Navigating VA Resources for Veterans Experiencing Homelessness

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Guest Speaker: Sonya Gabrielian

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Housing Transitions

QUERI

What services does the VA offer to Veterans with homeless experiences?

Medical care

- Physical health care is offered in patient-centered medical homes, branded as “patient-aligned care teams (PACT)” at VA

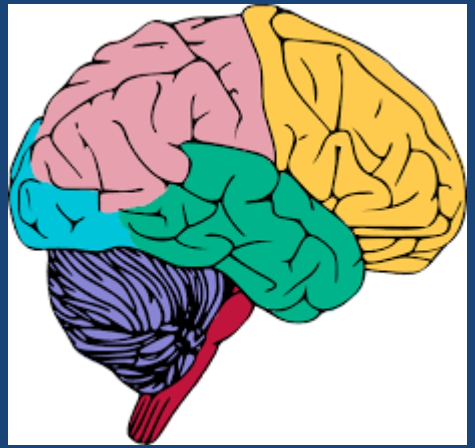
- Homeless Veterans receive care in mainstream PACT and PACTs specifically tailored for Veterans with homeless experiences, called Homeless-PACTs (HPACTs)
  - Many VA facilities have HPACTs, but some do not
  - HPACTs are designed to serve Veterans who are highly vulnerable

PACT empanelment is a critical linkage for Veterans who are healthcare eligible

- Enable central points of contact (RN care manager and social worker)
- Provide access to same-day care, including mental health services
- Decrease Emergency Department visits and hospitalizations
- Many VA facilities have specialized PACTs for subpopulations (women, geriatrics, Veterans diagnosed with HIV/AIDS, etc.)

Behavioral health care

- Mental health care (medication management, psychotherapy, day treatment) is offered across primary care and specialty mental health settings
- VA mental health clinics are particularly well versed in the sequelae of trauma
- High-intensity case management services are available for Veterans with serious mental illness (e.g., schizophrenia)



Behavioral health care

- Many substance use disorder services are available:
  - Detoxification (hospitals, community partner settings, other on-campus settings)
  - Residential rehabilitation (Domiciliary care for homeless Veterans)
  - Intensive outpatient programs
  - Harm reduction groups
  - Opioid agonist therapy and other medication management

- Psychiatric occupational therapy and recreational therapy is also available

Behavioral health services are available to Veterans who are not healthcare eligible

Emergency mental health care

Veterans can access emergency mental health care and 90-days of care subsequent to the emergency

Care for military-related conditions

Care for needs linked to military sexual trauma, for example, is covered regardless of healthcare eligibility

Adult Residential Facilities are in the continuum of homeless services for Veterans with serious mental illness

- The VA Community Residential Care program (CRC) links Veterans to adult residential facilities in the community
- These services are accessed by Veterans with mental illness who need more structured services
- Housing is a key component of CRC offerings

Social services are often offered in collaboration with community partners

- Homeless outreach
  - Determine VA healthcare eligibility in the field
  - Enable entry into VA
  - Provide education and resources

- Stand downs
  - Large scale community outreach efforts for homeless Veterans (physicals, outreach, housing services)

Homelessness prevention and rapid re-housing

- Supportive services for Veteran families (SSVF)
  - Funds offered to low-income Veterans and their families as short-term subsidies
  - Funds grants to non-profit community partners
  - Intended to promote housing stability

Services for justice-involved Veterans is prioritized

- Veterans Justice Outreach (VJO)
  - Aims to de-criminalize mental illness
  - Links Veterans who are justice-involved to mental health, substance use disorder, and housing services
- Healthcare for Re-entry Veterans
  - Addresses community re-entry among incarcerated Veterans
  - Work directly in state and federal prisons

HUD-VASH and GPD are VA's largest homeless programs

- As a Housing First program, HUD-VASH plays a central role in VA's strategic plan to end Veteran homelessness

  - Joint effort between HUD and VA
  - Veterans receive Housing Choice (Section 8) vouchers through city/County public housing authorities
  - The VA provides supportive services
  - There is a new initiative to enable adult residential facility placement using Housing Choice vouchers

60 yo man with OTH discharge, on SSI, stably housed x4 years

- SSI benefits are inadequate for rent payments → at risk for eviction
- History of incarceration and gang-involvement, limiting the neighborhoods in which he can live
- Limited medication adherence for multiple medical problems
- Suspiciousness and low frustration tolerance

Discussion points

What is the care transition?

There are elements of CTI that are well-suited for any person with vulnerability, but it is best suited for a care transition (which is the stated intent of the aftercare program)

What VA services can this Veteran access?

- Emergency mental health services
- GPD, SSVF, and HUD-VASH
- May be eligible for Vet Center resources

Could this Veteran upgrade his discharge status?

- Major consideration is the role of mental health symptoms in the Veteran's discharge
- Lawyers and Veterans Service Organizations can be important advocates

What housing options are open to this Veteran?

- HUD-VASH versus SSVF may be options (OTH Veterans are eligible)
- May need to explore GPD (THP, not aftercare) for this Veteran while exploring other housing subsidy options

Developing a local network of VA and community partner resources will be your best asset

We have developed a resources and processes worksheet that will help you identify resources for Veterans on your caseload

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Questions?

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CoP Case Presentations - Reminder

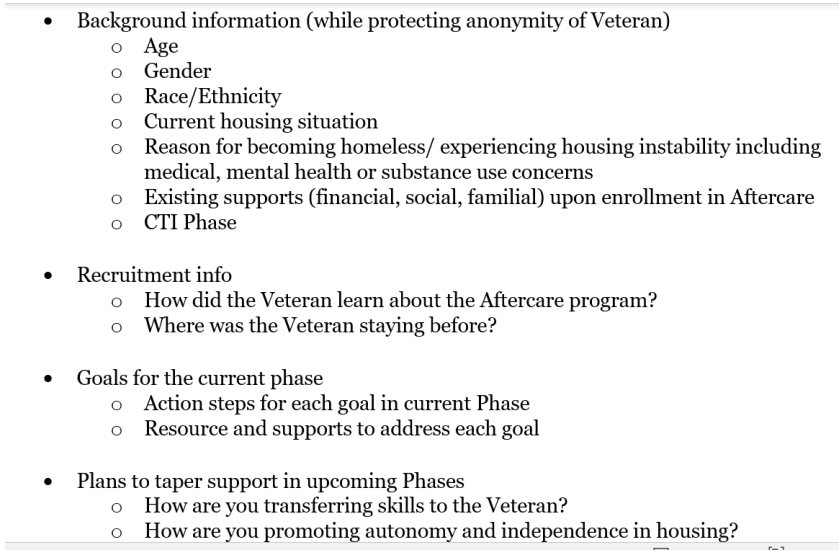
- One case will be presented from each *site*
  - If there are multiple case managers from each site, we encourage you to work together to present a case
- This will give you an opportunity to work through a Veteran case, identify ways to apply CTI and get feedback about resources and supports
- We encourage you to pick a Veteran currently on your caseload in months 1-3
  - If you are having trouble identifying a Veteran reach out to us

CoP Case Presentations – Link to sign up

- Link to sign up:

https://appt.link/ht-queri-community-of-practice/CoPCaseConsultationSignUp

- Presentation Questions:
  - Background, demographics, recruitment, goals, CTI Phase planning
  - You will know the questions ahead of time



- Background information (while protecting anonymity of Veteran)
  - Age
  - Gender
  - Race/Ethnicity
  - Current housing situation
  - Reason for becoming homeless/ experiencing housing instability including medical, mental health or substance use concerns
  - Existing supports (financial, social, familial) upon enrollment in Aftercare
  - CTI Phase
- Recruitment info
  - How did the Veteran learn about the Aftercare program?
  - Where was the Veteran staying before?
- Goals for the current phase
  - Action steps for each goal in current Phase
  - Resource and supports to address each goal
- Plans to taper support in upcoming Phases
  - How are you transferring skills to the Veteran?
  - How are you promoting autonomy and independence in housing?

SMART Goals- Review

- **S**pecific - What *exactly* will you accomplish? What will it take to achieve it?
- **M**easurable - How will you know when you have reached this goal? What will be different? What will you be doing more regularly? What will you be doing less of?
- **A**ctionable/Achievable – How can the goal be accomplished? What do you need to accomplish it? *What are the action steps?*
- **R**elevant - Why is this goal significant to your housing stability? To your life? How will it benefit you?
- **T**imely – When will you achieve this goal? How long will it take to accomplish it?

Goal Setting

SMART goal:

- “I will secure a part-time position working 15 – 20 hours per week and will save $200 each month to use toward traveling to my grandchildren to spend time with them.”
- “Being around my grandchildren makes me feel at peace and allows me to help my daughter out.”
- “I will spend 30 minutes at the library 3 days/week to develop a draft of my resume to send to my VA Voc Rehab specialist in 2 weeks. I will apply to 5 or more restaurants within 1 month.”

Veteran Vignette

Mr. Charles is a 75-year-old Veteran with alcohol use disorder, severe, who is in Phase 1 of CTI. One of Mr. Charles' recovery goals for Phase 1 is to increase his income by his reducing his monthly spending on alcohol and cigarettes. Sara, his Aftercare case manager, engaged Mr. Charles in motivational interviewing – he is contemplative about his alcohol and tobacco use. He is not ready to stop drinking or smoking and is not interested in more intensive treatment at this point, but he is willing to cut back so that he can pay his rent on time and avoid the stress of his landlord. Sara and Mr. Charles agree to a linkage with a VA harm reduction group at the local VA.

Next steps

- **(Optional) Drop-in Hour: January 11th, 2023**

  11-12am AKST/ 12am-1pm PST / 1-2pm MST / 2-3pm CST / 3-4pm EST

  - Stop by if you have questions, would like to discuss a case, or have a burning desire to learn more about CTI!

- **Next CoP: January 18th, 2023**

  10-11am AKST/ 11am-12pm PST / 12-1pm MST / 1-2pm CST / 2-3pm EST

  - Case Presentations
  - Please sign up if you haven't already and please stop by drop-in hours if you have any questions