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of Veterans Affairs

# 7<sup>th</sup> Annual Veterans Summit - Ohio

## Lean Forward: Employment and Housing Support for Veterans

**Homeless Services – Panel Facilitated by**

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*James Kennelly, LISW-S*

*VISN 10 Network Homeless Coordinator*

*November 18, 2021*



## *Homeless Topic Panel*

### Homeless System

Continuum of Care & Community Coordination - Diane Waite, VA NEOHCS

Intake and Assessment – Reaver Nelson, VA NEOHCS

VA – Community Partnerships – GPD, HCHV Contract and SSVF Programs - Sarah Stebelton, SSVF Outreach Specialist, Lutheran Social Services Faith Mission of Fairfield County

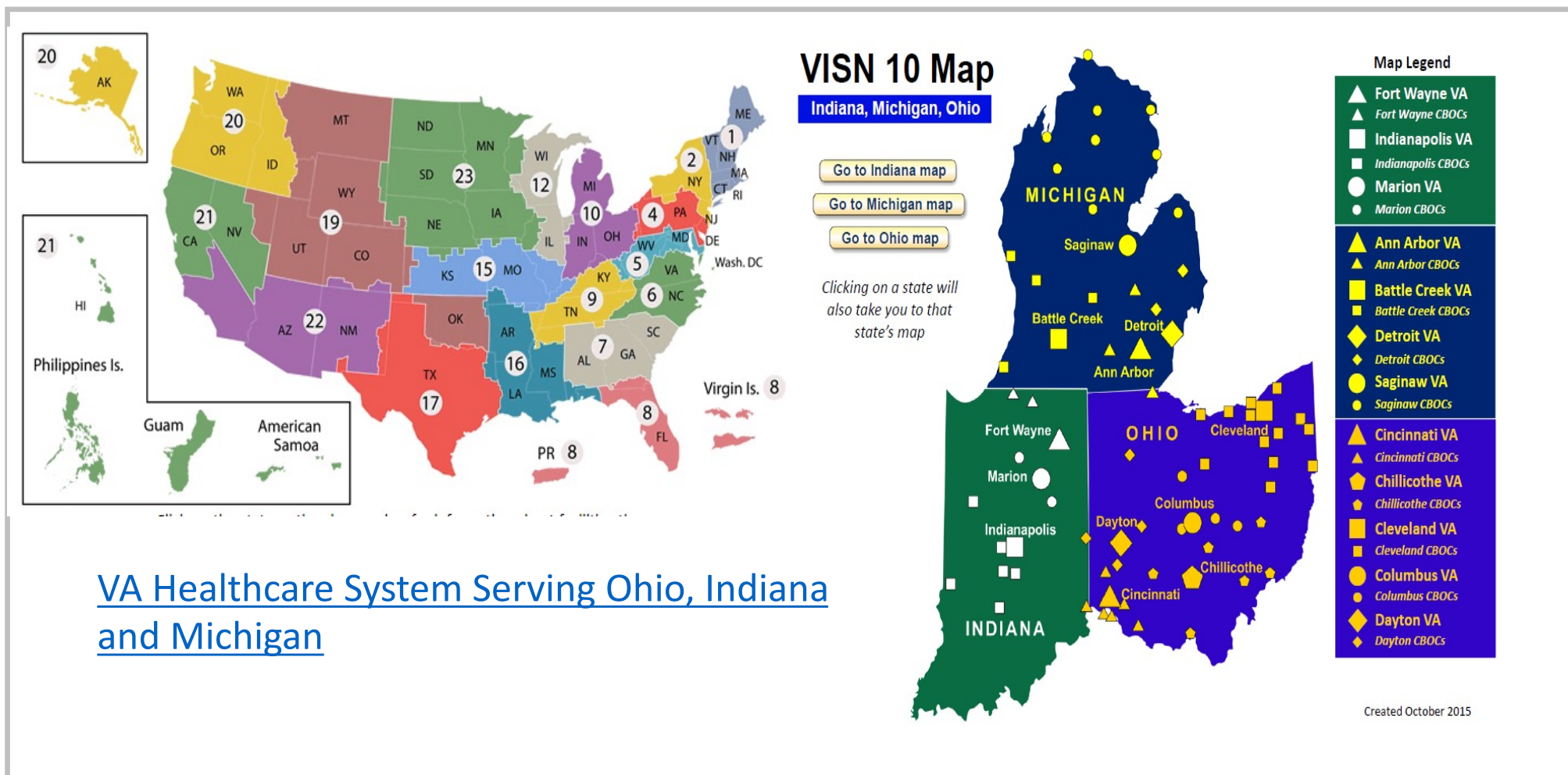
HUD-VASH Program – Patricia Ufferman, VA COHCS

Ending Veteran Homelessness – Dianne Smith-Foster, Dayton VAMC



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# Veterans Integrated Service Network (VISN 10)



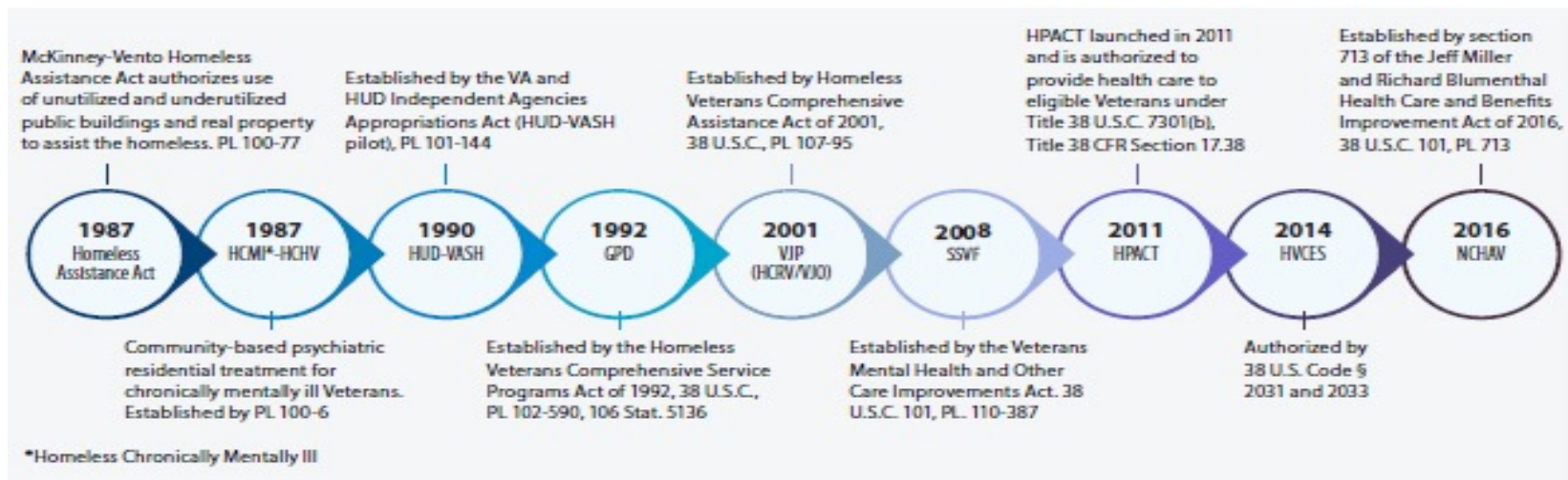
## VA Healthcare System Serving Ohio, Indiana and Michigan



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# LEGISLATIVE TIMELINE OF HOMELESS PROGRAMS

The graphic below shows VHA's legislative timeline for the authorization of VHA Homeless programs and services.



**Veterans Health  
Care Benefits  
Improvement Act of  
2020 ([PL 116-315](#))**

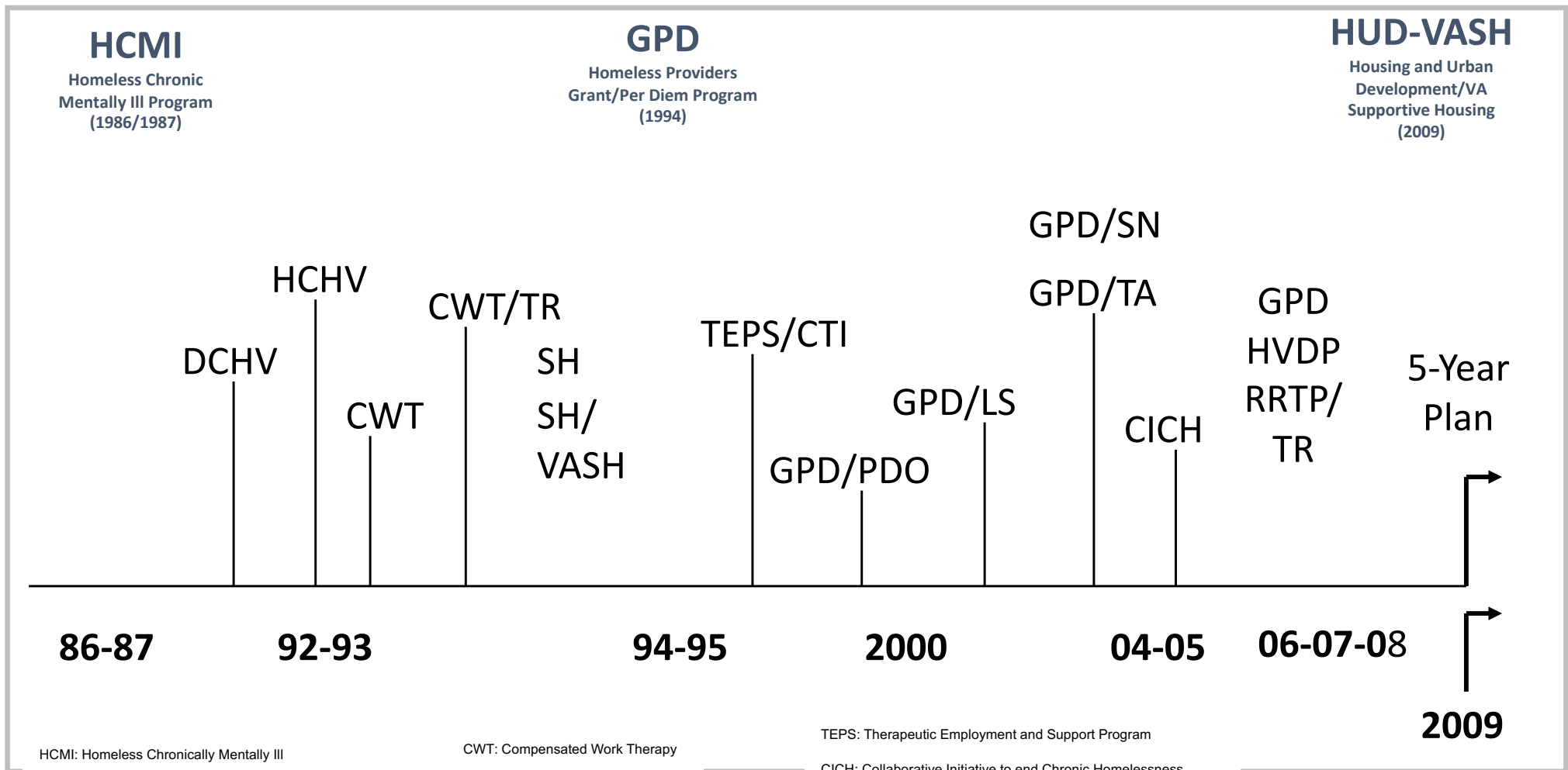
**National Defense  
Authorization Act  
for Fiscal Year 2021  
([PL 116-283](#))**

**Consolidated  
Appropriations Act,  
2021 ([PL 116-260](#))**



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# VHA Homeless Program History 1986-2009



HCMI: Homeless Chronically Mentally Ill

DCHV: Domiciliary Care for Homeless Veterans

HCHV: Health Care for Homeless Veterans

SH, SH/VASH: Supportive Housing; Supportive Housing/HUD VASH

GPD: (Homeless Providers) Grant and Per Diem Program

CWT: Compensated Work Therapy

CTI: Critical Time Intervention

GPD/PDO: GPD Per Diem Only

GPD/LS: GPD Life Safety

GPD/SN: GPD Special Needs

GPD/TA: GPD Technical Assistance

TEPS: Therapeutic Employment and Support Program

CICH: Collaborative Initiative to end Chronic Homelessness

HVDP: Homeless Veterans Dental Program

RRTP/TR: Residential Rehab Treatment Program/Transitional Residences

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HCRV: Health Care for Reentry Veterans

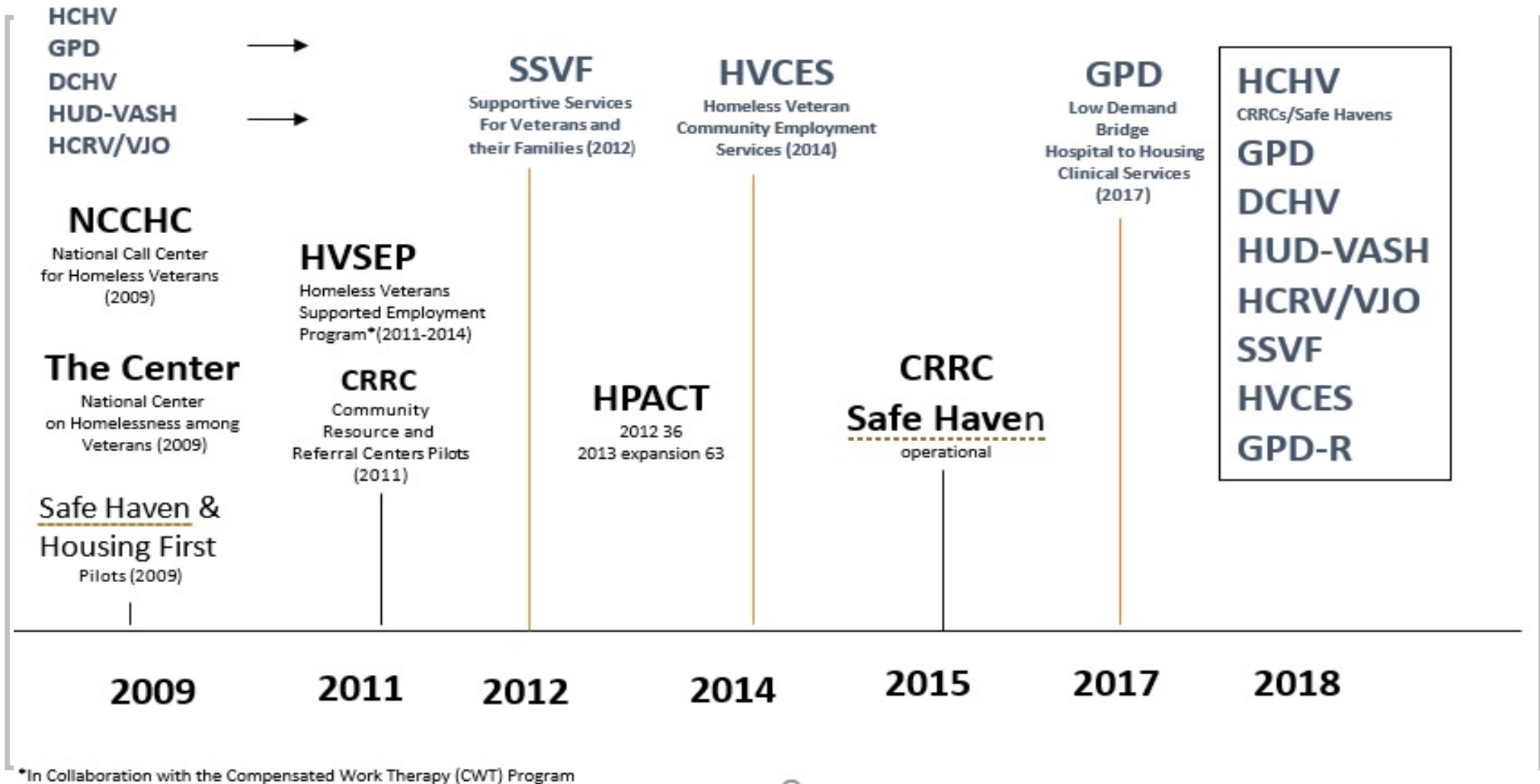
HUD VASH: Housing and Urban Development/VA Supportive Housing



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# VHA Homeless Program History 2009 - 2018



NCCHC: National Call Center for Homeless Veterans

The Center: National Center on Homelessness among Veterans

HVSEP: Homeless Veterans Supported Employment Program

SSVF: Supportive Services for Veterans and their Families

HPACT: Homeless Patient Aligned Care Teams

HVCES: Homeless Veterans Community Employment Services

CRRC: Community Resource and Referral Centers



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# **VA Participation in the Continuums of Care Coordinated Entry System: A New Way to Connect Veterans to Homeless Services**

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*Northeast Ohio VA Healthcare System*

*Diane M. Waite, Coordinated Entry Specialist*

# HUD Definitions

## Veteran

HUD defines a Veteran as someone who, regardless of discharge status, has served on active duty in the Armed Forces of the United States. This does not include inactive military reserves or the National Guard unless the person was called up to active duty by Presidential Order.

## Literally Homeless

- Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
  - (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
  - (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
  - (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution







Veterans - National Alliance to End Homelessness

*Updated April 2021*

# National Alliance to End Homelessness Updates: Veterans



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# National Alliance to End Homelessness Updates: Veterans

- Since 2011, the number of veterans experiencing homelessness has dropped by 43.3 percent. But since 2019, the number has increased 0.5%
- On a single night in January 2020:
  - 37,252 veterans were experiencing homelessness.
  - 22,048 veterans were sheltered, while 15,204 veterans were unsheltered.
  - Most homeless veterans were without children; only 2 percent were homeless as part of a family.
  - 91.3 percent were men, while 8.4 percent (3,126 veterans) were women.



# If the Number of *Known* Homeless Veterans is Decreasing...What is the problem?

Even though VA has several programs to support Veterans at risk for or experiencing homelessness, fewer than 1 in 5 Veterans who were homeless report using such services, with significantly fewer Veterans who live in nonurban areas accessing such services.

Together, we can identify and serve more veterans in crisis through a process called **Coordinated Entry**.



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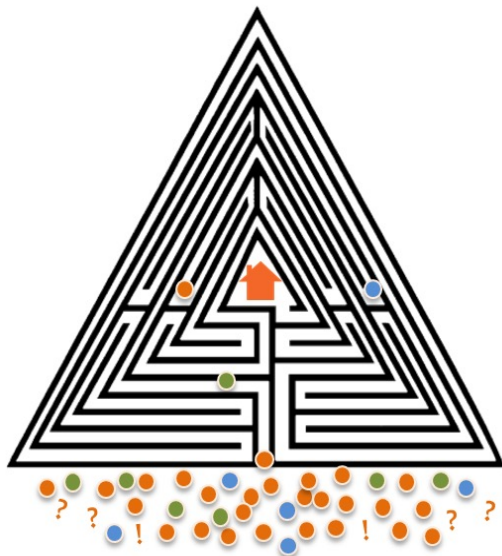
# What is Coordinated Entry?

An approach to coordination and management of a crisis response system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness.

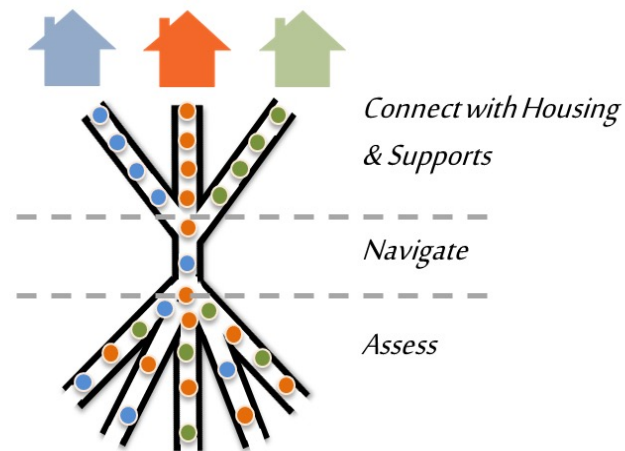


# Why Coordinated Entry?

Without CES



With CES



# VA Issues the DUSHOM Memo (2017)

- HUD requires all communities develop and operate a coordinated entry system (CES) for all homeless individuals, including Veterans.
- A Coordinated Entry System is a critical element in our work to end Veteran homelessness.
- The DUSHOM memo establishes the roles and responsibilities of the VA in each of their Continuums of Care (CoC) and the CoC's Coordinated Entry System.





# VA Issues the DUSHOM Memo (2017):

## VA Role in Coordinated Entry

- **Community Case Conferencing**

Act as a bridge of communication between the CoC providers and the VHA homeless programs.

- **By-Name-Lists**

Maintain a list of all known veterans experiencing homelessness at the local level and facilitate monthly review with collaborative partners.

- **Assessment Tools**

Work with the local CoC to incorporate the VAMC's screening and prioritization process into the larger CoC prioritization system.

- **Data Sharing**

Implement the use of a Universal Release of Information (ROI) for veterans processed through Coordinated Entry and implement policy to support ongoing data sharing.





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# VA Participation in the Continuums of Care Coordinated Entry System: Intake and Assessment

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*Northeast Ohio VA Healthcare System*

*Reaver Nelson, CRRC Program Coordinated*

# CRRC and Coordinated Entry Systems

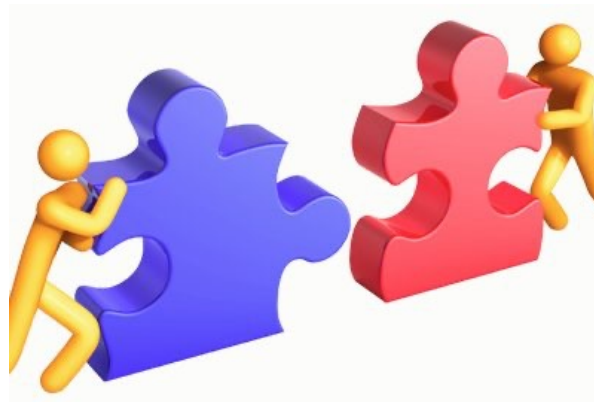
- 32 Community Resource and Referral Centers are established at VA facilities across the country serving as the entry point for veterans who are unsheltered (literally homeless or in uninhabitable conditions) or at-risk of homelessness due to notice of eviction, foreclosure, or “couch surfing”.
- CRRCs are an integral part of the continuum of homeless services. Cleveland VAMC covers 21 counties (5 shared geographies) throughout Northeast Ohio. Cleveland VA was awarded 2 CRRC (Cleveland and Akron)
- Interact with Coordinated Entry systems daily to assist community partners with verifying eligibility status and connecting veterans to the appropriate community access points for shelter throughout our catchment areas.



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# Assessment and Referral

- CRRC staff enter veterans into the VA HOMES system which tracks episodes of homelessness and admissions/exits to and from VA homeless programs.
- CRRC staff conduct biopsychosocial assessments to determine internal and external referrals to link veteran other services (MH/SUDS/Homeless/Primary Care).
- CRRC connects with veterans through calls and walk-ins at our facilities, street outreach, responding to referrals from the of the National Call Center for Homeless Veterans, and consults from local VA providers.



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## **Facility Services**

- Laundry/Shower Room
- Bed Bug Oven
- Veterans Resource Room
- Storage Room
- Clothing
- Houseware
- Hygiene Items

***Hours of Operation***  
***8:00am-4:00pm***



# 7<sup>th</sup> Annual Veterans Summit - Ohio

Lean Forward: Employment and  
Housing Support for Veterans

November 18, 2021



**LUTHERAN  
SOCIAL SERVICES**

## VA- Community Partnerships: GPD, HCHV Contract and SSVF Programs

- Lutheran Social Services Faith Mission of Fairfield County
- Sarah Stebelton, SSVF Outreach Specialist





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Fairhaven was built in 2001 to provide transitional housing to formerly homeless persons. It was a 20-unit apartment building with a main office and common area. Over the years LSS Faith Mission in Fairfield County has grown to meet the needs of the community and the Fairhaven building has been adapted for those needs. In 2007 the Emergency Shelter was relocated into three of those apartments and the community room was reconfigured to house 5 offices for staff. Then the Veterans Emergency Housing program took four more of the apartments in 2010. Now in 2021, there are only 4 rental apartments available, as the building houses a total of 6 housing programs and 10 staff members.

## All Programs Offered in Fairfield County

- **ADAMH Psychiatric Aftercare**
  - 1 Female & 1 male
- **Sober Living Transitional Housing**
  - Promise House 1 & 2 (10 total men) ; Female House (6 total Female)
    - Plus 1 Peer Support Specialist currently & 1 coming
- **Community Emergency Shelter**
  - 24 Beds; 8 Female and 16 Male
- **Shelter Plus Care (PSH) Vouchers**
  - 25 Vouchers
- **Health Care for Homeless Veterans (HCHV)**
  - 10 Beds
- **Grant Per Diem (GPD)**
  - 16 Beds
- **Supportive Services for Veteran families (SSVF)**
  - Households Served across 9 counties in the Balance of State last FY
- **4 residential apartment properties**
  - 33 total apartments total previous clients
- **1 social enterprise**
  - Patriot Pride Painting company





## Health Care for Homeless Veteran's Program (HCHV)

- Since 2010, Faith Mission of Fairfield County has contracted with the VA to provide ten (10) emergency housing beds and services for veteran men and women referred by the Chillicothe VA Medical Center in Chillicothe, Ohio.
- The HCHV program is located at 1681 East Main Street and consist of 4 separate apartments which can provide emergency housing for up to 10 veterans (3 beds per apartment).
- Each apartment contains a bathroom, kitchenette and shared sleeping quarters. All veterans have access to the Common Area and free laundry facilities.
- Veterans are provided housing for up to 90 days. Meals and case management services are also provided.
- Last FY our HCHV program served 36 of veterans; these numbers are lower than normal due to pandemic and a push for veterans to be placed in hotels.

## Grant Per Diem (GPD)

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- The GPD program is located at 1681 East Main Street and consist of 4 separate apartments.
  - Our GPD program provides housing for 16 veterans for a maximum of two years, with an average stay of 6-8 months.
  - During this time, residents work on medical issues, personal finances and obtaining employment in order to move to permanent, stable housing.
  - Classes are offered to the veterans, teaching life skills such as budgeting, shopping, cooking and cleaning.
  - In 2018 the grant adopted a Clinical Model approach and focuses on providing treatment to Veterans with an AOD and/or a mental health diagnosis.
  - Last FY our program served 12 veterans; these numbers are lower than normal due to pandemic and a push for veterans to be placed in hotels.
  - Of the 12, 7 were permanently housed straight from the program.



## Supportive Services for Veteran Families (SSVF)

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- This program helps veteran families in Adams, Brown, Fairfield, Fayette, Highland Hocking, Perry, Pickaway and Ross counties obtain stable housing, whether they are currently homeless or on the verge of becoming homeless.
  - Families who are imminently at risk of losing their housing work with case managers to provide needed temporary financial assistance, linkage with community and VA benefits and a plan to improve their housing stability.
  - Initially awarded the grant in 2014, the program has been CARF accredited since 2016.
  - This program currently places Veteran families into permanent housing in an average of 36 days with a success rate of close to 100%
  - The goal is to serve 115 households per year; the most recent grant year, over 160 Veteran households received assistance
  - The SSVF program has continued to develop new best practices through innovative initiatives to better serve the veteran population.

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- In 2018, **Rapid Resolution** was launched. It is an intervention designed to assist veterans upon contact with the crisis response system to attempt to avoid a homeless episode, or immediately after entry into the emergency shelter system with the goal of rapidly exiting the Veteran from homelessness.
  - In 2019, **The Returning Home** initiative became available to all grantees. This offers homeless Veteran households the option of returning to their community of origin or to a community where they have available supports to facilitate housing placement.
  - In 2020, all grantees were tasked with onboarding a **Health Care Navigator** to help veterans navigate the health care systems, while continuing to work with housing specialist to focus on obtaining or maintaining permanent housing.
  - In 2021, the roll out of a **Shallow Subsidy** was an added component to the program, allowing for the possibility to provide a 2-year subsidy to appropriate households.

## Supportive Services for Veteran Families (SSVF)

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- In 2021, SSVF released a new initiative for grantees to expand on helping veteran families have the option to work with Legal services, through MOUs with local attorneys/practices, to overcome barriers that could threaten their housing stability.
  - This new initiative will allow grantees to cover costs accrued for services provided by partnering legal counsel.
  - All SSVF households will be expected to be assessed for service needs at entry into the program, and again once the household has been placed into housing. This is to help continue to eliminate barriers veteran families might be facing.
  - The SSVF program office is working hard currently to provide grantees with guidance on how grantees will move forward with this new plan. SSVF programs should be able to provide these expanded services within the coming months.

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### FOR MORE INFORMATION REGARDING OUR VETERAN PROGRAMS, PLEASE REACH OUT TO:

- Eddie Rapp, Director
  - [Erapp@Lssnetworkofhope.org](mailto:Erapp@Lssnetworkofhope.org)
- Kerry Dreyer, Assistant Director
  - [Kdreyer@Lssnetworkofhope.org](mailto:Kdreyer@Lssnetworkofhope.org)
- Sarah Stebelton, SSVF Outreach Specialist
  - [SStebelton@Lssnetworkofhope.org](mailto:SStebelton@Lssnetworkofhope.org)

### OR VISIT OUR WEBSITE AT:

- <https://lssnetworkofhope.org>



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## HUD-VASH Program

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*VA Central Ohio Healthcare System*

*Patricia Ufferman, HUD-VASH Program  
Supervisor*

# HUD-VASH Program

The HUD-Veterans Affairs Supportive Housing (HUD-VASH) is a joint initiative between the Department of Housing and Urban Development and the Department of Veteran Affairs.

The HUD-VASH program combines HUD's Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the [Department of Veterans Affairs \(VA\)](#). VA provides these services for participating Veterans at VA medical centers (VAMCs), community-based outreach clinics (CBOCs), through VA contractors, or through other VA designated entities.



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HUD-VASH is  
recognized as  
the gold  
standard for  
ending  
veteran  
homelessness.

- As of end of FY 2021, over 105,000 subsidized housing vouchers were allocated to local housing authorities. More than 80,000 now formerly homeless Veterans are living in their own permanent housing.
- In Ohio, there are 2,725 HUD-VASH vouchers with more than 2,292 Veterans permanently housed with these vouchers.



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# Eligibility

Veteran participants to HUD-VASH must meet the legal definition of homelessness or imminent homeless.

HUD-VASH veterans are also expected to demonstrate a need for case management through individual assessment.

Those veterans with the most need based on their unique clinical and/or psychosocial circumstances are prioritized for HUD-VASH services.

HUD-VASH is targeted to those veterans with the most homeless time as length of homelessness most often indicates greater clinical need for services.



# HUD-VASH Program Services:

- Team based and interdisciplinary
- Varies in services and frequency based on the individual needs and goals of the veteran
- Provide care beyond housing searches and retention
- Long lasting. Veterans may stay in the program indefinitely as long as they still demonstrate need for the program.
- Case management acuity range from intensive to graduation.





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# Ending Veteran Homelessness

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*Dayton VA Medical Center*

*Dianne Smith-Foster, Homeless Program  
Manager*

# Ending Veteran Homelessness

- Success in ending homelessness among Veterans is happening community by community. And measuring that success is now easier: New guidelines released by the [United States Interagency Council on Homeless \(USICH\)](#) help communities benchmark their progress toward ensuring that every Veteran has a place to call home.
- Criteria and Benchmarks
  - Identifying all Veterans Experiencing homelessness
  - Capacity to provide immediate shelter to any unsheltered Veteran
  - Dedication to Housing First - Limited service-intensive transitional; Rapid PH Placement
  - System capacity for sustainment

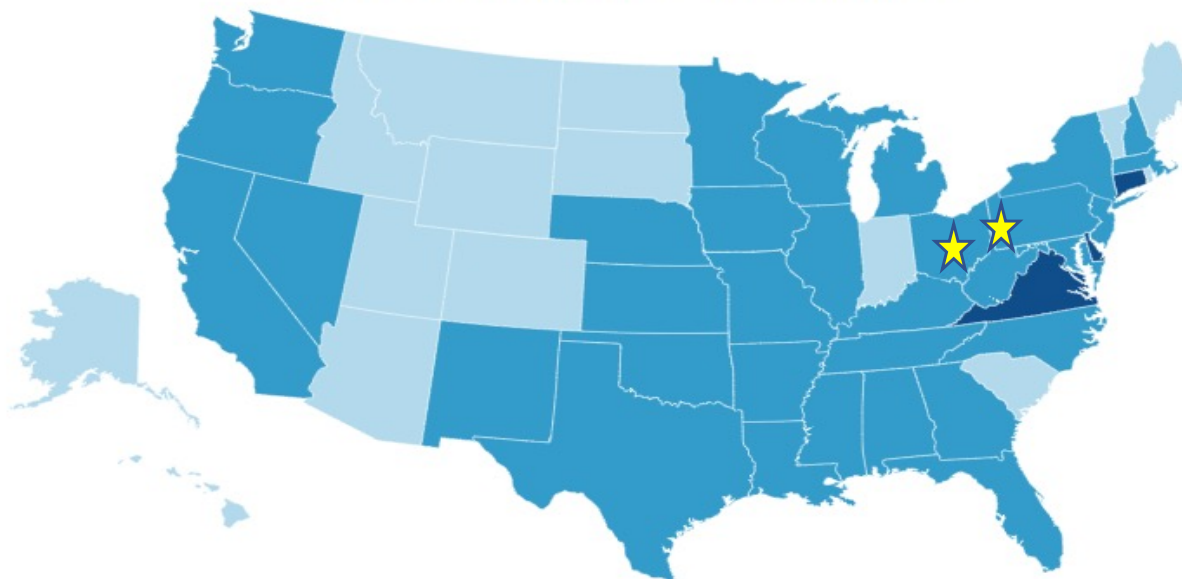


# Ending Veteran Homelessness

VA is committed to ending Veteran homelessness, community by community. Our work in collaboration with large and small localities proves that—through their leadership, cooperation and evidence-based practices—it's possible to ensure that every Veteran has a home.

[Ending Veteran Homelessness - VA Homeless Programs](#)

**3 STATES** and **82 COMMUNITIES**



## Ohio

Dayton/Montgomery County

Akron/Barberton/Summit County



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## Dayton VA Ends Veteran Homelessness

- **2014 Call to Action:** White House Joining Forces Initiative/HUD/US Department of Veteran Affairs, US Interagency Council on Homelessness and the National League of Cities
- **Accepting the City of Dayton Mayor's Challenge**
- **Targeted and Intentional Collaboration:** Dayton VA and Dayton-Kettering-Montgomery County Continuum of Care (CoC) and other Key Community Partners
- **Mission Accomplished:** 1<sup>st</sup> VA in VISN 10 to Effectively End Veteran Homelessness
- **Challenges and Barriers to Sustainment**



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# VHA Homeless Program Office Strategic Plan 2021 – 2025: Practices and Pillars

VHA's Homeless Programs ability to achieve targeted outcomes resides on the integration of services and programs and three essential practices:

- **Conducting** coordinated and preventive outreach by proactively seeking and identifying Veterans in need of assistance.
- **Connecting** homeless and at-risk Veterans with housing solutions ([Housing Assistance For Veterans - VA Homeless Programs](#)), health care ([Health Care - VA Homeless Programs](#)), community employment services ([Homeless Veterans Community Employment Services - VA Homeless Programs](#)), and other supportive services.
- **Collaborating** with federal, state, and local agencies; employers; housing providers; faith-based and community nonprofits; and others to expand employment and affordable housing options for Veterans exiting homelessness.

VHA's Homeless practices, programs, and services center on commitment to ending homelessness among Veterans and are based on eight pillars foundational to the many homeless programs and services established over the years that have evolved to meet the needs of homeless Veterans and their families.

## Our Eight Pillars



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# VHA Homeless Program Office Strategic Plan 2021 - 2025

**OBJECTIVE 1:** Expand and increase housing stock.

**OBJECTIVE 2:** Prevent and resolve returns to homelessness.

**OBJECTIVE 3:** Enhance targeted services to address the needs of high-acuity and vulnerable populations (e.g., Veterans who are older, have a history of opioid misuse, or are at risk for suicide).

**OBJECTIVE 4:** Support the development of a highly skilled workforce.

**OBJECTIVE 5:** Use research and state-of-the-art analytical data, evaluation tools, and processes to make informed and timely decisions.

**OBJECTIVE 6:** Provide equitable services and outcomes through all homeless programs and services.



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*Thank you-*

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# Additional Information – Resource Links

## Information

- [VA Homeless Programs](#)
- [VA Homeless FAQs - VA Homeless Programs](#)
- [Homeless Veterans Resources - VA Homeless Programs](#)
- [National Center on Homelessness among Veterans - VA Homeless Programs](#)
- [VA Employment Programs for Homeless Veterans - VA Homeless Programs](#)

## Videos

- [Face Behind the File: Shelter from the Storm - YouTube](#)
- [HUD-VASH: Providing Safe Housing, Quality Health Care for Veterans – YouTube](#)
- [Homelessness among Veterans: Risk Factor Profiles and VA's Tailored Interventions – YouTube](#)
- [Federal Eviction Moratorium: Resources for Veterans Experiencing Housing Instability – YouTube](#)
- [Help for Homeless Veterans -- Legal Professionals – YouTube](#)
- [How to Help Homeless Veterans - YouTube](#)

