Effective Practices in Integrating Grant and Per Diem Transitional Housing Programs into Community Coordinated Entry Systems

An Innovative Practice in VHA Homeless Program Operations

White Paper

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INTRODUCTION

The VHA Homeless Program Office identifies and disseminates innovative practices in homeless program operations. The Bay Pines VA Healthcare System (VHS), the VA Northeast Ohio Healthcare System (HCS), the Indianapolis VA Medical Center (VAMC), and community partner Liberation Veteran Services in Richmond, Va. have been identified as sites with innovative practices in fully integrating Grant and Per Diem (GPD) transitional housing services into the local coordinated entry (CE) systems.

PRACTICE OVERVIEW

Originally authorized by Public Law 102-590 in 1992, the Homeless Providers GPD program is one of VA's longest running homeless programs, specializing in the development and provision of transitional housing and services to homeless Veterans. As funding permits, VA provides grants and per diem payments to eligible organizations to either provide transitional housing or operate service centers to assist Veterans experiencing homelessness. In the nearly 30 years since its inception, GPD underwent several modernization efforts to ensure that the services delivered stayed relevant to the ever changing needs of homeless Veterans. For example, the Transition in Place (TIP) model was added in 2012. Previously, GPD participating Veterans lived in residential settings and, upon completion of the program, exited to permanent housing. TIP enhances the options available to Veterans by providing housing, case management, and supportive services in fair market apartments while the GPD provider maintained the lease. The lease would then transition to the Veteran who could continue to live in the housing unit once their services ended. In 2014, GPD began exploring more options to provide intentional services based on the needs that they saw with Veterans. These pilots included bridge housing, low-demand type services, and meeting a need for Veterans who were homeless and discharging from a hospital setting where enhanced care and coordination were needed. In December 2016, GPD published a Notice of Funding Availability (NOFA) that codified the GPD modernization pilots into to five distinct models[1]. With the addition of these five new models, GPD providers could offer more specialized, residential services to fill critical needs in their communities while assisting Veterans with the goal of obtaining permanent housing. The Bridge Housing (BH) model provides short-term

[1] The Transformation of VA Grant and Per Diem Programs: Considerations for Communities: https://www.usich.gov/resources/uploads/asset_library/GPD-transformation-considerations-for-communities-june-2019.pdf

stays for Veterans who have pre-identified permanent housing interventions or destinations and need places to live while they completed housing processes. The Low Demand (LD) model operates from a harm reduction philosophy to engage Veterans in safe environments that have low barriers to program entry and low demands for continued stay. Low demand-style programs traditionally serve hard-to-reach, hard-to-engage, long term or chronically homeless Veterans with severe mental illness or substance use disorders. The Hospital to Housing (HH) model provides recuperative and respite care to homeless Veterans who were recently hospitalized. The Clinical Treatment (CT) model provides mental health or substance use disorder treatment alongside housing-focused and income-focused services. Last, the Service-Intensive model (SI) provides a wide range of services to help Veterans, who choose transitional housing, work towards obtaining permanent housing as rapidly as clinically appropriate. In 2019, GPD's Case Management Grant was added to the portfolio of community housing resources. This grant provides housing retention case management to formerly homeless Veterans who have transitioned to permanent housing and need additional support.

Concurrent to these GPD modernization efforts was the release of new requirements for VA participation in community CE systems[2]. CE is designed to ensure that all people experiencing housing crises in a given community have fair and equal access to housing resources and are quickly assessed, matched, referred, and connected to housing and supportive services based on their strengths, preferences, and needs. The U.S. Department of Housing and Urban Development (HUD) mandated that all homeless Continuums of Care (CoC) establish or update their existing CE systems, in accordance with Notice CPD-17-01[3], by January 23, 2018. Of the many requirements for VA to integrate with these newly established or updated CE systems, one key requirement is the dedication of VA resources (such as HUD-VA Supportive Housing [HUD-VASH] vouchers and GPD beds) for their inclusion into the greater pool of homeless service resources accessed by Veterans through CE. To accomplish this, VAMCs are given wide latitude in terms of flexibility and customizability to ensure that

[2] VA Participation in Coordinated Entry: VA Guidance and Implementation Assessment Checklist: https://www.hudexchange.info/resource/5638/va-participation-in-coordinated-entry-va-guidance-and-implementation-assessment-checklist/

[3] Notice CPD-17-01: Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System: https://www.hudexchange.info/resource/5208/notice-establishing-additional-requirements-for-a-continuum-of-care-centralized-or-coordinated-assessment-system/

the processes connecting Veterans screened through CE are streamlined based on a community's unique characteristics.

Insights from the *2019 VA, HUD, and United States Interagency Council on Homelessness (USICH) Community Planning Survey* revealed that only 47 percent of communities reported "coordination or enhanced coordination" with their local GPD program(s). With more work to do to reach full integration of GPD into CE nationwide, the VHA National Homeless Program Office reviewed four communities who reported full or near full integration of GPD locally: Bay Pines VHS, VA Northeast Ohio HCS, Indianapolis VAMC, and community partner Liberation Veteran Services in Richmond, VA. Through focused review of their practices and integration process, four major themes were identified: the importance of building strong, collaborative relationships; matching Veterans to GPD models based on their unique and individual needs; utilizing common assessment tools (CATs) to prioritize the order of admissions; and intentionally providing GPD services while focusing on permanent housing interventions.

> ***"We really had to emphasize with our GPD partners that GPD is still going to be here. The program may look a little different than it has in the past. We're working to gear our services to meet the particular needs at this particular time."***
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> **Lonnie Williams, LCSW**
> **Grant and Per-Diem Liaison**
> **Bay Pines Veterans Healthcare System**

BUILDING RELATIONSHIPS

One of the most foundational strategies to effective integration of GPD into local CESs was the development of strong, collaborative relationships. In any change process, the value of the change must resonate with the stakeholders involved. For GPD providers, integration needed to make sense in the short term and the long term, addressing financial as well as psychological needs. At Bay Pines, integration took 10 months of focused work consisting of regular meetings between VA GPD Liaisons and GPD providers. During these meetings, education and practical support towards real world implementations of harm reduction and housing first principles were routine. Over time, with continued discussion and support, GPD providers progressively lowered both their barriers to entry, through the removal of sobriety and treatment compliance requirements, as well as barriers to retention in the form of removing "zero tolerance" rules. Another important area of focus was the gradual shift away from the historical viewpoint that Veterans could stay in a GPD program for up to two years, and that they could engage with GPD over multiple episodes in their lifetime. In many cases, GPD participants would only stay, on average, six months. However, there were other circumstances where a small group of Veterans might

stay for two years or request multiple episodes of GPD support. While these were statutorily permissible, it was problematic for Veterans and communities to prolong episodes of homelessness. In these instances, it was important for VA and the community to better understand the value of by-name lists and community case conferencing so that when Veterans needed higher levels of care, they were able to be progressively engaged as soon as possible. To reframe the historical perspective with their GPD provider and Veterans views, VA staff at Bay Pines emphasized that they viewed GPD as one of many valid pathways for Veterans to exit from homelessness and that the shift was simply to do so as quickly as clinically appropriate.

Loss of autonomy was a common concern expressed by GPD providers at all sites. This was often mitigated by increasing the degree of community-wide trust in partner agencies to accurately and consistently assess and match Veterans to resources. At Indianapolis, VA GPD Liaisons spent nine months hosting monthly meetings with CoC leads and GPD providers to work through these issues. The first few monthly meetings were characterized by significant venting of frustrations, with VA GPD Liaisons acting as neutral mediators. Structurally, the GPD Liaisons were well positioned to listen supportively and redirect conversations to be solutions focused. If disagreements occurred, they encouraged stakeholders to stay at the table. Integration work at Northern Ohio started earlier than some of the other sites; in 2014, community leaders hosted process mapping meetings to explore how Veterans accessed services in Cuyahoga County, OH. These meetings focused on ensuring that each provider within the community knew how to connect Veterans to the resources most helpful to their individual needs. All sites utilized some form of visual or flow chart to assist with understanding the system. Additionally, consistency in messaging to Veterans was just as important as consistency in assessment and referral to resources since the success of a coordinated entry system often relied on Veterans having clear expectations on what services were available and specifically how those services would help. At Richmond, strategies for GPD integration focused on highlighting the value of utilizing GPD beds with appropriately matched Veterans, finding ways to streamline matching decisions and admissions, ensuring that needed information was readily available and quickly verifiable, and above all else, ensuring that everyone knew their “role” within the system. Role clarity, both in terms of how programs fit within the community as well as how individual staff within and across programs operated, was absolutely critical for well-functioning CE systems. The Richmond CE Veteran’s workgroup, Vetlink, insisted on in-person meetings since attendees were more likely to collaborate when sitting in front of each other, making human connections, and vocally agreeing to test ideas. Leaders with Vetlink

also stressed that if an idea was tested and did not work, it was okay to try something else. If an idea was successful, there were still opportunities to further refine and improve it.

MATCHING VETERANS BASED ON MODEL TYPES

Through Notice CPD-17-01, HUD required CoCs to "develop or select standardized tools to facilitate their standardized assessment process that gather only the information necessary to determine the severity of need and eligibility for housing and related services, and that can provide meaningful recommendations to persons being assessed". While a variety of common assessment tools (CATs) have emerged over the years to accomplish this need, most of these tools did not make service recommendations for transitional housing programs. Instead they often provided indications, through scoring rubrics, for referrals to permanent support housing or rapid rehousing programs. Rather than modify the selected tools to develop transitional housing matching criteria based on score ranges, each of the sites review forwent use of CAT scores altogether and simply matched Veterans to GPD models based on the degree to which their individual needs could be addressed by a specific model type.

All four sites reviewed matched Veterans to BH, LD, HH, and CT programs based on the model specific services described above. For TIP programs, communities were encouraged to match Veterans to TIP programs similar to permanent housing interventions. It was advised that, in designating a range of CAT scores or other matching criteria, Veterans are connected to TIP beds commensurate with the specific intensity and complexity of supportive services offered by individual GPD providers. Interestingly, SI beds were frequently utilized for Veterans who did not easily fit with the other GPD model types or, as in the case of Indianapolis, Veterans who did not have concrete and actionable housing plans while also declining more clinically focused services. Occasionally, Veterans made use of SI beds as stable transitional housing to work on acquiring income. At Northern Ohio, SI beds had relatively low barriers to admission and continued stay, so it often served as an LD+ model, wrapping more traditional services around Veterans while retaining the harm reduction approach. This setup was also of benefit to Veterans who had prior difficulty with GPD service engagement. Since the models were new, quite a bit of learning occurred as to what models were needed and how services could be customized. With the release of the per diem only NOFA in 2019 for funding beginning October 2020, it is anticipated that many communities will undergo additional refinement with the models and the configuration of GPD resources. This might include adapting what is currently available to incorporate what has been learned over the past three years.

Key to the success of the matching process was ensuring either that staff associated with CE had real-time updates on bed availability to make direct referrals to GPD provider or that GPD providers had real-time access to prioritization lists to identify and accept Veterans into their programs. Richmond reported implementing dynamic prioritization strategies when connecting Veterans to GPD beds. Dynamic prioritization ensured that all available housing resources were flexibly and immediately offered to the individuals who needed them, most acutely and in that moment, regardless of whether the individuals might have been better served in the future by a program not presently available to them. Richmond's Vetlink, maintained a GPD "queue" that tracked the number of vacant GPD beds in comparison to Veterans matched to specific GPD models. If a specific model bed stayed empty for a prolonged period of time, the community's dynamic prioritized process allowed GPD providers to admit the next highest person on the queue from a separate but relevant matched model. This ensured that Veterans with lower vulnerability were not consistently passed over by other Veterans with higher vulnerability, and instead were considered for other GPD resources that may have been immediately available.

COMMON ASSESSMENT TOOLS TO PRIORITIZE ADMISSIONS

Although CATs often did not make service recommendations for transitional housing programs, and that none of the sites reviewed used CAT scores to match Veterans to specific GPD models, all four sites found that their community's CAT scores were still of value in helping to prioritize admissions to the indicated GPD models. Concretely, if a GPD provider had three CT bed openings, any Veterans matched to CT would have their admissions prioritized by their individual CAT scores. Similar to other interventions, the use of a CAT for prioritization was not to exclude Veterans from services, but to triage and maximize the use of the resources, focusing on the most vulnerable Veterans with the highest service needs.

In most communities, outreach-focused staff or housing navigators were tasked with completing CATs for Veterans being assessed for services. As community partners may experience difficulty trusting the scores from other providers in the community, sites stressed the importance of good training in CAT administration to ensure consistency. When prioritizing the order in which Veterans were admitted to GPD programs, it was important to not rely solely on CAT scores. Sites like Northern Ohio supplemented their GPD prioritization with bi-weekly community case conferencing to ensure that Veterans' choice and other mitigating factors were considered. As Indianapolis observed that using community-wide CATs for GPD admissions could pose challenges for GPD providers accustomed to

having more influence and autonomy in admissions decisions, they recommended including GPD grantees as active participants early in the planning process, validating the providers' specific concerns, and working collaboratively to develop concrete solutions to address those concerns. As mentioned earlier, investing time to build relationships and clarify roles can help keep these conversations about prioritization productive.

GPD SERVICES WITH A FOCUS ON PERMANENT HOUSING SOLUTIONS

At both Indianapolis and Richmond, GPD was neither a prerequisite to housing nor an alternative to housing. Instead, it was a concurrent service that provided clinically indicated, temporary supportive housing as Veterans navigated the housing process through HUD-VASH, SSVF, or a community housing support program. This embodiment of a holistic system view of housing helped GPD providers see the direct connection between transitional housing and permanent housing. Additionally, this housing-focused perspective influenced the way they approached coordination, provision of services, and also communication with Veterans. Notably, this was in contrast to housing readiness approaches that required treatment compliance and sobriety that was demonstrated through stepwise engagement in transitional housing programs as preconditions to independent housing. It also took the work with the Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness[4] to the next level. The Criteria and Benchmarks provide exemptions for certain Veterans who decline permanent housing interventions and instead elected to enroll in SITH programs which, for the purposes of the Criteria and Benchmarks, included GPD models LD, HH, CT, and SI. However, Indianapolis and Richmond challenged themselves to think beyond exemptions and to really dig in to having permanent housing conversations with every Veteran and by striving to identify the option upfront. Concretely, at Indianapolis and Richman, Veterans both accepted permanent housing interventions and also elected to enroll in SITH programs. While this may impact how the Benchmarks will be calculated for these communities, they did it as they believed it was the right thing to do for the Veterans served. Depending on the time it took to house Veterans from the moment of program enrollment to move in, these Veterans needed safe living accommodations. GPD not only filled this critical need but did so in a way that allowed Veterans to stay in settings tailored to their clinical presentation and interest in services.

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[4] Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness: https://www.usich.gov/tools-for-action/criteria-for-ending-veteran-homelessness

Veterans who had high barriers and needed temporary stay in a harm reduction-focused location while they searched for housing could enroll in LD. Veterans who were in the housing process and wished to begin addressing mental health or substance use disorders could enroll in CT.

CONCLUSION

GPD has been, and continues to be, a key tool for communities in ending Veteran homelessness. As GPD providers consider adoption of the strategies discussed, the potential exists for better program referrals that match Veterans' needs to the most relevant models, improved processes that ensure Veterans do not languish in the system, improved performance outcomes, increases in access to community resources, and the providers being seen as full community partners. The potential benefits for communities include reducing the time Veterans spend homeless, improved communication in coordinated entry, and reductions in unsheltered Veteran homelessness. When integrating GPD services into community coordinated entry systems, intentionality in relationship building is needed to ensure that all stakeholders both understand and embrace their valued roles in efforts to end Veteran homelessness. This must be paired with equally intentional, and continual, strategic planning to ensure that the array of services available continues to be relevant to the ever-changing needs of the Veterans served.

We would like to thank the dedicated staff at the Bay Pines VHS, the VA Northeast Ohio HCS, the Indianapolis VAMC, and Liberation Veteran Services for sharing their practices with us. For more information, please contact Lonnie Williams, LCSW, GPD Liaison for Bay Pines, at Lonnie.Williams@va.gov; Cynthia T. Moore, MSSA, LISW-S Supervisor, Grant & Per Diem, Safe Haven, & HCHV Contract Residential Bed Programs for Northern Ohio, at Cynthia.Moore11@va.gov; Nancy Lobdell, LCSW, GPD Liaison for Indianapolis, at Nancy.Lobdell@va.gov; and Desiree L. Taylor, M.S, Housing Stabilization Counselor for Liberation Veterans Services, at DTaylor@lvsrva.org.