2023 VA Permanent Housing Conference

HUD-VASH Enhanced Project-Based Staffing Pilot Programs Across the Country

Introductions

- Placeholder TA

- Bedford, Massachusetts HUD-VASH Program
  - Melanie Sarna, LICSW, HUD-VASH Project Based Supervisor
  - Kelly Sargent, RN, HUD-VASH Nurse
- Northern California HUD-VASH Program
  - Kristen Yahn, LCSW, Program Manager
  - Hannah Simkins, LICSW, Assistant Program Manager

Who is in the room?

- SSVF Staff
- HUD-VASH Staff
- VA leadership

The Current Situation

- More than 60% of Veterans in the HUD-VASH program are older than 60 years.
- It is expected that between fiscal year 2020 and fiscal year 2035, the subgroup of Veterans age 85 and older is expected to increase by 66%, and specifically the subgroup of women Veterans aged 85 and older is expected to increase by 159%.
- Americans with three or more health challenges will double for populations between 65 and 75 years of age; By the age of 75, a majority of Americans have three or more chronic medical conditions.
- According to the 2019-2020 Annual Homeless Assessment Report to Congress (AHAR) nearly a quarter of a million people 55 and older were estimated by the government to have been homeless in the US during at least part of 2019.
- The latest AHAR Part 2, shows the number of people experiencing sheltered homelessness who were 55 and older was 18%, up from 16.5% in 2019.

Homelessness Accelerates Aging

- A recent study from the Center for Vulnerable Populations, UCSF, shows that:
  - 44% of people in the survey group first experienced homelessness when they were 50 or older.
  - More than half (56%) reported their health as fair or poor, and the prevalence of geriatric conditions were higher among the study group with a median age of 57 than they are among the general population in their 70s and 80s.
  - The researchers concluded that 50 is the new 75 for this population.
  - Source: http://ohioaging.org/wp-content/uploads/KUSHEL-CLOSING.pdf
- Veterans in HUD-VASH often have numerous medical conditions, mental health conditions, ongoing substance use, extremely low income, and housing insecurity

BEDFORD HUD-VASH PROJECT BASED HOUSING:

Our PB HUD-VASH Team:

- **3 HUD-VASH case managers (2 at BG; 1 at PSA)**
- **Project Based Supervisor**
- **Enhanced Services (started spring 2023):**
  - Registered Nurse
  - Occupational Therapist
  - Physical Therapist
  - Certified Nursing Assistant
  - Recreation/Art Therapist
- **Part of larger HUD-VASH Team:**
  - 1 Nurse Practitioner
  - 1 SUD Specialist
  - 3 Certified Peer Specialists

BEDFORD HUD-VASH PROJECT BASED HOUSING:

Bedford Green Apartments-

Bedford, MA- across from VA campus (EUL):

- 27 Graduates
- 9 Handicap units and 3 sensory units
- Opened in 2016. 69 one-bedroom apartments. New construction.
- LEED for Gold and Energy Star certified
- Transportation via shuttle driver to access community for social needs, local stores, etc.
- Recreational/game room, gym, outdoor patio and grill, dog park, community garden, next to golf course, etc.

BEDFORD HUD-VASH PROJECT BASED HOUSING:

Pleasant Street Apartments-

Beverly, MA

- Opened in 2013. 32 studio apartments.
- Converted old mattress factory building into housing
- 2 handicap units and 2 sensory units.
- 11 Graduates; 7 Veterans from original lease up in 2013 & 2014
- Housing two Expanded Eligibility Veterans

Both sites include:

- Onsite Property Manager, Resident Service Manager, Maintenance, and Live In Responder
- Community room, computer room and laundry facilities
- Full furnished apartment- ex. furniture, bedding, towels, pots/pans, dishware, utensils, etc.
- Built to “Age in place” - Ex. Front loader washer/dryer, low lip to enter shower, etc.

BEDFORD HUD-VASH PROJECT BASED HOUSING:

Gordon H. Mansfield Veteran Community- Tewksbury, MA

- In process- projected to open early 2024
- 18 one-bedroom apartments & 3 studios; 12 units will be devoted to HUD-VASH
- Managed by Soldier On. Aside property management, Soldier On will provide meals, transportation, programming, etc.

Bedford HUD-VASH Project Based Housing:

Our Service Model:

- **Target population:** Priority for chronic homeless, frequent hospitalization, complex medical care, etc.
  - **Bedford Green:** 55+ with complex medical needs; proximity to healthcare. Need for on site CM and Enhanced Services. HUD-VASH eligible VA Employees
  - **Pleasant Street:** Any age; complex needs. Access to commuter rail for Boston VAHCS. Expended Eligibility
  - **Gordon Mansfield:** Higher need Veterans; Elder or disabled
  - Team Based Approach
- Utilize Phases but provide long term CM model
- Promote independence skills and emphasis on PB being Veteran's private home
- Finding balance between our role and that of other services (Property Management, MHICM, CTI, HBPC, VNA, Senior Services, etc.)

Bedford HUD-VASH Project Based Housing:

Partnerships with Peabody Properties:

- Regular/frequent contact with management
  - Weekly meeting between VASH CM and PP team
- Monthly Resident Meeting facilitated by PP and VASH
- Yearly retreat with PP and VASH staff; focus on team cohesion
- Collaboration between VASH and Resident Service Manager for programming and social outings

Contact Information:

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Kelly Sargent: Kelly.Sargent@va.gov

Websites:

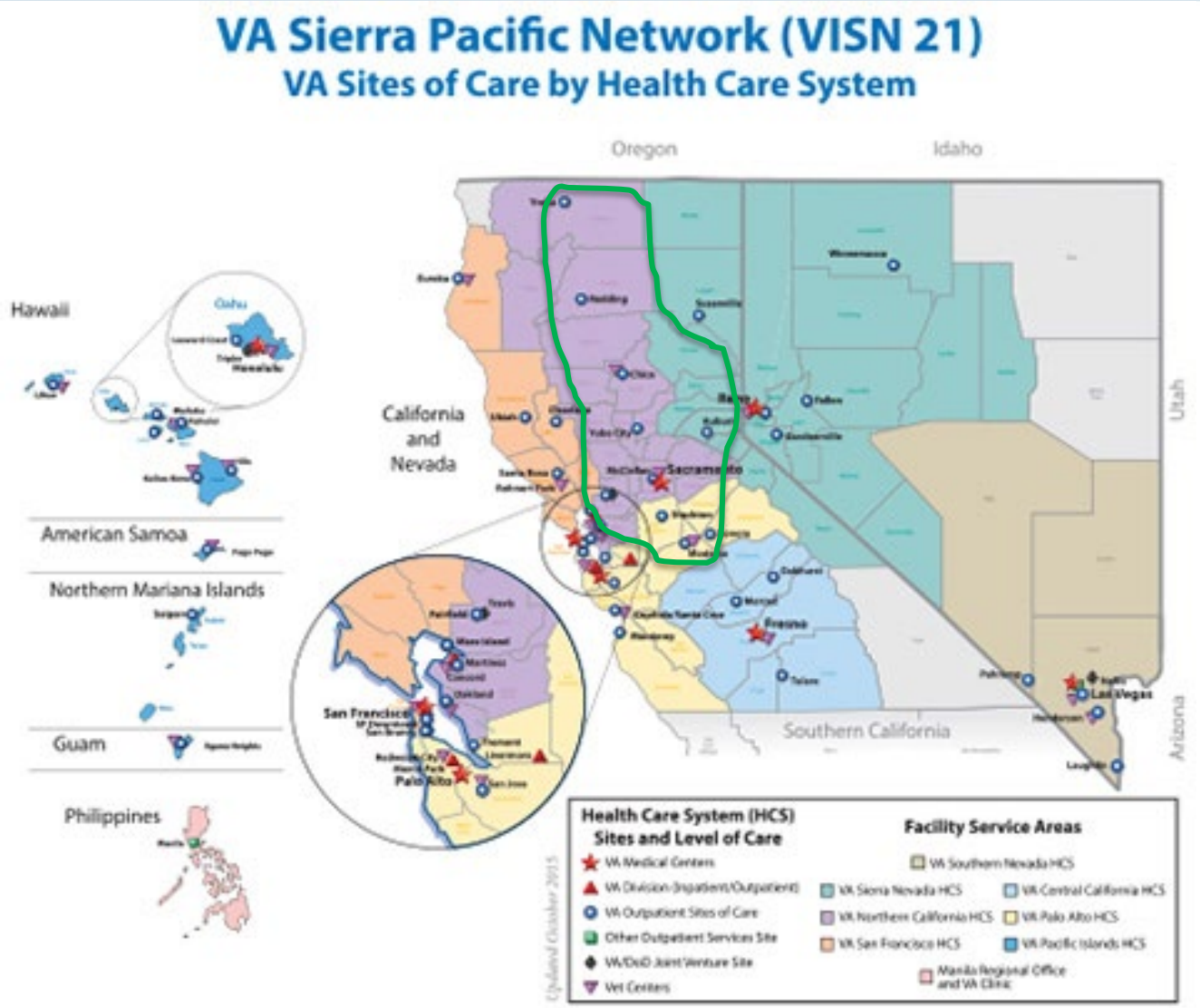
Bedford Green Apartments | Bedford, MA | Welcome Home (bedfordgreenveteransapts.com)

Apartments for Rent in Beverly, MA | Pleasant Street Apartments - Home (pleasantstreetaptsma.com)

Northern California HUD-VASH Program

- Total number of vouchers: 2,557
- Number of PHAs: 18
- Over 100 staff working at 12 VA facilities
- Number of Project-Based sites: 16
- Disciplines:
  - Social Work
  - Housing Specialists
  - Peer Support Specialists
  - Occupational Therapists
  - Registered Nurses
  - Recreation Therapist

** All data is as of September 2023



Nor Cal Aging and Disabled Veteran (ADV) Program

- Enhanced staffing for project-based HUD-VASH sites
- Target population: aging (55+ years old) and/or disabled HUD-VASH Veterans
- Goal of the program is to reduce institutionalization and hospitalization of the participants
- Northern California has ADV programs in three locations:
  - Sacramento (Mather VA Medical Center)
  - Stockton VA Clinic
  - Martinez VA Medical Center

Sacramento ADV Program

- Mather Veterans Village (project based site next to Mather VAMC)
- Staff:
  - Program Coordinator (Social Worker)
  - Occupational Therapist
  - Registered Nurse
  - Certified Nursing Assistant
  - Peer Support Specialist
- Events
  - Educational series (Fall Prevention, Medication Management, Managing Finances, Tips to Pass Your Housing Inspection)
  - Monthly social events: Game Day, catered luncheon
  - Outings: Bowling, California State Fair

ROLES

- **Registered Nurse:**
  - Assesses medical needs of Veterans
  - Medication/medical supplies management and education
  - Care coordination with other providers for in home, outpatient or inpatient care (VA and community)
  - Education about acute and/or chronic medical conditions in both individualized and group settings
- **Certified Nursing Assistant (CNA)**
  - In-home personal care: dressing, bathing, feeding, cleaning, etc.
  - Education on personal care and home skills
  - Tracking of appointments and assistance with attending appointments
  - Care coordination with other providers for in home or outpatient care (VA and community)

Roles

- **Occupational Therapist (OT):**
  - Evaluation of Veteran's safety in the home
  - Assesses need for adaptive equipment to promote independence and ease of daily living
  - Care coordination with other providers for in home, outpatient or inpatient care (VA and community)
  - Develops OT goals as determined by Veteran and OT, to maximize ability to function as independently as possible

- **Physical Therapist (PT):**
  - Assesses PT needs of Veteran including mobility, strength, range of motion, pain management, etc.
  - Assesses need for adaptive equipment to facilitate mobility
  - Develops PT goals as determined by Veteran and PT, to maximize ability to function as independently as possible
  - Care coordination with other providers for in home, outpatient or inpatient care (VA and community)

Roles

- **Recreation and Creative Arts Therapist (RCAT):**
  - Evaluates the history, interests, aptitudes and skills of Veterans to develop and implement therapeutic interventions.
  - Facilitates social and/or therapeutic outings; partners with community organizations or activities
  - Onsite therapeutic activities and groups
  - Connection to volunteering/leisure opportunities
  - Care coordination with other providers (VA and community) for improvements with recovery and wellness

Roles

- **Peer Support Specialist:**
  - Provide socialization opportunities to reduce isolation (individual and group settings)
  - Assist with transportation to appointments
  - Help veterans identify and achieve goals related to improving their qualify of life, including those related to recovery from mental health conditions and/or substance use issues
  - Identify and connect veterans to VA and community resources
- **Program Coordinator (Social Worker):**
  - Manage the administrative processes of the program (referrals, intake procedure, standards of work, documentation, data tracking)
  - Care coordination with other providers for in home, outpatient or inpatient care (VA and community)
  - Organize Educational Series (monthly trainings)
  - Identify and connect veterans to VA and community resources
  - Outreach VA and community providers to provide education about HUD-VASH and enhanced staffing model of care

Intros:

- Links to videos of staff introducing themselves

Partnerships:

VA Services:

- Outpatient medical care
- Home Based Primary Care (HBPC)
- Community Care contracted VNA and/or HHA
- Mental Health Intensive Case Management (MHICM)
- VA Police Department
- Healthy Teaching Kitchen
- VA Chapel and Chaplain
- Whole Health
- Transportation- shuttle to other VAs and parking lot shuttle
- VA Produce Market
- Center for Development and Civic Engagement
- CHOIR
- Geriatrics and Extended Care (GEC)

Partnerships:

Community Partnerships:

- Peabody Properties Management
  - Management
  - Resident Service Manager for social outings/events
- Bedford Council on Aging; town SWers
- Minuteman Senior Services (CM, Protective Services, Meals on Wheels, HHA/HMKing, etc.)
- Veteran Service Officer
- Bedford Local Transit
- Bedford Police Department
- Bedford Fire Department (EMTs)
- Bedford Town Pantry
- Home Depot
- Misc: Green Solutions, IPODs for Vets, equine therapy

Spotlight: Veterans Support to Self-Reliance (VSSR) Pilot Program

- Grant funded by Cal Vet and Swords to Plowshares
- 3-year pilot program with Nation's Finest in Sacramento
- Provides a higher level of on-site supportive services for veterans aged 55+ with high-acuity and over who reside in permanent supportive housing (PSH) projects throughout California
- The goal of this program is to demonstrate that with these enhanced supportive services, and within the construct of Housing First and evidence-based practices, aging veterans experiencing chronic homelessness will be able to age in place and enjoy the stable and thriving quality of life that they deserve
- Veterans can be co-enrolled in ADV and VSSR Programs - teams meet to discuss coordination of care and to prevent duplication of services
- Services at MVV include:
  - 2 mental health clinicians
  - 2 service assistants
  - 1 veteran peer support specialist
  - 1 transportation specialist

NATION'S FINEST

Groups, Presentations and Social Outings:

- Housing Skills
- Coffee and Conversation
- Mindfulness/Meditation
- Movement
- Recovery: WRAP, MISSION-VET (dual diagnosis), SUD
- Special interests – book club, computer, art, music, etc.
- Memorial Services to commemorate tenants who have passed away
- Current events – ex: racial injustice
- Graduation Party
- Fishing trips, holiday shopping, apple picking, kayaking, museum tours, etc.
- Medical Education Presentations: Infectious Diseases, Diabetes, Oral Health, Acupuncture, Alternatives to Pain Management, etc.
- Presentations: pro bono bills, Clear the Clutter program, conflict resolution, etc.

Barriers:

- Comorbidities:
- Medical, mental health, substance abuse, financial, cognitive and/or physical decline, isolation, etc.
- Managing systems, communication- VA and community
- Gaps in services for aging and complex individuals
  - Eligibility and accessibility for next higher level of care
- Time management and staff burn out…
  - Divide and conquer
  - Importance of Team Approach

Case Study

- 72 year-old, Caucasian, widowed, NSC, Vietnam-era Army Veteran
- Became homeless after the death of his wife, lived in various places including motels for several years after her death
- Permanently housed in September 2021 at MVV in HUD-VASH project-based unit
- Diagnoses include: hypertension, chronic pain, hernias, A-fib, vascular dementia, substance use
- Receiving in-home supportive services (16 hours/week)
- One of the first Veterans referred to the ADV Program, presenting concerns at the time included:
  - Poor cognition (did not remember Case Manager's name or role)
  - Incontinence
  - Self-neglect (poor hygiene, lack of food)
  - Substance use (alcohol)
  - Inability to perform ADLs independently
  - Not making medical appointments
  - Fall history
  - Concerns about caregiver (financial abuse, neglect)

Case Study

- ADV Interventions:
  - CNA: daily morning visits for assistance with ADLs, meal prep, transportation to/from medical appointments, care coordination with in-home services
  - RN: medication management, medical education, appointment management, referral/coordination with VA providers
  - OT: fall prevention, mobile alert, in-home safety, medical supplies
  - SW: appointment scheduling, coordination with VA providers, alternate housing options
  - Peer Support: transportation to/from appointments, socialization

Case Study

- Results
  - Hygiene improved, mood improved
  - Referrals made to: primary care, audiology, geriatrics, neuropsychology, podiatry, home care coordination
  - Increased attendance at medical appointments
  - Greater communication between all VA providers
  - Completed neuropsychology testing to determine cognitive and decision-making needs

Case Example:

Pleasant Street Apartments Tenant:

– 68 year old Caucasian male Navy Veteran
– 100% Service Connected
– Permanently housed in November 2022
  - Stayed at Boston shelter prior
  - 1 year of being unhoused
  - Diagnoses/PMH:
  - PTSD, hyperlipidemia, glaucoma, DMII (poorly controlled), Falls, hip fracture, abnormal MRI results, urinary incontinence, MDD, Barrett's esophagus, chronic low back pain, degeneration of lumbar disc, legal involvement, alcohol use

Challenges:

- **Multiple chronic and acute medical issues:**
  - Cognitive impairment
    - Difficulty understanding/following medical recommendations
  - Inconsistency with medication adherence and monitoring diabetes- leading to other concerns
  - Managing multiple appointments
    - Different VA locations
    - Coordinating transportation
  - Mobility/ability to access community
  - Home safety concerns
- **Psychosocial concerns:**
  - Mental Health:
    - PTSD/trauma reaction
    - Low frustration tolerance
    - Hyper fixation
  - Conflict with others
  - Needing larger apartment
  - Money management

Opportunities:

- Improved medical compliance and understanding
  - Prioritizing medical appointments and needs
  - Consistent messaging/education from VASH team
- Onsite PT/OT services
- Critical Time Intervention (CTI) referral
- Applying for increased benefits
- Social skills building
- Looking for alternative housing

Case Example

Care Coordination:

- HUD-VASH:
  - CM: Social skills, following terms of lease, applying for increased income, referrals for appropriate services, coordination with Senior Services, probation, etc.
  - RN: appt review/problem solving, confirming travel booked, encouragement to follow medical recs, medication education and training
  - OT: put together DME, coord w/ wheel chair clinic, improving safety awareness, organizational skills to improve routine, environmental modifications, incontinence training
  - PT: Work on indoor ambulation progressing to outdoor ambulation with use of newly issued rolling walker, work to increase strength and stamina

Other referrals:
- VJO
- Senior Services
- CTI

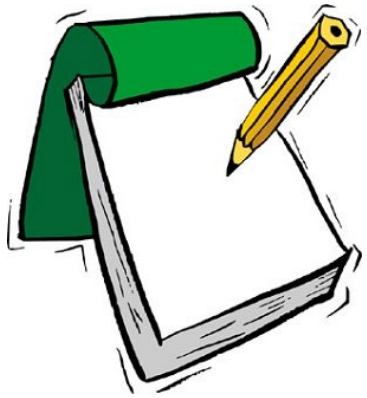
- Medical Referrals:
  - Endocrinology
  - Cardiology
  - Ophthalmology
  - Psychiatry
  - Optometry
  - Urology
  - Prosthetics
  - Podiatry
  - Nutrition
  - Nuclear Medicine
  - Sleep Clinic
  - Orthopedic
  - Gastroenterology

Best Practices and Innovative Solutions

- Structure:
  - Standards of Work
  - Tracking spreadsheets
  - Regular meetings
  - Having a structure in place helps with expansion to other sites and scaling up the program
- Having the time to dedicate to each Veteran to meet their needs
- Educational series
- Incorporate feedback
  - Ex: welcome meetings with new vets as a result of feedback (too many people)
- Team approach – flexibility/adaptability
- Outreach – to VA and community providers
- Balance needs of specific sites with larger program needs

Lessons Learned

- Identify your vision and keep it in mind as you develop and implement an ever-changing program; try to anticipate the future needs of the population you are working with
- Continual feedback from Veterans and staff
- Flexibility is essential – don't be afraid to try new things and adjust as needed (example: welcome meetings)
- Staffing
    - Our staffing requests for the larger HUD-VASH program have diversified since starting ADV; there is a large need for additional disciplines on the mobile voucher side of the program
    - Logistical considerations for developing new disciplines: functional statements, scopes of practice, performance evaluations, coordination with other medical center departments
    - Hiring considerations: personalities, adaptability, program development experience



Lessons Learned:

- Need for involvement in development of program as well as ongoing communication for “pulse check”
  - Focus on team cohesion and understanding each others’ views
  - Sharing and celebrating success stories among team as well as VA and community providers
- Be involved with construction
  - Request extra office space
  - Flow of common areas matter
  - Develop with aging in place and disabilities in mind
- Advocate for adequate staffing initially
  - Acuity, tenant turn over, benefit of multidisciplinary team
- Efficiency of groups- notice trends and create group support
  - Ex. Support around holidays- SUD recovery; intake/orientation; Housing Transition Skills for new applicants

Future Directions

- Expansion of ADV to two other VA clinics (4 additional project-based sites)
- Adding new disciplines to the team: Dietitian, Nurse Manager, Nurse Practitioner, Physical Therapist, Recreational Therapist
- Ongoing collaboration with VA Geriatrics and Extended Care (GEC)
  - Adult Day Programs
  - Special housing types
  - Neuropsychology testing
- Expand HUD-VASH mobile voucher holders' access to specialty disciplines (RN, OT, CNA, RT, PT, Dietitian) in the community
- Integrate the work of ADV and HUD-VASH into the VA's High Reliability Organization model

Figure 1. Pillars of HRO

1. Adapted from Chassin, Mark R. and Loeb, Jerod M. "High-Reliability Health Care: Getting There from Here," The Milbank Quarterly 2013; 91(3):459-90.

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