



# VA Homeless Programs

Working to end Veteran Homelessness



# The State of Veteran Homelessness Nebraska: VA Gap Analysis



## Ending Veteran Homelessness

This tool assists your VA Medical Center (VAMC) or Continuum of Care (CoC) in developing an actionable plan to achieve this target

Quantifies the gap between the need and available assets in terms of permanent housing (PH) placements

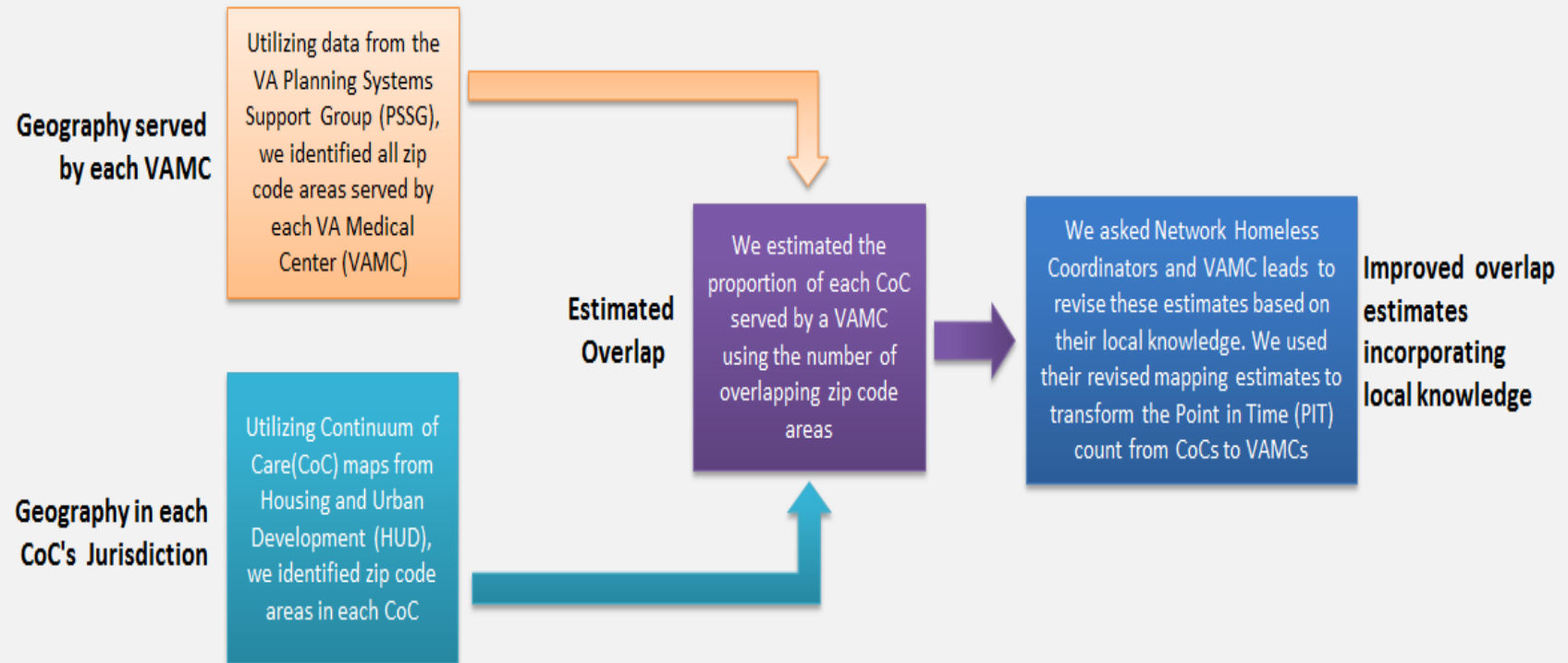


Enables collaborative strategy development among VA and Non-VA stakeholders at national and local levels to close the gap



Identifies monthly placements that can be achieved with assets and strategies

We will begin by understanding how Continuum of Care (CoC) jurisdictions overlap with VA Medical Center (VAMC) catchment areas. VAMCs are analyzed at the parent VAMC level and includes all campuses, divisions and medical centers under the parent VAMC's leadership.



We will utilize these mappings to identify the number of 2015 and 2016 Point in Time (PIT) homeless Veterans in the area.

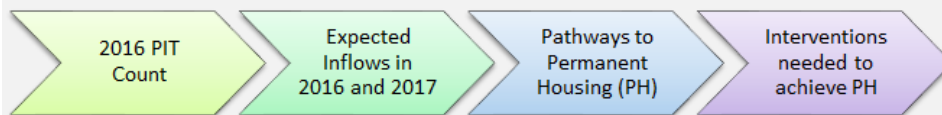
# Point-In-Time Information



Continuum of Care (CoC) to VAMC PIT Count Mapping

Continuum of Care (CoC)	CoC Num	2015 Count: PIT Homeless Veterans in CoC Jurisdiction	2016 Count: PIT Homeless Veterans in CoC Jurisdiction	Proportion of CoC served by VAMC (%)	2015 Estimate: PIT Homeless Veterans in area served by VAMC	2016 Estimate: PIT Homeless Veterans in area served by VAMC
Iowa Balance of State CoC	IA-501	81	58	5%	4	3
Nebraska Balance of State CoC	NE-500	16	13	95%	15	12
Omaha, Council Bluffs CoC	NE-501	150	134	100%	150	134
Lincoln CoC	NE-502	81	72	100%	81	72

	For 2015	For 2016
<b>Total Homeless Veterans in the area based on the Point in Time (PIT) Count (Sheltered and Unsheltered)</b>	<b>250</b>	<b>221</b>

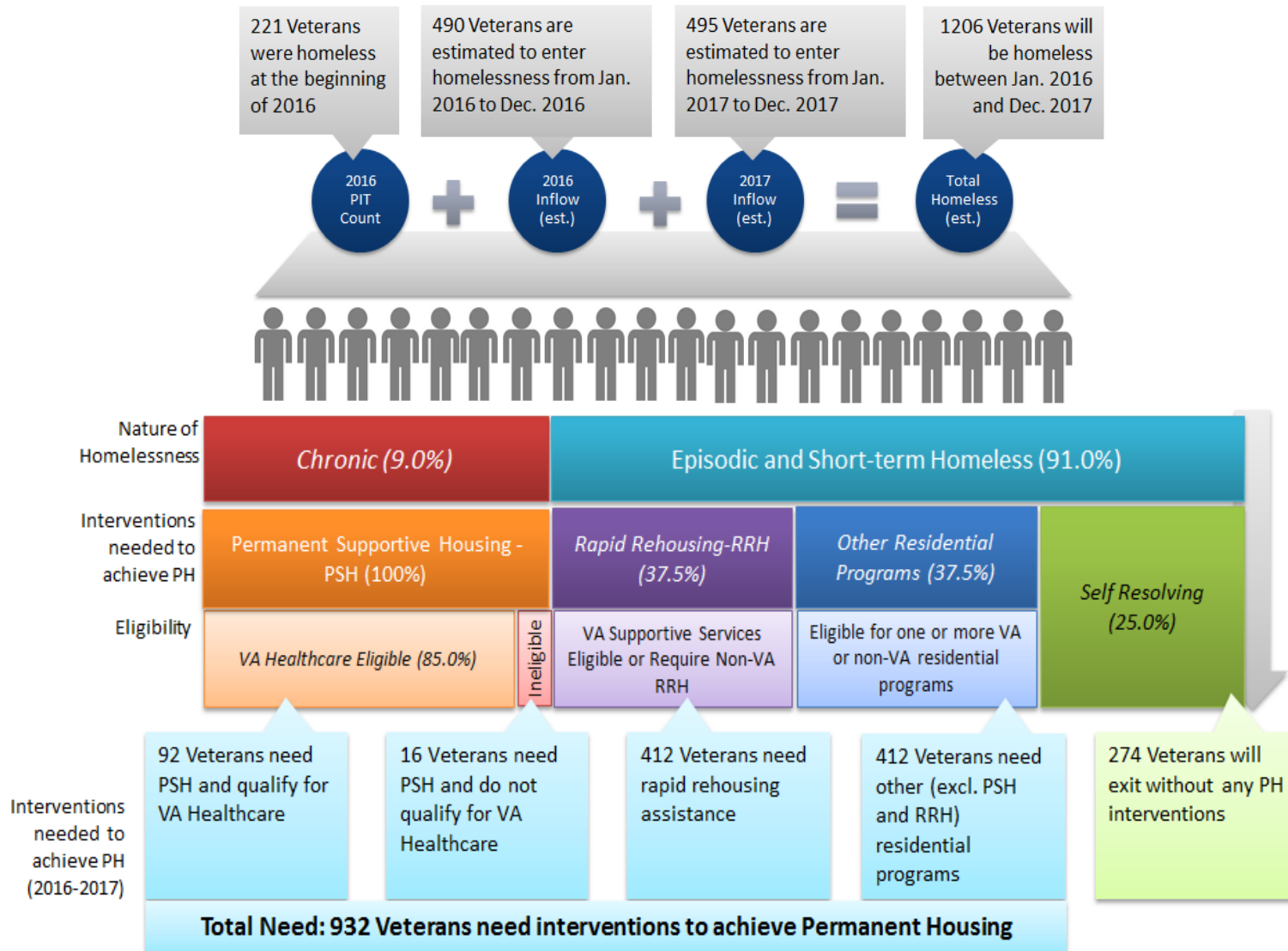


We will now estimate the total number of Veterans who will be homeless in 2016 and 2017. We will then estimate the number of Veterans per need category based on the nature of their homelessness, interventions needed to achieve permanent housing and their eligibility for VA healthcare services.

For the purpose of this Gap Analysis, we will use a Standard Planning Scenario developed by the National Office to estimate the need. The National Office utilized planning scenarios developed by the United States Interagency Council on Homelessness (USICH), VA operational data and HUD data to develop a standard scenario suitable for use in planning by most VA Medical Centers. This is a planning scenario and NOT a forecast.



The figure below shows planning scenario calculations building up from the 2016 PIT Count to the interventions needed to achieve Permanent Housing for all Veterans who are estimated to be homeless between Jan. 2016 and Dec. 2017 in the selected area.



Gaps at the end of December 2017

Need	Programs meeting the Need (Multiple programs can help a Veteran achieve a PH Placement)	Permanent Housing (PH) Placements Needed (Jan 2016-Dec 2017)	PH Placements possible with available assets (Jan 2016-Dec 2017)	Gap in PH Placements (Jan 2016-Dec 2017)	Preliminary Excess PH Placements (Jan 2016-Dec 2017)
Chronically Homeless Veterans <b>NOT</b> eligible for VA-Healthcare and need Permanent Supportive Housing	Non-VA PSH	16	16	-	-
Chronically Homeless Veterans eligible for VA-Healthcare and need Permanent Supportive Housing	Non-VA PSH Excess after serving VHA ineligible Veterans	92	18	-	18
	HUD-VASH alone, HUD-VASH along with SSVF RRH and HUD-VASH along with VA Residential Programs (GPD, DCHV, CWT/TR and HCHV )		276		184
Episodic and Short-term homeless who need Rapid Rehousing	SSVF Rapid Re-housing (RRH) alone	412	207	205	-
	Non-VA Rapid Re-housing		-		-
Chronically Homeless Veterans <b>NOT</b> eligible for VA-Healthcare and need Permanent Supportive Housing	Non-VA PSH	16	16	-	-
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	HUD-VASH alone, HUD-VASH along with SSVF RRH and HUD-VASH along with VA Residential Programs (GPD, DCHV, CWT/TR and HCHV )		276		184
Episodic and Short-term homeless who need Rapid Rehousing	SSVF Rapid Re-housing (RRH) alone	412	207	205	-
	Non-VA Rapid Re-housing		-		-
Episodic and Short-term homeless who need other interventions	VA Residential Programs (GPD, DCHV, CWT/TR and HCHV) alone, VA Residential Programs along with SSVF-RRH	412	223	189	-
	Non-VA Residential Treatment Programs		-		-
<b>Total*</b>		<b>932</b>	<b>740</b>	<b>192</b>	<b>-</b>
	Episodic and Short-term homeless who will self-resolve and do not need any	274			

# VA Programs & Services



- Community Resource and Referral Center (CRRC)
  - 2,059 currently and recently homeless Veterans were served by the Nebraska Western Iowa VA Healthcare System in FY15. Of these, 168 were women and 94 were OEF/OIF/OND
  - Walk-in Service with immediate access for assessment and services
  - Community Partners on-site
  - Food Pantry for distribution of needed food items and engagement
  - Access to showers, laundry, telephone, newspaper, computer & material assistance
  - Vocational Services on-site
  - Primary Healthcare Team on site



# VA Programs & Services



- Healthcare for Homeless Veterans (HCHV)
  - Contract Residential – 22 beds
    - Occupancy rate 96.1% Exits to Permanent Housing 46.76%
    - Negative Exits 17.91%
  - Grant & Per Diem – 136 Transitional Housing Opportunities
    - Occupancy rate 91.4%
    - Exits to Permanent Housing 74.83%
    - Negative Exits 19.61%
    - Employed at time of discharge 60.24%
  - Outreach Team – 4 staff including MSW SUD specialist
    - Daily outreach with variable times on streets, shelters, hospitals and other places where homeless veterans congregate
    - Participation in MAACH Street Outreach Team
    - Focused shelter outreach in the evening hours
- \*FY2015 Data

# VA Programs & Services



- Veterans Justice Outreach - 2 staff w/ in reach to local jails
  - Partnered with Douglas County Corrections and other community partners for a 32 bed Veteran Unit at Douglas County Corrections
  
- Healthcare for Re-entry Veterans (HCRV)
  - Focused on providing housing options to Veterans leaving the prison system
  
- – HUD/VASH – 436 PSH Vouchers
  - 99.73% of vouchers under lease
  - 84.85% of admissions housed within 90 days. Average housing time 63 days
  - Negative exits 7.14%
  - 67.55% of admissions were chronically homeless

\*FY2015 Data

## Best Practices: Housing First

- Housing First - prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed.
  - *Few to no programmatic prerequisites to permanent housing entry*
  - *Low barrier admission policies*
  - *Rapid and streamlined entry into housing*
  - *Supportive services are voluntary, but can and should be used to persistently engage tenants to ensure housing stability*
  - *Tenants have full rights, responsibilities, and legal protections*
  - *Practices and policies to prevent lease violations and evictions*
  - *Applicable in a variety of housing models*

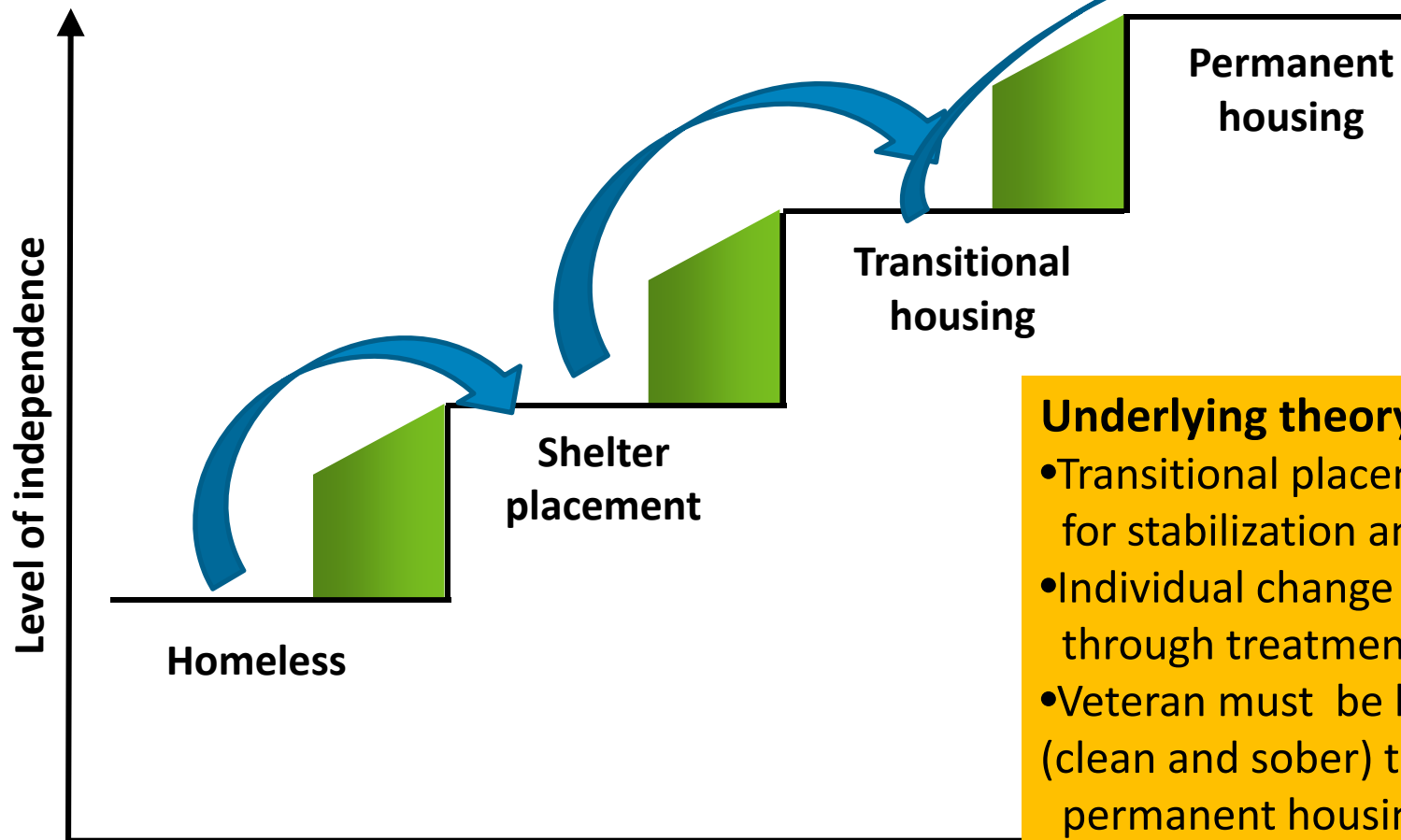
# Housing First Critical Elements



1. There is a focus on helping individuals and families access and sustain permanent housing *as quickly as possible*
  - 1a. Direct, or nearly direct, placement of targeted homeless Veterans into permanent housing
2. A variety of services are delivered primarily following a housing placement to promote housing stability and individual well-being
3. Services are time-limited or long-term depending upon individual need (Veteran centric/recovery focused)
4. Housing is not contingent on compliance with services – instead, participants must comply with a standard lease agreement and are provided with supports to help them remain housed

# Treatment First Model

HONORING  
EMPOV  
HEA

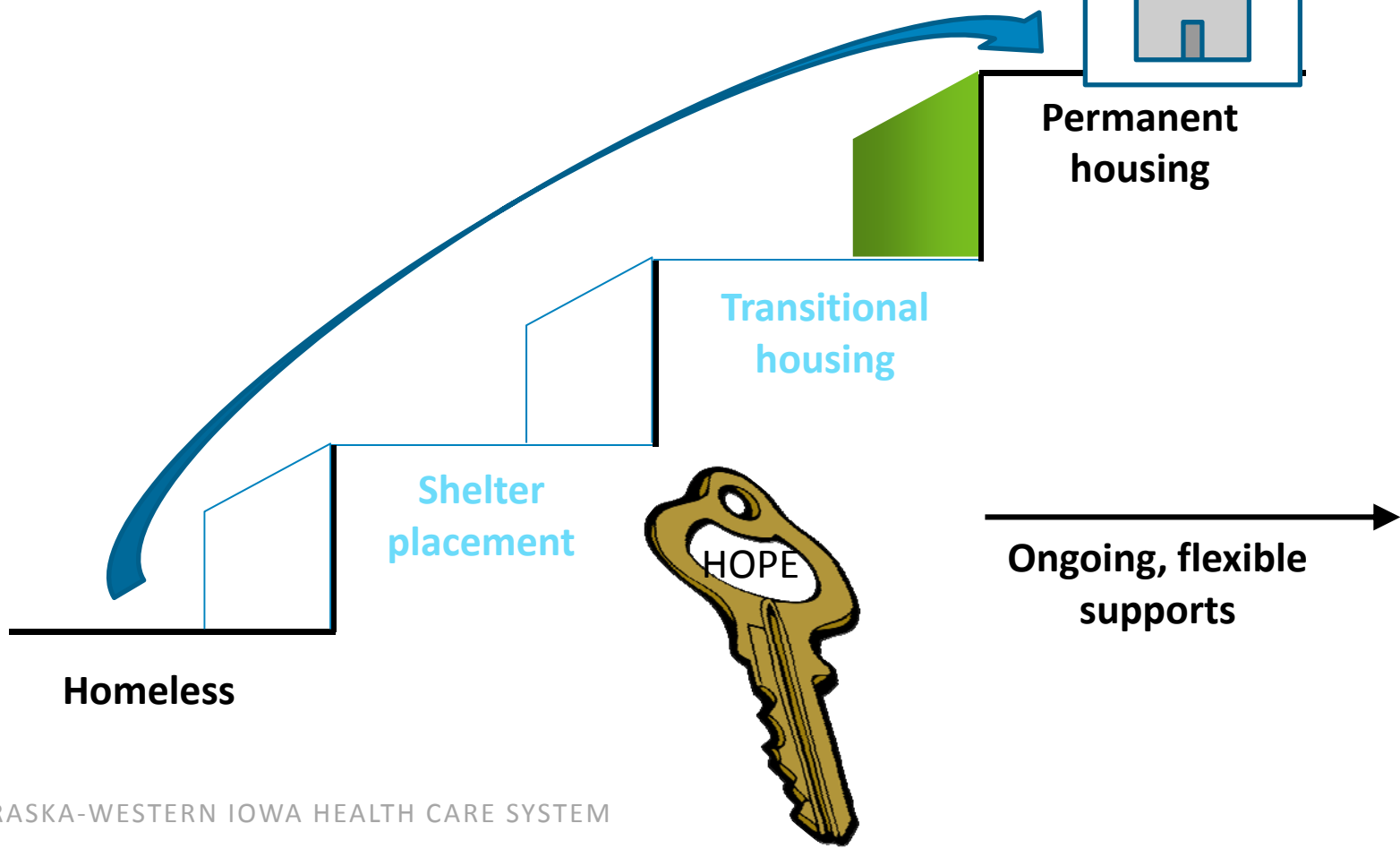


## Underlying theory and values:

- Transitional placements provide for stabilization and learning.
- Individual change is required through treatment.
- Veteran must be housing ready (clean and sober) to obtain permanent housing

# Housing First Model

HONORING SERVICE  
EMPOWERING  
**HEALTH**





# Why Housing First?



- Housing First ends homelessness
- Housing First eliminates the need for costly shelter care, transitional and short term treatment services aimed at preparing Veterans to be housing ready
- Studies demonstrate that Housing First reduces ER visits, unscheduled mental health visits and medical hospitalization
- Housing First decreases the frequency and duration of homelessness

# Cost Off Sets

HONORING SERVICE  
EMPOWERING  
HEALTH

The screenshot shows a web browser window displaying the Pathways to Housing website. The main content area features a 3D bar chart comparing the cost of different housing models. The chart shows that the Pathways Housing First model is significantly cheaper than other options.

Housing Model	Cost per Capita per Night
Pathways Housing First	\$57
Shelter	\$73
Jail	\$164
Emergency Room	\$519
Psychiatric Hospital	\$1185

The website also includes a navigation menu with links for Home, Our Model, Housing + Services, Work With Us, Pressroom, Research Library, and Training + Consulting. There are also buttons for DONATE and LOCATIONS. On the right side, there are sections for Awards, Annual Report, Documentary, and Training + Consulting. At the bottom, there is a Testimonials section and a footer note stating that Pathways to Housing was founded by Dr. Sam Tsemberis in 1992.

VA NEBRASKA-WESTERN IOWA HEALTH CARE SYSTEM

## Best Practices: Housing First/Operation Reveille

- Operation: Reveille was conceptualized in February 2013 in the City of St. Louis in response to a national effort of ending homelessness among Veterans by 2015. Operation: Reveille was implemented on July 30, 2014. St. Louis was the first city to end Veteran homelessness.
- Creating Housing Opportunities to immediately place veterans in permanent housing.
  - NWI
  - PIT Count. 5 opportunities available for housing. 2 veterans housed that night.
  - Lincoln HUD/VASH program – 3 pre-inspected units
- Requires Collaboration and Cooperation. A sense of urgency. Low Barrier/No Barrier housing

## Best Practices: Critical Time Intervention



- Intensive case management model originally developed for persons with mental illness who were transitioning out of homelessness
- At least a 9 month intervention to ensure a successful transition
- Is proven to reduce time homeless
- Reduces re-hospitalization
- Reduces negative symptoms

# Critical Time Intervention



Acuity	Criteria	Frequency
High intensity	Multiple treatment failures, frequent ER visits, active mental health and or addiction symptoms, safety issues, limited support network	1-2 times a week until stable
Standard	New to the program, housed less than 6 months, still progress with recovery	Weekly to twice a month contact assisting with housing location and stabilization, also addressing treatment engagement
Low intensity	Housed 6 months or longer, fully engaged with primary care and mental health, adequate community supports	Once a month to promote full community reintegration

## Best Practices: Critical Time Intervention



- CTI Focuses on Specific Needs:
  - 1. Housing
  - 2. Access to benefits and community resources
  - 3. Engagement with mental health and SA treatment
  - 4. Link to medical treatment
  - 5. Developing social supports, including family
  - 6. Money management
  - 7. Independent living skills



## Best Practices: Critical Time Intervention



- Keys to Engagement:
  - Outreach and development of relationship
  - Flexible strategies to engage clients
  - Meet in community or office
  - Funding for concrete needs – housing startup, food
  - Will provide service regardless of person's willingness to engage in treatment, although engagement in treatment is a goal

# Best Practices: Using Peer Support



- Peer Support lends a different type of support
  - Peer support occurs when people provide knowledge, experience, emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters and can take a number of forms such as peer mentoring, listening, or counseling.
  - A Certified Peer Support Specialist is a person with significant life-altering experience. This is also referred to as lived experience. These specialists support individuals with struggles pertaining to mental health, psychological trauma, substance use, homelessness, etc.
  - Peer support contributes to relationship building, better housing rates, participation in mental health and substance abuse services and stabilization in housing.

## Best Practices: Housing Specialist

- The Housing Specialist develops relationships with landlords, homeowners, real estate associations and other groups to educate and engage the community in the housing needs of homeless veterans
- A Housing Specialist becomes familiar with the housing market, trends regarding rentals in the community, and community resources in order to help identify housing to meet veteran housing preferences
- The Housing Specialist serves as a liaison between landlord, housing authority or other entities and the Case Management Team. This streamlines and promotes communication
- The Housing Specialist understands Fair Housing and HUD rules/regulations and provides education and support to the Case Management Team when situations arise

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  - Phone: 402-995-5124
- Lea Anne Peterson, HUD/VASH Program Coordinator
  - Phone 402-995-5145
- VA Community Resource and Referral Center
  - Phone 402-995-4010
- National Call Center for Homeless Veterans
  - 877-424-3838
  - 877-4AID-VET