised of government agencies, academic institutions, professional associations, and other organizations to disseminate trainings. Available since 2003. It is a clearinghouse of learning opportunities with a centralized, searchable database of courses.

VHA TRAIN is a gateway into that learning network and supported by the VHA Employee Education System, the internal education and training program office of the Department of Veterans Affairs. The EES developed learning programs have a focus on Veteran patient care.
Anyone can create an account and take courses. You only need one TRAIN account to access multiple sites. Join multiple groups or subgroups from the homepage and profile.

In addition to the VHA National Library, which is highly-technical and skill based, it is recommended that our non-VA partners use VHA TRAIN to align learning with the VA programs with whom they work.

Training suggestions consistent with VA patient care, special topics, or areas of interest can be made by VA program office managers, DFOs, workgroups. Non-VA learners can create their own learning plan, too.

Since 2015, there have been over 19,511 total course completions, over 23,000 total continuing education hours awarded, and over 250 VHA courses delivered.

VHA TRAIN is supported by the VHA Employee Education System, the internal education and training program office of the Department of Veterans Affairs.
**Types of learners:**

- ACMO Committee members
- VA Grantees and healthcare navigators
- VA Contractors
- Community health care providers
- Other VA partners

**Benefits:**

- Free continuing education credits to maintain credentials and licenses
- Access the latest public health trainings for specific areas or expertise to stay up-to-date
- “Train the Same” learn side-by-side with VA staff
- Trainings specific to the VA and Veteran patient care
- Create learning plans for required or recommended trainings
- Track learning and transcripts
Demo

Create an account
Homepage
Courses available
- VHA train email announcement example - notifications
- Searches
- Catalog
- TRAIN calendar
Register for courses
- Take course
Post course
- Surveys and tests
- Continuing education certificate
To create a profile and take courses, please visit https://www.train.org/vha/welcome

FAQs - https://www.train.org/vha/help/faq

Online Catalog (updated monthly) - TRAINcatalog.pdf (va.gov)

Webpage - VHA TRAIN - Employee Education System (va.gov)

For more information and how-to videos, please visit the PHF TRAIN site at https://www.train.org/tutorials/
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Per Diem Only Transitional Housing Models

Clinical Treatment
Hospital to Housing
Clinical Treatment Overview

• Targeted Population—Homeless Veterans with a specific diagnosis related to a substance-use disorder and/or mental-health diagnosis. Veteran actively chooses to engage in clinical services.

• Model Overview—Clinically focused treatment is provided in conjunction with services effective in helping homeless Veterans secure permanent housing and increase income through benefits and/or employment.
Clinical Treatment Framework & Expectations

• Characteristics & Standards
  – Although the programming and services have a strong clinical focus, permanent housing and increased income are a required outcome of the program. Treatment programs must incorporate strategies to increase income and housing attainment.

  – Individualized assessment, services and treatment plan are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.

  – Program stays are to be individualized based upon the ISP for the Veteran (not program driven).
– Staff are to be licensed and/or credentialed to perform the substance use disorder/mental health services provided as directed by state and local law.

– Treatment services must be provided by the applicant or through contract arrangement. (VA staff cannot be the treatment provider for this model.) Veterans are offered a variety of treatment service modalities (e.g., individual and group counseling/therapy, family support groups/family therapy, psychoeducation).

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The Clinical Treatment model specific questions below are intended to assist with making placement decisions in GPD projects. In general, Veterans should be aligned with the housing model that most meets their needs, however, since bed availability and access to all housing models does not exist in every community, not all models may be an option for the Veteran. Clinical judgement and Veteran choice are always top priorities.
Clinical Treatment Performance Targets

Your GPD liaison is expected to provide you with your performance outcome information from the Homeless Scorecard, at a minimum, quarterly. Request more frequently as helpful.

Clinical Treatment

- Exits to permanent housing > 65%
- Negative Exits < 20%
- Employed at exit > 55%
Negative Exit

- Veteran was asked to leave because of a rule violation/failure to comply with program requirements (threat of violence to self or others is excluded from this measure)
- Veteran left without consulting staff

Negative exit = a missed opportunity to permanently house a Veteran.

Potential Pitfalls

- Veteran being discharged for not engaging in programming
- Veteran relapses and is asked to leave the program
- Veteran leaving “AWOL”
How can we decrease negative exits?

• Ensure the Veteran is aware of all program rules and expectations so less likely to break them
• Use every opportunity to build rapport with the Veteran, especially early on
• Work with Veterans, using motivational interviewing, to help them reach their goals
• If the Veteran leaves without consulting program staff, make every attempt to locate and re-engage. Stay in communication with your liaison if you are successful in re-engaging the Veteran in a relatively short amount of time.
• Do not discharge a Veteran for not attending case management meetings or individual or group sessions. Work with them to meet them “where they are at” and utilize an individualized approach.

• Don’t wait for residents to come to your group, class or case management session. Reach out and engage them, make them feel welcome.

• Adapt programming tailored to each Veteran. Do not use a “one size fits all” approach.

• Treat relapse as an opportunity, not a failure.

• Evaluate program policies and procedures to assess if they are low barrier. Is a zero-tolerance approach truly effective?

• Recovery-Oriented: Build on the strengths and resilience of Veterans, utilizing a holistic approach
The Four Major Dimensions of Recovery:

- **Health**: overcoming or managing one’s disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being
- **Home**: having a stable and safe place to live
- **Purpose**: conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**: having relationships and social networks that provide support, friendship, love, and hope

*SAMSHA has a helpful website on recovery and recovery support: [https://www.samhsa.gov/find-help/recovery](https://www.samhsa.gov/find-help/recovery)*
Exit to Permanent Housing

- Housing owned by Veteran; no ongoing housing subsidy
- Housing owned by Veteran; with ongoing housing subsidy
- Housing rented by Veteran; no ongoing housing subsidy
- Housing rented by Veteran with HUD-VASH voucher
- Housing rented by Veteran with non-HUD-VASH housing subsidy
- Permanent housing for formerly homeless persons (such as: CoC project)
- Staying or living with family; permanent tenure
- Staying or living with friends; permanent tenure

Potential Pitfalls

Program offers phased treatment and does not refer to housing until certain phases completed-results in longer length of stay and is not Housing First focused

Some Veterans are referred by treatment court or probation and impose requirements on the Veteran staying in treatment, which leads to longer length of stay
How can we increase the number of Veterans successfully exiting GPD to permanent housing?

- Discuss the Veteran’s housing goals right from the start.
  - Notions about waiting a long time for the Veteran to “get settled”, to first work through other non-housing issues, or to engage with mental health and/or substance use treatment does not align with Housing First principles.
  - Housing markets are tight and there can be long waits to get into housing. Learning the Veterans’ goals and connecting them to appropriate resources early on is key.

Permanent Housing Placement National Challenge Information (includes office hours information, Kick-Off call recording) [here](#). We need all hands on deck! Thank you for your support as we work together to reach this achievable goal.
• Be very involved in the Veteran’s application and housing process.
  o Some Veterans in this program model may need more support and involvement from their case managers to complete necessary steps.
  o Ensure any judicial referring entity is aware, at time of referral, that the goal is permanent housing, without delay.
  o Connect with the Veterans’ HUD-VASH case manager, SSVF case manager, or community case manager for collaboration. Conquer and divide action steps to help the Veteran reach the goal of becoming permanently housed.
Hospital to Housing

• What is Hospital to Housing?
  - Respite care is a medical model to address the housing and recuperative care needs of homeless Veterans who have been hospitalized.

• Targeted Population
  – Homeless Veterans identified and evaluated in emergency departments and inpatient care settings for suitability for direct transfer to a designated GPD Program for transitional housing and supportive care.
Admission Criteria

- Individual must be functional, be able to perform independent Activities of Daily Living (ADL); not require acute detox, has no apparent psychosis; and has a post discharge plan coordinating care with the medical center (e.g., H–PACT Team, Mental Health, Substance Abuse, etc.).
Characteristics & Standards

- Housing sites are expected to be in close proximity to the referring medical center, so that ongoing clinical care, including specialty care, can continue to be provided.

- Have a post discharge care plan as pre-requisite to program placement that addresses ongoing physical, mental health, substance use disorder, and social work needs as well as care management plans to transition the Veteran to permanent housing upon clinical stabilization.

- The VA Homeless Patient Aligned Care Team (H–PACT), or other appropriate care unit, will facilitate and coordinate the ongoing care needs upon transition.
Required Minimum Performance Metrics/Targets

- Discharge to permanent housing is 65 percent
- Negative exits* are less than 20 percent

*The term “negative exit” is defined as the removal of a Veteran from the GPD program because of a violation of program rules, a failure to comply with program requirements, and/or leaving the program without consulting GPD grantee staff (a.k.a. “going AWOL,” elopement, etc.).
• A Memorandum of Understanding must be in place with the local VAMC that details participation in the Hospital-to-Home (H2H) program.

• Included in this should be an acceptance criteria for Veterans being referred from local facility emergency departments and inpatient wards, a detailing of how follow-up care with the medical center is organized, and a commitment to engaging enrolled Veterans in permanent housing as part of program objectives.
• Potential Pitfall

- In-Home Nurse or Medical Team not set up prior to discharge from the hospital
- Medications not filled prior to arrival to GPD
- Supportive Medical Equipment not ordered or does not accompany Veteran upon discharge to GPD
- Veterans discharged to GPD H2H who were unable to care for their own needs while on inpatient units due to medical/mental health conditions
- Misplace or Loss of identification and other difficult to obtain documents while in the hospital
**Referral ACUITY:** High Mental Health, Substance Abuse, or Medical Acuity of Veterans being referred to H2H. No standardized acuity tool used for H2H and acuity level can be underestimated when initial referral is made.

**Discharge Needs:** Lack of resources for Veterans who are admitted to H2H and Liaison/Grantee discover the Veteran needs higher level of care to meet the medical or mental health complexities.

**Communication & Coordination:** Documentation and discharge planning coordination from inpatient units is limited and not flexible.
Ensuring Fidelity Ensures Housing: Communication

Does your MOU:

• List **specific disciplines and primary points of contact** with defined roles & responsibilities

• Spell out the **admission expectations** with Activities of Daily Living (ADL), Independent Living Skills (ILS), medication management….

• Site the **FREQUENCY** of your H2H staffing's or interdisciplinary meetings and **WHO** should attend

• Does it identify who is responsible for **each piece** of the process from H2H pre-admission to post-discharge follow-up
Ensuring Fidelity Ensures Housing: Communication

• Craft a consult or template that is **purposeful** and could be used by internal or external stakeholders to identify Veterans for H2H

• A KEY to strong Inter-agency/inter-discipline discharge planning is providing tools and education to the referring sources

• Once the draft of your consult or template is complete, circulate to the grantee, HPACT/PACT, for review or input
Ensuring Fidelity Ensures Housing: Communication

H2H Feedback Loop:

- Do you have a built-in feedback loop to the referral source for Veterans who were discharged to H2H (trouble-shoot any communication breakdowns, Kudos, or other miscellaneous items)

H2H Huddles and set staffing times:

- **Co-lead Huddle**: HPACT representative/Liaison & grantee to quickly review emerging needs of the day
  
  *(which could include potential admissions/discharges, medication needs etc.)*

- **Set a Time each week for case conference opportunities**: These are cases that may need longer discussion than the huddle can serve
  
  *(instead of waiting for the 30-60-90 day Individual Service Plan Review)*
Opportunity to meet the 38,000 permanent housing placement goal

• H2H GPD model is to provide both PROACTIVE clinical follow up care and housing case management seamlessly for homeless Veteran following an inpatient stay or emergency department visit

• Veterans considered for the H2H program would otherwise be discharged to the streets, an emergency shelter or longer inpatient episodes.

• Traditional medical respite models provide an alternative to discharging a patient to homelessness; however, they typically do not create a concurrent permanent housing plan during the recuperative period.
Future Planning: USING DATA TO BUILD COMMUNICATION

- Are there program trends that the team can target?
- What change may lead to an improved outcome?
- Were there any unexpected results during the last quarter?
- Are there educational needs that the grantee or HPACT team could benefit from?
- Is HPACT part of your Quarterly Reviews?
- Are there any outliers not reflected in the data?

**Other:** Activities at a local or national level, community involvement (to include coordinated entry), any administrative or program changes, barriers, challenges, or highlights
SQUARES is an online system that provides grantees with information regarding Veteran eligibility

• Grantees using SQUARES Must…
  – Designate a SQUARES Manager and backup POC in your SQUARES Mangers Portal
  – Notify SQUARESAdmin@va.gov if your SQUARES Manager leaves the organization, so their account can be deactivated
  – When registering using your agency’s business address
  – Identify your SQUARES Manager in GPD’s electronic grants management portal (eGMS)

• SQUARES Managers Must…
  – Participate in the Semi-Annual Recertification Process (March and Sept)
  – Approve users from their agency within 24-48 hours
  – Reactivate user accounts within 90 days
  – Login at least every 30 days to avoid inactivity deactivation (all users)
  – Provide users with their organization description (name, program-city/state, VAMC, and CoC) so the users accounts can be aligned with the correct organization

• Resources
  ➢ SQUARES Video
  ➢ SQUARES Users Guide
  ➢ SQUARES Manager Guide
  ➢ SQUARES Website
Thank You

Next Call: Tuesday, June 14, 2022 at 2pm EST