Supportive Services for Veteran Families (SSVF) Webinar

GPD Models and Integration into a Coordinated Entry System

January 11th at 2pm EST
Webinar Format

• Webinar will last approximately 90 minutes
• Participants’ phone connections are “muted” due to the high number of callers
  – Questions can be submitted during the webinar using the Q&A function
• Questions can also be submitted anytime to SSVF@va.gov
Questions

Submit questions and comments via the Questions panel.
Presenters & Agenda

• **Welcome & Introductions**
  – Tamara Wright, SSVF Regional Coordinator
  – John Kuhn, SSVF National Director

• **Topic: Grant and Per Diem service models and targeted clients.** The webinar will also discuss how each of these models could align with coordinated entry systems.
  • Adrienne Nash Melendez, Health Care for Homeless Veterans Program Specialist, Coordinated Entry
  • Amanda Barry, MSW, LCSW, National Grant and Per Diem Office
  • Lori Bowley, MSW, LCSW, Grant and Per Diem Liaison
  • Natalie Siva, Roads Home Senior Program Manager, Berkeley Food and Housing
  • Michael Raposa, CEO, St. Vincent de Paul CARES
Opening Remarks
Department of Veterans Affairs

Memorandum

Date: OCT 17 2017

From: Deputy Under Secretary for Health for Operations and Management (1ON)

Sub: VA Medical Center Participation in the Continuums of Care Coordinated Entry System (VA/Q7844648)

To: Network Director (1ON1-23)

1. 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, By-Name-Lists (BNL), assessment tools, and data sharing.

2. 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.

3. 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.

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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. Recruit 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 participate in each CoC’s catchment area?
  - 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 Benchmarks for Ending Homelessness Among Veterans (https://www.va.gov/hospitals/docs/NaBO5dشن/6edr33edr-33edr-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

Community

Image: Chris Ko, United Way of Greater Los Angeles
HUD Coordinated Entry History

- HEARTH Act 2009 Amends McKinney-Vento Act
- 2011 HEARTH Defining “Homelessness” Final Rule
- HUD Prioritization Notice 2014
- 2015 HEARTH Defining “Chronically Homeless” Final Rule
- HUD Prioritization Notice 2016

2012 CoC Program Interim Rule

2012 ESG Program Interim Rule

2015 Coordinated Entry Policy Brief

2017 CES Additional Requirements Memo (January 2017)

CoCs must have Coordinated Entry by January 23, 2018

2010 USICH Releases “Opening Doors”

2011 SSVF Begins

2013 Veteran Boot Camps

2014 VA 25 Cities

2014 Mayor’s Challenge Launched

2014 SSVF Surge (P1)

2015 Federal Criteria and Benchmarks

2015 Com Solutions’ Functional Zero

2015 Vets@Home TA

2017 Updates to Federal Criteria and Benchmarks and Opening Doors

2017 VA Memo on CES

2017 VA, HUD, USICH Community Planning Survey
Components of Coordinated Entry

Access
Assessment
Prioritization
Referral
Coordinated Entry System in Context

- **Targeted Prevention**
  - Diversion
  - Households avoid homelessness

- **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, Permanen Supportive Housing

Source: HUD
Grant and Per Diem Program
A community resource to support the plan to end Veteran Homelessness

Amanda Barry, MSW, LCSW
National Grant and Per Diem Program Office
VA Central Office, Office of Homeless Programs
Overview of Today’s Presentation

• Who Can GPD Serve?

• GPD Grant Models

• GPD Transformation and Evolving Homeless Services

• Community Collaboration (SSVF Grantee, VA Liaison & GPD Grantee)
Whom do we serve in the GPD Program?

Homeless Veterans in need of supportive housing & supportive services

**Homeless:** A Veteran who is homeless as that term is defined in section 103(a) of the McKinney-Vento Homeless Assistance Act: Reference: [https://www.hudexchange.info/resources/documents/HomelessAssistanceActAmendedbyHEARTH.pdf](https://www.hudexchange.info/resources/documents/HomelessAssistanceActAmendedbyHEARTH.pdf)

**Veteran:** For purposes of GPD means anyone discharged or released from active service, regardless of length of service. Types of Discharges Eligible for GPD: Honorable, General, Other than Honorable, Bad Conduct (Special court-martial).

*Types of Discharges Ineligible for GPD: Dishonorable, Bad Conduct (General court-martial)*

**In need:** The Veteran is clinically appropriate for GPD admission

**Supportive Housing:** Must include supportive services, is not shelter care, & must lead to permanent housing
Current Types/Models of GPD Programs

- SITH: Service Intensive Transitional Transitional Housing
- CT: Clinical Treatment
- LD: Low Demand
- H2H: Hospital to Housing
- TIP: Transition in Place
- BH: Bridge Housing
Service Intensive Transitional Housing (SITH) GPDs

- **Targeted Population** - Homeless Veterans who choose a supportive transitional housing environment providing services prior to entering permanent housing.

- **Model Overview**: Provides transitional housing and a milieu of services that assist Veterans in increasing income and moving into permanent housing.

- Treatment or service plans should be individualized and facilitate the movement of Veterans to permanent housing as rapidly as clinically appropriate.
Clinical Treatment GPD Programs:

- **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 provided in conjunction with supportive housing and services

- **Clinical Treatment GPD Programs**:
  - Incorporate strategies to increase income and permanent housing attainment
  - Complete individualized assessments, services, and treatment plans
  - Have licensed and/or credentialed staff for the SUD/MH services provided
Low Demand GPD Programs: Overview

- **Targeted Population** – Chronically homeless Veterans who suffer from mental health or substance use problems or who struggle with maintaining sobriety.

- **Model Overview:** Low Demand housing is a program design using a low demand/harm reduction model to better accommodate chronically homeless Veterans.
  - A harm reduction model to better accommodate chronically homeless Veterans and Veterans who were unsuccessful in traditional treatment settings.
  - The goal is to establish permanent housing in the community while providing for the safety of staff and residents.
Hospital to Housing (H2H) GPD Programs

- **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.

- **Model Overview:** H2H is a medical model to address the housing and recuperative care needs of homeless Veterans who have been hospitalized.
  
  - H2H pre-requisites, Veterans must:
    
    - Have a post-discharge plan coordinating care with the VAMC
    - Have a care management plan to transition the Veteran to permanent housing upon clinical stabilization
    - Be independent in Activities of Daily Living
    - Not require acute detox
    - Have no apparent psychosis
Transition in Place (TIP) GPD Programs

Model Overview: Transition in Place housing is a housing model where Veterans are provided time-limited transitional housing assistance with the lease converting to the Veteran as their permanent housing.

- Veteran assumes the lease which enables the unit to become the Veterans permanent housing
- Model does not support discharge planning to HUD–VASH
- Support services transition out of the residence over time
- Time-limited supportive services optimally for 6–12 months, but not to exceed 24 months
Bridge Housing GPD Programs:

- **Targeted Population**: Homeless Veterans that have been offered and accepted a permanent housing intervention (e.g., SSVF, HUD-VASH, Housing Coalition/CoC) but, are not able to immediately enter the permanent housing.

- **Model Overview**: Bridge Housing reflects the need for safe, brief, temporary housing that supports Housing First initiatives such as HUD-VASH and SSVF.
  - Length of Stay (LOS) is individually determined based on need but, in general not expected to exceed 90 days.
  - Veterans are expected to receive case management and support which should be coordinated with the HUD-VASH or SSVF team.
  - Grantees will assist Veterans with accessing services as needed/requested by the Veteran.
GPD Homeless Services continues to evolve

- Changes incorporate evidence-based practices such as Housing First
- The changing needs of community
- The importance of collaboration
Community Collaboration
(VA GPD Liaison, SSVF Grantee & GPD Grantee)

Lori Bowley, MSW, LCSW
Grant and Per Diem Liaison
VHA Northern California Health Care System

Natalie Siva
Roads Home Senior Program Manager
Berkeley Food and Housing
Brief Introduction

• Lori Bowley, MSW, LCSW
  – Grant and Per Diem Liaison, VHA Northern California Health Care System

• Natalie Siva
  Roads Home Senior Program Manager, Berkeley Food & Housing SSVF Grantee
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
- By Name List (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 Meeting
- 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 Vet
- VA
  - Monitor Care of Vet
  - 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

<table>
<thead>
<tr>
<th>FROM:</th>
<th>TO:</th>
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<tbody>
<tr>
<td>50 “Service Intensive” Beds</td>
<td>25 – Bridge</td>
</tr>
<tr>
<td></td>
<td>15 – Low Demand</td>
</tr>
<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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<tbody>
<tr>
<td># Unduplicated Clients</td>
<td>120</td>
<td>158</td>
<td>32%</td>
</tr>
<tr>
<td># Positive Discharges</td>
<td>51</td>
<td>87</td>
<td>72%</td>
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<tr>
<td>Average Length of Stay</td>
<td>213 days</td>
<td>170 days</td>
<td>- 20%</td>
</tr>
<tr>
<td>Occupancy Rate</td>
<td>96%</td>
<td>92%</td>
<td>- 4%</td>
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## Grant and Per Diem

<table>
<thead>
<tr>
<th>FY 2018 YTD Data</th>
<th>Bridge</th>
<th>Low Demand</th>
<th>Hospital To Home</th>
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<tbody>
<tr>
<td># Unduplicated Clients</td>
<td>39</td>
<td>44</td>
<td>11</td>
</tr>
<tr>
<td># Positive Discharges</td>
<td>17</td>
<td>4</td>
<td>2</td>
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<tr>
<td>Average Length of Stay</td>
<td>30 days</td>
<td>51 days</td>
<td>15 days</td>
</tr>
<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
Q & A

Panelists:

• Adrienne Nash Melendez, Health Care for Homeless Veterans Program Specialist, Coordinated Entry
  – adrienne.nashmelendez@va.gov
• Amanda Barry, MSW, LCSW, National Grant and Per Diem Office
  – Amanda.Barry@va.gov
• Lori Bowley, MSW, LCSW, Grant and Per Diem Liaison
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• Natalie Siva, Roads Home, Senior Program Manager, Berkeley Food and Housing
  – nsiva@bfhp.org
• Michael Raposa, CEO, St. Vincent de Paul CARES
  – michael@svdpsp.org
Additional Questions

SSVF Program Office
Email: ssvf@va.gov

Website:
www.va.gov/HOMELESS/ssvf.asp

A recording of this presentation will be provided to webinar registrants and posted at SSVF University.