THE HOMELESS EVIDENCE AND RESEARCH SYNTHESIS ROUNDTABLE SERIES
Aging and the Homeless Community

December 2015

EXECUTIVE SUMMARY

The Aging and the Homeless Community HERS symposium held on November 19, 2015 brought researchers on homelessness and aging together with policy makers and advocates to discuss the projected population growth and special needs of the older homeless Veteran population and the impact this may have for the VA and its community partners.

There is evidence of an aging trend among homeless adults in the United States, including Veterans. The cohort born between 1954 and 1965 faces an elevated risk of homelessness. The median age is over 50, yet this group has health problems similar to those in the general population in their 70s and 80s: high rates of cardio-metabolic diseases and substance use complicated by geriatric conditions such as cognitive deficits, visual and hearing impairments, urinary incontinence, mobility challenges, and the need for assistance with activities of daily living. Mortality rates are high, with heart disease and cancer as the leading causes of death. A current study on palliative and end-of-life care for homeless Veterans indicates that lack of appropriate housing is a significant concern.

All of these issues have important implications for designing both the built environment and care systems and strategies. Suggested recommendations to this end include better integrating VA and community health care, social services, and housing programs to enable Veterans to age in place for as long as possible and avoid nursing home placement; creating more flexible housing criteria; and educating end-of-life and homeless care providers about resources available in and outside of VA.

INTRODUCTION

On November 19, 2015, the U.S. Department of Veterans Affairs (VA) Homeless Programs Office and the National Center on Homelessness Among Veterans (NCHAV) hosted a virtual research symposium on aging and the homeless community. The symposium was the second in the Homeless Evidence and Research Synthesis (HERS) Roundtable Series, for presenting and discussing critical issues affecting Veterans experiencing homelessness.

NCHAV Acting Director Dr. Tom O'Toole welcomed presenters from NCHAV, the VA Eastern Colorado Health Care System, and the University of California, San Francisco, to share their work on issues of aging and homelessness:

- Tom Byrne, PhD, an investigator at NCHAV and Assistant Professor at Boston University, explained why homelessness among older Veterans is likely to increase and the projected impact on the use of health services.
- John Schinka, PhD, an investigator at NCHAV and Professor of Psychiatry at the University of South Florida, presented his research on mortality risk and factors influencing death in older homeless Veterans.
- Evelyn Hutt, MD, a geriatrician-internist and palliative care physician at the VA Eastern Colorado Health Care System and Associate Professor at the University of Colorado School

of Medicine, shared preliminary findings from her study of planning palliative care for homeless Veterans at the end of life.

- Margot Kushel, MD,Professor of Medicine at the University of California San Francisco in the Division of General Internal Medicine at San Francisco General Hospital, discussed emerging clinical issues in the aging homeless population.

Following the presentations, Dr. O'Toole led a roundtable discussion with leaders from the VA and the homeless Veterans advocacy community: Baylee Crone, Executive Director, National Coalition for Homeless Veterans; Lisa Pape, National Director of VA Homeless Programs Office; and Dr. Scott Shreve, National Director of VA Hospice and Palliative Care.

PRESENTATIONS

1. Projecting Changes in the Scope and Health Service Utilization of Older Veterans Experiencing Homelessness

Dr. Byrne presented evidence of an aging trend and growth projections in the Veteran homeless population through 2025. He also discussed the potential impact of older homeless Veterans on the cost of VA health services and the implications for service planning.

Aging cohort effect in the single adult male and Veteran homeless population

An analysis of Census data from 1990 through 2010 shows a shift in the age distribution of the single adult male homeless population over time, with a cohort of males born between 1954 and 1965 comprising the bulk of the homeless population in each decade. In 1990, this cohort comprised 23% of the population but by 2010 accounted for 43%.

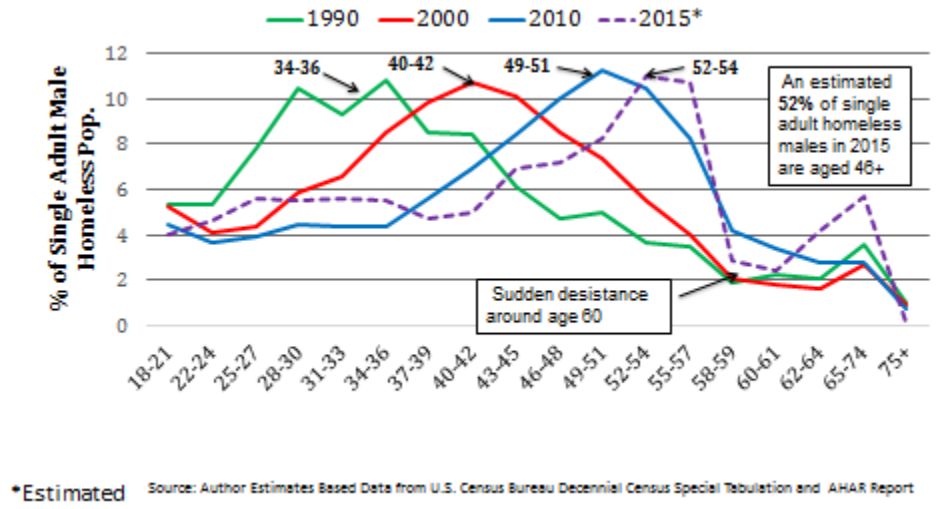
The aging trend among single adults experiencing homelessness is distinct from the aging of the general population: in 2010, the single largest age group among homeless adult males was those aged 49-51, who constituted 11.3% of the single adult male homeless population. By comparison, males aged 49-51 represented only 5.9% of the general adult male population. This trend is consistent in every state and city across the country and for the Veterans who used VA specialized homeless programs from 2000–2010.

Projecting changes in size of population and use of health services

Dr. Byrne and his NCHAV colleagues worked with a team of demographers to create projections of future age distributions of single adult and Veteran homeless populations in 2015, 2020, and 2025. The estimated age distribution for 2015, shown in Figure 1, continues to shift to the right, with a sudden drop-off in the homeless population after age 60. Dr. Byrne maintained that mortality alone is not the cause; it may also be that people are accessing Social Security benefits and may have increased ability to afford housing or may be entering nursing homes.

Additional projections focused on the percentage change in the number of Veterans experiencing homelessness on a given night in 2015, 2020, and 2025, stratified by age. Veterans in the 62–74 age bracket are projected to grow by 50–250%, depending on their age and year in question. The number of Veterans age 60 and older is projected to increase from 16,921 in 2015 to 21,350 in 2020, levelling off at 22,175 in 2025, as this age cohort reaches its life expectancy.

Figure 1. Projected Age Distribution of Single Adult Homeless Population in 2015



*Estimated Source: Author Estimates Based Data from U.S. Census Bureau Decennial Census Special Tabulation and AHAR Report

Average life expectancy for single homeless adults is 64 for males and 69 for females in some studies. Given that homeless individuals 50 and older have health problems similar to those in the general population in their 70s and 80s, the growth in the older homeless Veteran population will have a large impact on VA health care resources. Byrne and colleagues looked at the VA health care costs incurred by users of VA homeless programs by discrete age categories and found that health care costs for this population tend to increase with age, particularly inpatient care, as shown in Figure 2.

Figure 2: Health Care Costs for Homeless Veterans

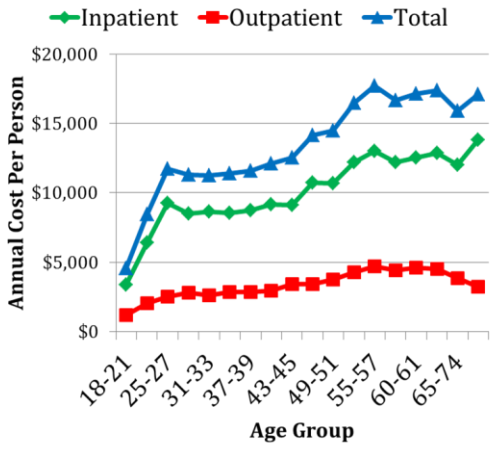
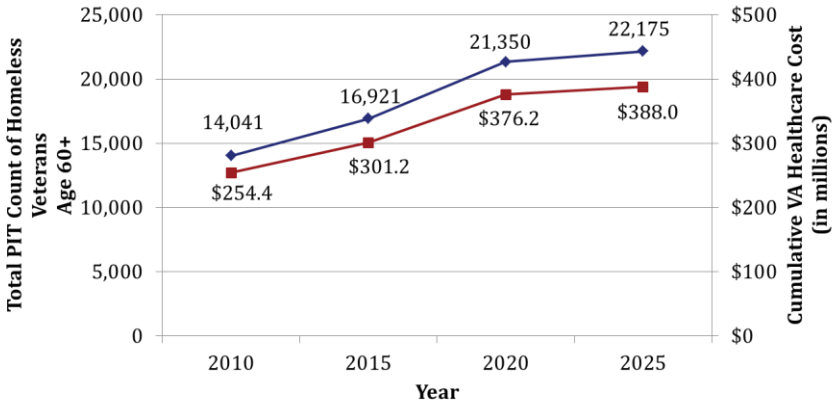


Figure 3 illustrates the mapping of estimated health care costs onto the population projections for Veterans aged 60 or more to gauge the cumulative impact on the VA health care system.

Figure 3: Projecting Health Care Costs



Implications of aging trend

The aging homeless Veteran population will require us to address geriatric conditions and end-of-life issues in HUD-VASH and other VA homeless programs, which may include staff training, building and facility changes to accommodate accessibility challenges faced by an older population, and increased systematic efforts to target older Veterans experiencing homelessness.

2. Mortality Risk and Factors Influencing Death in Older Homeless Veterans

Dr. Schinka presented his recent research on mortality and risk factors influencing deaths among older homeless Veterans. Today, 35% of the people who enter VA homeless programs are age 55 or older, many with health problems and high rates of nonfatal suicidal behavior.

Mortality patterns in Veterans 55 or older

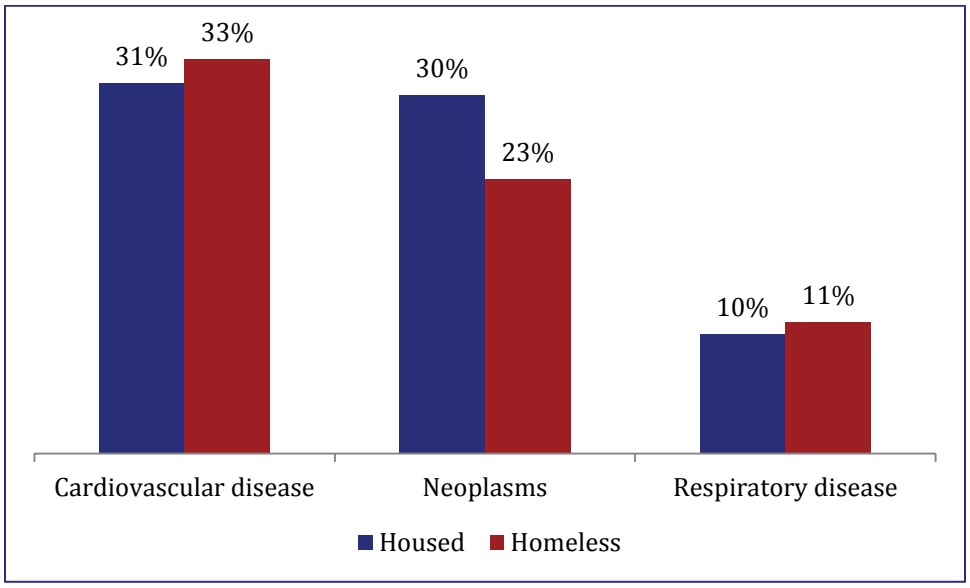
Dr. Schinka and his colleagues examined mortality patterns in 4,775 Veterans 55 or older who entered national VA homeless programs in 2000–2003. Using VA administrative data and Centers for Disease Control and Prevention National Death Index records, they found that 1,560 (35%) homeless Veterans died from all causes, compared with 3,649 (18%) of a housed control group; these differences were magnified when the impact of increasing age (55–59 vs 60+) was considered. (See Table 1)

Table 1. Mortality Rate Among Housed and Homeless Veterans

Age	Housed	Homeless
55–59	15%	31%
60+	24%	43%

Eleven causes of death accounted for 95% of deaths of Veterans in both groups, most frequently cardiovascular diseases, neoplasms, and respiratory diseases (See Figure 4). Compared with the control group, the homeless group had higher proportions of deaths due to digestive diseases, mental or behavioral disorders, infectious or parasitic diseases, and accidents or self-harm. Deaths due to neoplasms and to endocrine, nutritional, or metabolic diseases were more common in the control group versus the homeless group. Death by suicide was rare, but the odds of dying by suicide were greater in homeless Veterans (0.4%) than those who were housed (0.2%).

Figure 4. Causes of Death Among Housed and Homeless Veterans

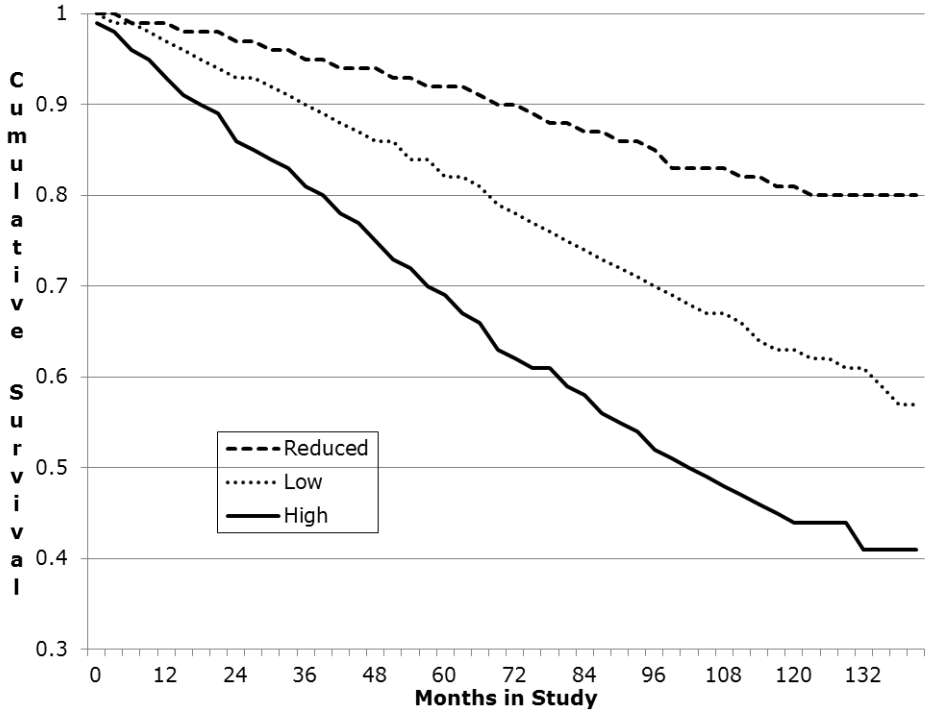


Predictors of death among older homeless Veterans

In another set of analyses, Dr. Schinka and colleagues examined predictors of death in a subsample of 3,620 homeless Veterans who completed a structured interview formerly required for admission to VA homeless programs, which captured sociodemographic, psychosocial, health, housing, alcohol abuse, and employment data. Five variables—serious medical problem, hospitalization for alcohol abuse, alcohol dependency, unemployment for three years, and age 60 or more—were modestly associated with increased risk of death. Three variables—non-White, drug dependency, and dental problems—were modestly associated with a reduced risk for death. This reduced risk was attributed to living in neighborhoods where both VA and non-VA health and social services were more readily available. A previous study (Nunez, Gibson, Jones, & Schinka 2013) showed that homeless Veterans receiving dental care as part of homeless services had significantly improved housing and employment outcomes. This result was attributed to the direct effect of dental care (e.g., improved nutrition and appearance, reduced pain) and the indirect effect that Veterans stayed in the intervention longer to receive dental care, thereby promoting greater exposure to other therapeutic and training modalities.

To examine the impact of cumulative risk from these eight variables, a risk score was calculated using weighted values based on logistic regression modeling (+1 for variables with HRs greater than 1, -1 for variables with HRs less than 1). The possible range of scores was -3 to 5. Based on the risk score, the full sample was categorized into three groups: reduced risk (risk score less than 0), low risk (risk score of 0-2), and high risk (risk score greater than 2). Figure 5 presents the survival functions for the three groups. Overall, there was a significant difference in the survival functions of the three groups, and all pairwise comparisons of the functions of the groups revealed significant differences.

Figure 5: Mortality Rate for Homeless Veterans by Risk Category



In summary, this research provides support for the hypothesis that homelessness increases mortality rates in older Veterans, especially in those aged 60 and older. While there are several predictors of early mortality for older homeless Veterans, the combination of predictors as an overall risk index may have the potential to identify those Veterans at greatest risk.

3. Planning Palliative Care for Homeless Veterans at the End of Life

Dr. Hutt discussed an ongoing study funded by VA Health Services Research and Development (HSR&D) in 2013 to inform palliative care for homeless Veterans. The study was motivated by the experiences of the inpatient palliative care team at the Denver VA Medical Center where great need was observed.

The goals of the study are to:

- Characterize existing approaches to the care of homeless Veterans at the end of life;
- Understand barriers and facilitators to providing excellent end of life care for homeless Veterans; and
- Develop a program framework for meeting their needs that can be tested and replicated across the nation.

Dr. Hutt and her team conducted an email survey of end of life and homeless care programs at 152 VA Medical Centers (VAMCs) and achieved a 33% response rate. Respondents to this survey reported that they treated an average of 9.4 homeless Veterans at end of life annually; the most critical challenge was a lack of appropriate housing. To understand the problem in greater depth,

the team conducted visits to four VAMC sites that were chosen based on the size of the homeless population and the strength of their program either in homeless care, end-of-life care, or both. The team conducted 21 key informant interviews with decision makers in palliative care and homelessness inside and outside the VA, 33 interviews with homeless Veterans with chronic illness, and 10 focus groups with front line providers and middle managers. The interviews focused on substance abuse and mental illness; pain management strategies; need for cross specialty educational activity; location of care and associated regulations; advance directives and how to access resources; burial assistance; grief loss and family support; entitlement and service connection; and culture of homelessness.

Barriers and facilitators to care

Findings from the interviews revealed that:

- Symptom management in the context of addiction, unstable housing, and behavioral health problems is challenging.
- Current housing options are too often limited to places that insist on functional independence and a "clean and sober" lifestyle.
- Discontinuity of care between and within VA systems restricts end of life care delivery.
- VA regulations challenge collaboration with community providers, to the detriment of frail, vulnerable homeless Veterans.
- Dedicated homeless and end of life program staff collaborate informally.

Ways to improve care

During the study's final year, a National Policy and Program Development Forum is bringing together focus group participants from each site with national VA palliative and homelessness care leadership to develop policies, collaborations, and programs to facilitate high quality end of life care for homeless Veterans. At an initial meeting in Philadelphia in the summer of 2015 the following preliminary recommendations were made and are in the process of being refined:

- Educate end of life providers about needs of those with unstable housing and homeless care providers about palliative care.
- Educate end of life and homeless care providers about VA resources that are available.
- Facilitate ongoing informal communication among VA and non-VA homeless and palliative care providers.
- Develop more flexible housing criteria for those needing palliative care.
- Establish policy that gives homeless Veterans at the end of life priority housing access.
- Pilot test intense collaboration between Homeless Patient Aligned Care Team (HPACT) program and VA end of life providers.

Stakeholders interested in moving any of these items forward should contact Dr. Hutt.

4. The Aging of the Homeless Population: Emerging Clinical Issues

Dr. Kushel described the clinical issues presented by the aging homeless population and the implications for practice and policy. Homeless Veterans have a median age over 50 with health problems similar to people in the general population who are in their 70s and 80s. Key health concerns include chronic diseases, substance use, and geriatric conditions such as cognitive,

functional, and visual impairment, falls, and incontinence. These issues have implications for designing both the built environment and care systems and strategies for these individuals who may be at high risk for nursing home placements.

Managing chronic diseases

High rates of cardio-metabolic illnesses such as heart disease, diabetes, and stroke are related to high rates of smoking and poor access to care. The leading causes of mortality in homeless individuals 45 and older are heart disease and cancer. Managing chronic disease is a tremendous challenge, requiring longitudinal coordinated care. Individuals need to adhere to complex medication regimens, follow special diets, and perform recommended activities, which is particularly difficult tasks for individuals who are homeless. Guidelines for care management also need to be considered not just in terms of age, but also with respect to life expectancy and co-morbidities.

Substance use

A major concern for homeless older Veterans is the rising rate of substance use. Illicit substance use (cocaine and heroin) disorders have decreased with age in the homeless population, but remain higher than the general population or than the older homeless population from 20 years ago. Many treatment facilities are not designed to serve older people with the functional impairments and chronic disorders associated with alcohol and drug abuse.

Geriatric conditions

Older homeless Veterans have high rates of geriatric conditions such as dependency on assistance with activities of daily living (ADL) and independent activities of daily living (IADL); urinary incontinence; falls; cognitive impairment; depression; and visual and hearing impairments.

Similarly, high rates of cognitive impairment, strongly associated with alcohol use disorders, have been found. Recent studies by Dr. Kushel and her colleagues at the University of California San Francisco yielded the following findings regarding older homeless individuals:

- 39% had difficulty with one or more ADLs and 17% with three or more
- 49% reported difficulty with at least one IADL
- 27% reported difficulty walking
- 38% showed global cognitive impairment and 17% had moderate to severe impairment
- 40% demonstrated executive function impairment, a disorder which affects the ability to manage complex tasks
- 34% reported one or more falls in the past six months
- 48% screened positive for incontinence
- 45% had visual impairments and 36% were hearing-impaired

ROUNDTABLE DISCUSSION

Tom O'Toole thanked the presenters for the information they had shared and acknowledged that it had raised awareness and introduced many questions.

1. *What particular information or disconnects jumped out at you from the presentations?*

Ms. Crone responded that the data confirmed what community agencies are seeing in the field, which is working to support the rapidly aging Veteran cohort with ADLs and end of life issues. She stated that the sharp decrease in the Veteran homeless population at age 60 was a testament to the good work being done at the community level to respond to these individuals as they increasingly reach out for help. She added that the projected Point-in-Time counts and age distributions presented by Tom Byrne spoke to the need to improve targeting of the population, to continue HUD-VASH, and to develop new collaborations to meet the needs of aging Veterans.

Ms. Pape said that policy changes would be needed to accommodate the aging population bubble; changes would include expanding the current focus on job readiness and independent living in homeless programs to building capacity for the management of chronic disease and cognitive deficits. This would involve the coordination of medical, mental health, social work, legal, and community partnerships.

Dr. Shreve cited VA budget constraints as an issue. He also pointed to the challenge of providing programs like assisted living that do not fall within VA's legislative authority for housing supports. He raised the question of how much programs like Veteran Directed Care have been used to assist with the population.

2. *There seems to be a "disconnect" between what we're seeing "on the ground" in the communities and the policies, procedures, and mechanisms in place to care for the aging homeless population. It often feels like we live in a system of silos that do not necessarily speak to each other: the Homeless Programs Office, Geriatrics and Extended Care, and community partners. Who should own this?*

Dr. Hutt suggested that Ms. Pape and Dr. Shreve assemble a cross-disciplinary task force from VA Homeless Programs, Geriatrics and Extended Care, and community partners with the understanding that "we all own it." In her experience, putting the right people in the room together from the various silos will provide good ideas and energy.

Ms. Pape concurred with Dr. Hutt, emphasizing the importance of the community partners for their ability to do some of the work that is closed to the VA because of authority or legislative restrictions. She also welcomed participation from friends in Congress, the National Coalition of Homeless Veterans, and the National Alliance to End Homelessness.

Ms. Crone spoke of the opportunity such a task force would provide to identify gaps in expertise and resources and work towards filling them. As an example, she referenced the lack of financing for senior housing, which is connected to community services that can help Veterans maximize the amount of time that they are in their home so that they are aging in place instead of having to go to nursing facilities.

3. *Where do you see community providers within the mix?*

Ms. Crone offered four roles for community providers:

- Source of information: a means to identify what is and is not working in the field and where the gaps are.
- Conduit to services: a referral source for other needed services.

- Help in accessing benefits: many communities have experience working with SOAR (Supplemental Security Income Outreach Access & Recovery) and in pursuing Social Security and VA benefits.
- Providing housing opportunities: expertise in developing affordable housing and leveraging complicated financing tools to increase housing stock.

Dr. Shreve expressed the opinion that a homeless program might take the lead in a collaborative effort, with tighter linkages to the GeriPACT outpatient team and palliative care specialist support. The palliative care specialist could also empower the HPACTs to do more primary palliative care. In addition, there could be a stronger effort to educate primary care providers and front line social workers not involved with the homeless program. He also suggested the We Honor Veterans program as a mechanism for the VA to partner with 2,900 of the 5,000 hospice organizations nationwide that have made a commitment to improve the care of Veterans at the end of life and are adept at quickly enrolling Veterans in hospice.

4. *Can you speak more specifically to the unique challenges you have seen in the context of palliative care, end of life care, and care for cognitively impaired and functionally frail aging homeless Veterans? What is going to work and not work with individuals who may have co-occurring addictive behaviors and compliance issues?*

Dr. Shreve indicated that the 106 inpatient hospice units at 168 VAMCs are committed to doing whatever it takes to help a Veteran at the end of life. He stressed the importance of making community providers aware that every enrolled Veteran is entitled to hospice, regardless of their income. Policy and law require that VA must provide inpatient care with a hospice team if it is needed, unlike the Medicare model for general inpatient care under hospice.

5. *What targets should we be focusing on to provide care for rapidly aging frail older homeless and formerly homeless Veterans?*

Dr. Shreve: Increase the percentage of homeless Veterans who die with hospice services.

Ms. Crone: Ensure that Veterans are able to age in place, maintaining their independence and stability, for as long as possible by targeting integrated VA and community health care, social services, and housing programs to where they live.

Dr. O'Toole: Promote the financial cost and improved quality of care benefits of an aging-in-place strategy.

Ms. Pape: Identify a geriatric advocacy organization partner like NCHV to help us in this effort. Reach out as well to the U.S. Department of Health and Human Services.

Dr. O'Toole thanked everyone for their participation in the symposium, concluding that there were many excellent efforts underway to support older homeless Veterans and that it is important to make sure that people are aware of them.

SUGGESTED RECOMMENDATIONS

During the presentations and roundtable discussion a number of suggestions were made for improving the care of older homeless Veterans.

- Establish a joint homeless care/end of life care task force to develop recommendations for providing quality health care and appropriate housing accomodations for older homeless and formerly homeless Veterans. The task force should include community providers and other VA partners such as the U.S. Department of Health and Human Services
- Increase systematic efforts to identify and target older Veterans who may be at risk for or experiencing homelessness.
- Create more flexible housing criteria for homeless or formerly homeless Veterans needing palliative care.
- Develop better integrated VA and community health care, social services, and housing programs to enable Veterans to age in place for as long as possible and avoid nursing home placement both to promote independence and well-being and to lower costs.
- Promote the development of mental health and substance use treatment programs that are tailored to serve older people with functional impairments and chronic disorders.
- Consider cognitive and functional impairments of the older homeless population in the design and outfittting of housing and service spaces, living spaces, and the supports available within that housing.
- Develop a plan to educate end of life and homeless care providers in the VA and the community about VA structure, eligibility, housing, and end of life resources, including palliative care and hospice.
- Facilitate ongoing informal communication and collaboration among VA and non-VA homeless and palliative care providers.

NOTE: Opinions expressed in this paper represent only the position of the National Center on Homelessness Among Veterans, presenters and panel members and do not necessarily reflect the official policy of the U.S. Department of Veterans Affairs.

GLOSSARY OF TERMS

Activities of Daily Living (ADL): basic self-care tasks that include eating, toileting, grooming, bathing, walking and transferring (such as moving from bed to wheelchair).

Assisted Living Facilities (ALF): places where Veterans can live in a rented room or apartment with some shared living spaces and a trained caregiver on duty 24 hours a day, 7 days a week. This person can help the Veteran with activities of daily living such as bathing and getting dressed. Veterans may also be able to have the VA arrange for a health professional (e.g., a nurse) to visit and give them extra care. The VA does not pay for the Veteran's rent, which usually includes basic services. However, the VA may pay for some of the extra services the Veteran may need in an Assisted Living Facility.

VHA Geriatrics and Extended Care (GEC): a set of VA programs and partnerships designed to support the health, independence, and well-being of Veterans in the face of aging, disability, or illness. Programs include a broad range of Long Term Services and Supports, including Geriatric and Palliative Care, in home and community-based, residential and nursing home settings.

VHA Geriatric Patient Aligned Care Team (GeriPACT): Patient Aligned Care Teams (PACTs) that specialize in providing care for older and chronically ill Veterans who have complicated health problems that are made even more challenging by social factors. Their needs therefore cannot be addressed in the primary care clinic staff (PACT) alone. GeriPACTs include health care providers from a variety of disciplines. The team is usually led by a GeriPACT provider such as a physician

(MD or DO), physician assistant (PA), nurse practitioner (NP), or clinical pharmacist. Other team members include nurses, social workers, pharmacists and mental health providers. Dieticians, rehabilitation professionals, and chaplains may become involved as well.

VHA Health Care for Homeless Veterans (HCHV): program that initially served as a mechanism to contract with providers for community-based residential treatment for homeless Veterans. Many HCHV programs now serve as the hub for a myriad of housing and other services that provide VA with a way to reach and assist homeless Veterans by offering them entry to VA care. Another aspect of HCHV is the Contract Residential Treatment program, which places Veterans with serious mental health diagnoses into quality, community-based supportive housing.

VHA Homeless Patient Aligned Care Team (H-PACT): H-PACT provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans. At selected VA facilities, Veterans are assigned to an H-PACT care team that includes a primary care provider, nurse, social worker, homeless program staff and others who provide medical care, case management, housing and social services assistance, to provide and coordinate the health care they may need while assisting them in obtaining and staying in permanent housing.

VHA Homeless Providers Grant and Per Diem Program (GPD): The GPD program allows VA to award grants to community-based agencies to create transitional housing programs and offer per diem payments. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VA medical centers (VAMC) by augmenting or supplementing care.

Housing and Urban Development - Veterans Affairs Supportive Housing (HUD-VASH) Program: HUD-VASH is a collaborative program between the Department of Housing and Urban Development (HUD) and VA. Eligible homeless Veterans receive rental support from HUD in the form of a Housing Choice or Project Based Section 8 voucher as well as case management and supportive services from VA. These efforts collectively support housing stability and the recovery from physical and mental health problems, substance use disorders, and functional concerns contributing to and/or resulting from homelessness. HUD-VASH subscribes to the "Housing First" model, a best practice that has demonstrated that housing the homeless individual helps him/her to exit from homelessness, which then improves the ability and motivation to engage in treatment strategies. The program's goals include housing stability while promoting maximal recovery and independence in the community for the Veteran and the Veteran's family.

Instrumental Activities of Daily Living (IADL): complex skills needed to successfully live independently that include managing finances, handling transportation, shopping, preparing meals, using the telephone and other communication devices, managing medications, and housework and basic home maintenance.

SOAR: SSI Outreach Access & Recovery: national project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) that is designed to increase access to Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical condition, and/or a co-occurring substance use disorder. Using a three-pronged approach of strategic

planning, training, and technical assistance (TA), the SOAR TA Center coordinates this effort at the state and community level.

Supportive Services for Veteran Families (SSVF): The SSVF program was authorized by Public Law 110-387 and provides supportive services to very low-income Veteran families that are currently in or transitioning to permanent housing. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability.

Veteran Directed Care (VDC): program that helps Veterans continue to live at home or in their community. VDC provides skilled services, case management, and assistance with activities of daily living (e.g., bathing and getting dressed) or instrumental activities of daily living (e.g., fixing meals and taking medicines) for Veterans who are isolated or whose caregiver is experiencing burden. Veterans in this program are given a flexible budget for services that can be managed by the Veteran or the family caregiver.

We Honor Veterans: a program of the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs (VA) that invites hospices, state hospice organizations, Hospice-Veteran Partnerships and VA facilities to join a pioneering program focused on respectful inquiry, compassionate listening and grateful acknowledgment. By recognizing the unique needs of America's veterans and their families, community providers, in partnership with VA staff, will learn how to accompany and guide them through their life stories toward a more peaceful ending.

PRESENTER AND PANELIST BIOGRAPHIES

Thomas Byrne, PhD

Tom Byrne, PhD is an Investigator at the VA National Center on Homelessness Among Veterans and an Assistant Professor at the Boston University School of Social Work. As part of the research team at the National Center, Tom conducts research on a number of topics related to homelessness among Veterans and VA specialized homeless programs in support of VA's efforts to prevent and end homelessness among Veterans.

Baylee Crone, MS

Baylee Crone, Executive Director for the National Coalition for Homeless Veterans (NCHV), is a national voice in efforts to end veteran homelessness. In this capacity, she provides leadership and management over NCHV's Technical Assistance, Policy, and Communications activities and serves NCHV's Board of Directors to execute NCHV's mission and goals. As the only national organization solely committed to ending veteran homelessness, NCHV is a trusted source of information, training, and guidance for community organizations, philanthropic and corporate partners, and government employees at the state, regional, or Federal level. Ms. Crone earned a Master's Degree in Vocational Rehabilitation Counseling with an emphasis on Traumatic Brain Injury at the George Washington University and a Bachelor's Degree in Political Science with an emphasis in Public Service and Global Security from the University of California, Santa Barbara.

Evelyn Hutt, MD

Evelyn Hutt, MD founded and led the health services research effort at the VA Eastern Colorado Health Care System from 2002-2013. As a geriatrician-internist and palliative care physician, she has a long-standing interest in the care of underserved populations, and is currently funded by VA HSR&D to study Planning Palliative Care for Homeless Veterans at the End of Life. She has completed projects aimed to improve the care of pneumonia and heart failure in nursing home patients, and attends on the Palliative Care Consult Service at the Denver VAMC. In 2013-14 she extended her mentoring to faculty at the Institute of Palliative Care in Africa while on sabbatical in Uganda.

Margot Kushel, MD

Margot Kushel, MD is a Professor of Medicine at the University of California San Francisco in the Division of General Internal Medicine at San Francisco General Hospital. Margot's research interests include the health and health care utilization patterns of homeless adults and other vulnerable populations, with a focus on improving outcomes among older homeless adults. Her research is informed by her 20 years of experience as a practicing internist at San Francisco General Hospital. She is the PI of two NIA funded R01s that focus on older homeless adults. She is a practicing general internist at San Francisco General Hospital.

Thomas O'Toole, MD

Dr. Tom O'Toole is the Acting Director of the National Center on Homelessness among Veterans and National Director of the Homeless Veterans Patient Aligned Care Team (H-PACT) Program for the Department of Veterans Affairs. He is a general internist based at the Providence VA Medical Center in Rhode Island and a Professor of Medicine at Brown University. His research for the past 25 years has focused on access to care, health and social service needs and intervention studies for homeless and other vulnerable and disadvantaged populations with funding from VA HSR&D, NIH, SAMSHA, and private foundations. He has published over 70 articles and book chapters on the subject.

Lisa M. Pape, LISW

Lisa M. Pape, LISW, currently serves as the Executive Director, Homeless Programs for the Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA). Prior to her current role, she worked for many years holding progressively responsible positions at the VA Louis Stokes Medical Center in Cleveland. Her focus is on operationalizing plans and approaches designed to most effectively meet the needs of the nation's Veterans who are homeless or at risk of becoming homeless. Her primary efforts include oversight and implementation of homeless programs nationwide that provide prevention, outreach, treatment, transitional and permanent housing solutions and supportive services. Ms. Pape is the recipient of NASW's Knee/Wittman Outstanding Achievement Award in Health and Mental Health Policy among her many awards and recognitions.

John A. Schinka, PhD

John A. Schinka is an Investigator at the VA National Center on Homelessness Among Veterans conducting research on risks and outcomes in aging homeless Veterans. Prior to joining the Center,

Dr. Schinka served as the Director of the Neuropsychology and Memory Disorder Clinics at the Tampa VAMC. He is a Professor of Psychiatry and of the School of Aging Studies at the University of South Florida. Dr. Schinka is a Fellow of the American Psychological Association and the recipient of several research awards from the Association. He has also received the national VA Outstanding Professional Services Award. Dr. Schinka's research has focused primarily in the areas of cognition, aging, and neuropsychology.

Scott Shreve, MD

Dr. Scott Shreve is the National Director of the Hospice and Palliative Care Program for the Department of Veterans Affairs. He is responsible for all policy, program development, staff education and quality assurance for palliative and hospice care provided or purchased for enrolled Veterans. Dr. Shreve has led the implementation and oversight of the Comprehensive End-of-Life Care Initiative from 2009 to 2012 to change the culture of care for Veterans with serious illness and to ensure reliable access to quality palliative care. Clinically, Dr. Shreve commits half of his time to front line care of Veterans as the Medical Director and teaching attending at a 17 bed inpatient Hospice and Palliative Care Unit at the Lebanon VA Medical Center in Central Pennsylvania. Dr. Shreve is also an Associate Professor of Clinical Medicine in Penn State's College of Medicine.