Effectively Serving Chronically Homeless Veterans

Health Care for Homeless Veterans (HCHV)

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“Reframing for the Future”, National Conference on Ending Homelessness
Agenda

- HCHV Overview
  - Outreach & Case Management
  - Homeless Veteran Profile
  - Stand Downs
- Highlighted HCHV Data Points
- Low Demand/Safe Havens
Health Care for Homeless Veterans Outreach with Clinical Focus

- HCHV Outreach staff includes social workers, nurses and other human service professionals.
- Case Management is key – including coordinating care and Veteran advocacy to ensure comprehensive service delivery.
- Develop working relationships with community agencies and other local partners; serving as the Department of Veterans Affairs (VA) liaison or point of contact.
- Outreach staff develops and maintains good relationships with community partners to foster interagency collaboration and optimal coordination of care for Veterans.
- Contacts may include family members, police, landlords, judges, attorneys, facility administrators, Veteran Service Officers, community outreach workers, shelter workers, and student interns.
- Provides education regarding resources; addresses psychosocial needs and illnesses; interprets behavior, and influences patients and families from engaging in destructive behavior.
Health Care for Homeless Veterans

Background

- HCHV Program was developed from the original Homeless Chronically Mentally Ill (HCMI) Program, a 6-month pilot project established by Public Law (Pub. L.) 100-6, February 12, 1987.
- HCHV provides a gateway to VA and community supportive services for eligible Veterans who are homeless.
- HCHV Program:
  - Clinical Outreach
  - Case Management
  - Contract Residential Treatment Program
    - Emergency Housing
    - Rehabilitative Treatment
    - Low Demand/Safe Havens
Health Care for Homeless Veterans
Background: Clinical Outreach

- Active and engaging process that extends assistance outside the VA medical center.
- Provide services in community settings - encampments, shelters, drop in centers.
- Multiple contacts typical before intervention is successful.
- Focus on referrals for emergent services and case management:
  - medical and psychiatric inpatient and outpatient treatment programs/services
  - linkage/referral to community based residential programs, social services, and entitlement providers
  - housing assistance and placement
- Assessment and follow-up with indicated services is a vital component.
- Maintain low barriers and easy access to services in the VA and community partners.
Health Care for Homeless Veterans
Background: Case Management

• Plan and coordinate the homeless Veteran’s care:
  – Work towards the rapid placement of the Veteran in a safe, appropriate setting. Referral will be based on assessment of needs and patient interest in services.
  – Arrange, coordinate and/or provide direct clinical services (enrollment, assessment, treatment plan, reassessment, etc.) and support.
  – Using Recovery Model principles, actively involve the Veteran in treatment planning with specific and individualized goals and objectives. Input from other related clinical disciplines (e.g., psychiatry, nursing, vocational rehabilitation), should be included whenever possible.
  – Refer and provide linkage to VA medical facilities, VA Regional Offices, other Federal Agencies and partners, and/or community-based agencies for services necessary to prevent or eradicate homelessness.
  – Provide crisis management services and monitor psychiatric status and stability.
  – Intervene, when necessary, and advocate on behalf of the Veteran to fill gaps in the delivery of services. Typically, this assistance includes referrals for transportation assistance, credit problems and legal issues stemming from child support, fines, and warrants.
Health Care for Homeless Veterans
Homeless Veteran Profile

The average homeless Veteran:

- Post-Vietnam era
- Age 51, male, single, and equally likely to be African-American or Caucasian
- Unemployed and has an income of less than $125 per week
- Living outdoors or in a homeless shelter
- Suffers from medical and mental health/substance use disorders

Minority Veterans are overrepresented in the homeless population compared to the number of minority Veterans in the population.

Female Veterans are the fastest growing segment of the homeless population.
Health Care for Homeless Veterans
Background: Stand Downs

- 1-3 day events held by community agencies in partnership with VA.
- Stand Downs give homeless Veterans 1-3 days of safety and security from life on the streets.
- Since 1988 more than 500,000 Veterans and families have received services through Stand Downs.
- Range of services may include: food, shelter, clothing, health screenings, dental services, legal services, VA and Social Security benefits counseling. In addition, referrals to a variety of other services including medical, mental health and substance abuse treatment, as well as information on housing and employment resources.
- HCHV staff often serve as the local VA facility Point of Contact (POC) for these events.
  - POCs assist in coordinating the involvement of other VA staff members and outlining their roles in supporting Stand Downs.
HCHV Outreach - Veterans Served by Fiscal Year (FY)

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* as of 7/10/13
HCHV Contracted Residential Services
Veterans Served by FY

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* as of 7/10/13
HCHV Case Management Veterans Served by FY

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* as of 7/10/13
Health Care for Homeless Veterans
Highlighted Data Points

**HCHV:**
- 135 HCHV programs located in VA medical centers, programs in all 50 states as well as Washington, DC, Guam and Puerto Rico staffed by clinical outreach and case management teams, with an HCHV coordinator at each site.
- In FY 2012, HCHV programs provided outreach services to 119,878 homeless Veterans. Of these, over 11,307 (9 percent) were female Veterans.
- In FY 2012, HCHV programs contracted with 299 community agencies (3,430 beds) to provide residential services for homeless Veterans.

**Stand Downs:**
- There were 204 documented Stand Downs held in 2012, a slight decrease from the 220 held in 2011.
- Veterans and Family Members Served, 2012
  - Total Veterans served – 45,957
    - 41,945 male Veterans
    - 4,012 female Veterans
  - 6,965 spouses of Veterans
  - 3,417 children of Veterans
- Stand Downs provide much needed surplus clothing and materials to homeless Veterans and families as well as outlet for community involvement in ending Veteran homelessness.
- Value of Materials, Total 1994-date: $560m+
Low Demand/Safe Havens:

VHA version of proven residential model serving chronically homeless

“Reframing for the Future”, National Conference on Ending Homelessness
HCHV Contracted Residential Services – Beds by State

Bed Distribution
- 0 - 19
- 20 - 49
- 50 - 99
- 100 +
Department of Housing and Urban Development (HUD) Safe Haven Model

Background

• Safe Havens Initially authorized by the McKinney-Vento Act of 1994. Funded through HUD’s Permanent Supportive Housing Program (SHP).
• Primary mission - target dually diagnosed chronically homeless individuals who were ineffectively served by traditional homeless programs. HUD initially funded about 300 programs.

The 2010 Annual Homeless Assessment Report to Congress (AHAR) indicated that there are only 128 Safe Havens providing 2,199 year-round beds (HUD, 2011).


• Safe Havens provide an effective link between street homelessness and permanent supportive housing. Safe Havens effectively engage and retain residents, with over half of residents successfully transitioning into some type of permanent housing program.
• Housing outcomes:
  – 30 percent exited to affordable permanent housing with both subsidy and supports (permanent supported housing)
  – 13 percent exited to affordable permanent housing with subsidy but without supports
  – 7 percent went to affordable permanent housing with neither subsidy nor supports. Although most (72 percent) of the Safe Havens reported that they did not impose any time limit on length of stay, the average length of stay was only 262 days.
HUD Safe Haven Requirements

Safe Haven Design

• The Safe Haven must comply with all SHP requirements in addition to specific Safe Haven requirements:
  – Must serve hard-to-reach homeless persons with severe mental illnesses who are on the streets and have been unable or unwilling to participate in supportive services
  – Must allow 24-hour residence for an unspecified duration
  – Must have private or semi-private accommodations
  – Must limit overnight occupancy to no more than 25 persons
  – May include a drop-in center as part of outreach activities; and
  – Is a low demand facility where participants have access to needed services, but are not required to utilize them
Ward Family Foundation (2005) National Survey Findings:

- No structure: 37%
- Req Behavioral health activities: 9%
- Req weekly meeting participation: 30%
- Req meetings w/case manager: 61%
- Peer mentoring for new residents: 30%
- Scheduled times for various experts: 49%
- Activities of general interest offered: 53%
- Behavioral health activities offered: 71%
- Routine program governance: 75%
- Residents eat in common space: 90%
Ward Family Foundation (2005) National Survey Findings:

- **12-step orientation**
- **Harm reduction...**
- **Medication monitoring...**
- **Psychiatrist**
- **Case management**

- At program site
- Off-site, but clear commitment
- By referral only
Ward Family Foundation (2005) National Survey Findings:

- Representative payee
- Budgeting
- Conflict resolution
- Daily living skills
- Entitlements assistance
- Job placement
- Vocational training

Legend:
- Red: At program site
- Green: Off-site, but clear commitment
- Blue: By referral only

VETERANS HEALTH ADMINISTRATION
VHA Low Demand/Safe Haven Model (LDSH)

- Four model development projects introduced through VA’s National Center on Homelessness among Veterans in July 2010.
- Located in Bay Pines, FL*; Bronx, NY; Bedford, MA; and Philadelphia, PA.
- Provide street outreach and community-based residential services to hard-to-reach homeless Veterans with mental illness and substance use disorders.
- Small facilities provide non-intrusive environment designed to re-establish trust and re-engage Veteran in needed treatment services and transitional and permanent housing options.

* two separate sites

- Model does not require sobriety or full compliance with treatment for admission or continued stay; a harm reduction approach is a critical ingredient in clinical approach.
- Previous negative experience with traditional requirements lead to repeated non-compliance and discharge resulting in chronic homelessness. LDSH attempts to reverse that trend by continuously engaging the Veteran using state-of-the art, evidence-based therapies, but do not discharge the Veteran for failing to be fully compliant.
- The primary focus of the Veteran’s care in a Safe Haven program is housing stability.
LDSH Model - House Rules and Expectations

- Rules are kept to a minimum
- Focus on safety of residents and staff
- Simple and easily understood
- Infractions are used to engage residents
- Available and reviewed with Veterans:
  - No dealing or use of illicit drugs in the facility
  - No buying or selling of alcohol or drugs in the facility
  - No sexual activity between residents
  - No violence or threats of violence
  - Focus on Keeping the Resident in Stable Housing
The Low Demand/Safe Haven Model

Similarities to HUD design:

• Targets chronically homeless with mental illness and substance use problems
• Targets Veterans who have failed in traditional programs
• Does not require sobriety or compliance with mental health treatment as a condition of admission
• Does not require sobriety or compliance with mental health treatment as a condition of continued stay
• Demands are kept to a minimum
• Environment of care is non-intrusive as possible
• Rules focus on staff and resident safety

Key Differences in VA’s LDSH Program design:

• Program is a Model Development Initiative
• HCHV contract funding authority is used to support the program
• Program has time limits (Six months)
• Carries the expectation that Veterans and their families will transition to permanent housing
• Program effectiveness and fidelity will be measured on an ongoing basis
LDHS Lessons Learned

- Smaller is better
- Privacy (private room) is desired by both residents and staff
- Best facilities stayed fully occupied 80 percent of time
- Provide for residents to participate in program governance
- Have Senior residents provide mentoring and positive support to new residents
- Encourage programs of general interest (sports, cooking classes, birthday parties, etc.)
- Facility provided incentives for doing daily chores
LDSH – Early Fidelity Review Findings

- Basic demographics at admission indicate characteristics consistent with a difficult-to-serve population:
  - chronically homeless (68 percent);
  - spent the majority of the 30 days prior to program entry homeless or in treatment (80 percent);
  - unemployed, disabled, or retired (70 percent);
  - problems related to alcohol (92 percent), drugs (69 percent), mental health (97 percent), and medical issues (79 percent).
  - Average Length of Stay - 115 days;
  - 48 percent were discharged following successful completion of the program, an additional 39 percent left the programs by their own decision.

- 5% percent of residents asked to leave the program due to rule violations.

Following discharge:
- 47 percent of Veterans were in a housed situation
- 23 percent were either homeless or living in an unknown location
- 16 percent were receiving inpatient or residential treatment
- 56 percent of Veterans were receiving or had pending applications for VA benefits and 35% for non-VA benefits.
- Service linkages with VA and non-VA providers were in place for most of the Veterans following discharge: 60 percent for alcohol treatment, 41 percent for drug treatment, 67 percent for mental health treatment, and 66 percent for medical treatment.
LDSH – Expanding the Model

Based on early successful findings, LDSH expansion underway at 15 additional sites:

- Albuquerque, NM
- Austin, TX
- Boston, MA
- Canandaigua, NY
- Chicago, IL
- Cleveland, OH
- Detroit, MI
- Indianapolis, IN
- Kansas City, MO
- Los Angeles, CA
- Montgomery, AL
- San Diego, CA
- San Francisco, CA
- Shreveport, LA
- Topeka, KS