CSHIIP
Center for the Study of Healthcare Innovation, Implementation & Policy

Improving Housing and Health for Homeless Veterans

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VA Greater Los Angeles Healthcare System

Disclosures

- No relevant financial relationships to disclose

Agenda

- Homelessness, health, and Veterans
- Integrated care for homeless Veterans
  - Outreach and housing services
  - Healthcare services
- Innovations and future directions

Agenda

- Homelessness, health, and Veterans

Who are homeless persons?

- Lack a fixed, regular, and adequate nighttime residence
- Identify a primary nighttime residence that is:

Unsheltered	Sheltered
A public/private place not designated for or ordinarily used as regular sleeping accommodations for human beings	A supervised shelter designed for temporary living
Park benches *Abandoned buildings*	*Emergency shelters* *Transitional housing* *Emergency hotel/motel vouchers*

Stewart B. McKinney Homeless Assistance Act of 1987; 24 CFR 578.3 of the Homeless Definition Final Rule

Persons at-risk for becoming homeless are also vulnerable

- The U.S. Department of Housing and Urban Development expands this definition to include persons at-risk for becoming homeless:
  - Individuals and families who will imminently lose their primary nighttime residence

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH Act): Defining "Homeless." Federal Register/Vol 76, No. 233/Dec. 5, 2011

Housing is a critical determinant of health

- Persons experiencing homelessness have high rates of medical illness, psychiatric problems, and substance use disorders

- Homeless person’s health care needs are compounded by:
  - Poor social support
  - The need to navigate priorities (e.g., shelter) that compete with medical care

O’Toole TP et al., 2010

“Transinstitutionalization” left many persons with mental illness homeless

State Hospitals → Under-resourced community mental health system ↔ Jails/Prisons; Homeless; Hospitals & Emergency Rooms

Talbott JA. Deinstitutionalization: Avoiding the Disasters of the Past. *Hospital and Community Psychiatry*. 1979, pp. 621-624.

The VA aims to end Veteran homelessness

- In 2010, the first-ever federal strategic plan (“Opening Doors”) to end Veteran homelessness was released
  - Focused on rapid re-housing and homelessness prevention
- VA Health Services Research and Development (HSR&D) has designated relevant “priority areas:”
  - Healthcare equity, health disparities, and mental and behavioral health

Homeless Veterans are particularly vulnerable

- Homeless Veterans have an age-adjusted mortality that is nearly three-times higher than their housed peers
- Veteran homelessness dropped 47% (35,000) between 2010-2016
  - On a single night in January 2016, 39,471 Veterans were homeless in the U.S. (~9% of all homeless adults)
- In Los Angeles County, there was a 57% increase in Veteran homelessness from 2016-2017
  - Point-in-time count for Veterans in 2017 was 4,828

O'Toole TP et al., 2010; LAHSA Point-in-Time County 2017

The Greater Los Angeles VA has responded to the escalating needs of homeless Veterans

- Los Angeles' Community Engagement and Reintegration Service (CERS) is the largest VA homeless program in the nation
  - Housing resources for >9,500 homeless Veterans (emergency, transitional, permanent housing, and Veteran-designated Section 8 vouchers)
  - Annual budget of $90 million
  - >500 interdisciplinary staff
  - In FY17, served 3,896 unique patients

Agenda

- Integrated care for homeless Veterans
  - Outreach and housing services

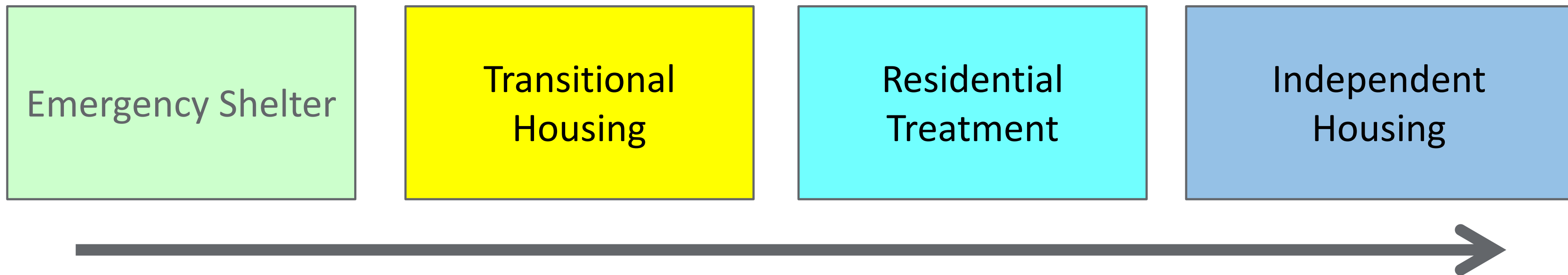
The VA has a longstanding commitment to community outreach

- Greater Los Angeles' example:

General outreach	Justice outreach	Walk-in services
• Street outreach • Stand downs • Direct Veteran engagement	• Homeless Veteran outreach targeting jails/prisons • Smoothly transition Veterans to care at release from the criminal justice system	• "Welcome Center" offers wrap around services, same day assessment, and bridge housing

How does the VA house homeless Veterans?

- Traditionally, services were offered on a linear "continuum of care"



- Homeless persons progress on this continuum when deemed "housing ready" by providers

Greenwood RM, Schaefer-McDaniel NJ, Winkel G, Tsemberis SJ. Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness. American Journal of Community Psychology. 2005 Dec;36(3-4):223–38.

Several VA programs exist on this linear continuum

- Domiciliary (296 beds in Los Angeles)
  - Residential rehabilitation and treatment services for homeless Veterans
  - Integrated medical, psychiatric, substance use disorder, and housing services

- Grant Per Diems (1,400 beds in Los Angeles)
  - Funds given to community agencies who provide housing and supportive services for homeless Veterans
  - Track options: Low Demand, Treatment, Hospital to Housing
  - Aim to train Veterans in skills needed for financial stability and independent housing

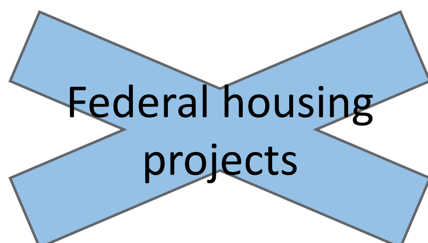
Paradigm for housing services transitioned to Housing First

- Emergence of recovery-oriented treatment for persons with mental illness and substance use disorders
  - Housing began to be viewed as a fundamental right
  - Distinct from adherence to treatment
- Treatment shifted to a Housing First model

Greenwood RM, Schaefer-McDaniel NJ, Winkel G, Tsemberis SJ. Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness. American Journal of Community Psychology. 2005 Dec;36(3-4):223–38.

HUD-VASH is the VA's Housing First Program

- The U.S. Department of Housing and Urban Development (HUD) recognizes that housing is a critical determinant of health



Housing Choice (Section 8) vouchers were "mobilizing"

- 1992: HUD partnered with the VA to form the HUD-VA Supportive Housing program
  - Section 8 vouchers and case management for eligible Veterans: "voucher variant" of Housing First

Housing First is accepted as an evidence-based practice

- Prior research substantiates positive health and psychosocial outcomes of Housing First programs
  - Decreased substance use
  - Fewer hospitalizations
  - Increased perceived autonomy
  - Improved housing retention
- HUD-VASH is the crux of the VA's plan to end Veteran homelessness: >85,000 vouchers distributed nationwide (~6400 in Los Angeles)
  - Yet, 6% of participants return to homelessness each year

Hwang SW, Burns T. Health interventions for people who are homeless. Lancet. 2014 Oct 25;384(9953):1541–7.

James Corner

- 38-year-old man with schizophrenia and cocaine use disorder
  - Chronically homeless (6 years on the streets)
  - Initially threatening to staff, responding to internal stimuli, but improved markedly with medication changes
- Obtained an apartment in South LA
  - Invited drug dealer to live with him to pay off debts
  - Felt threatened by dealer and left apartment in fear, seeking temporary housing placement at the VA
- Ultimately, the patient was LPS conserved
  - Now lives in a board and care

There is a dearth of knowledge about HUD-VASH exits

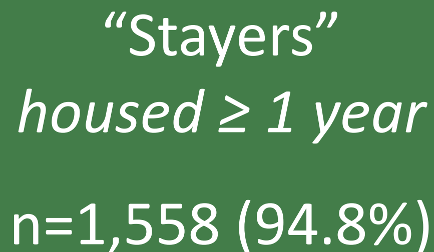
- In secondary analyses of national VA administrative data, several factors were associated with shorter HUD-VASH tenure:
  - Days intoxicated in the month before admission
  - Lower income
  - History of institutionalization
- Optimal housing and rehabilitation approach for very vulnerable subgroups of persons, e.g., active substance users, is unclear

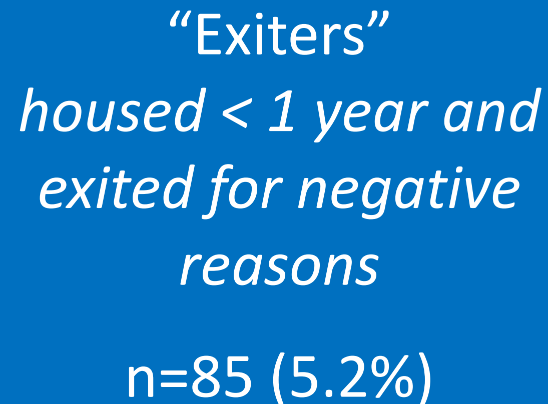
Research Questions

- What factors are associated with exits from HUD-VASH after achieving housing?
  - We hypothesized that mental health problems would be particularly salient
- What is the experience of losing supported housing?
- What clinical interventions can improve HUD-VASH retention?

Study Sample

- We used homeless registry (HOMES) data to identify Los Angeles HUD-VASH enrollees who were housed in 2011-2012.





Study Sample

- Larger sample
  - Abstracted medical record data for all 85 exiters and a randomly selected sample of 85 stayers
- Smaller sample
  - Purposively selected 20 exiters and 20 stayers for semi-structured interviews
  - Maximized sample variation on age, gender, and presence vs. absence of a serious mental illness diagnosis
- Staff participants
  - Semi-structured interviews with leadership (n=3)
  - Two focus groups (n=9) and individual interviews (n=3) with HUD-VASH social workers, nurses, and peer supports

Conceptual Framework*

Predisposing

(Demographics, homelessness chronicity, +/- OEF/OIF status)

→

Enabling

(Income, primary care assignment, distance between apartment and primary care team)

↓

Need

(+/- common medical and psychiatric conditions, drug use disorder, alcohol use disorder)

←

Health Behaviors

(VA health service use, including ER visits, hospital admissions, “no-show” rates, engagement in primary care/mental health care)

↓

Outcomes

(Stayers vs. exiters)

*This framework dictated our medical record review

Gelberg L, Andersen RM, Leake BD. The Behavioral Model for Vulnerable Populations: application to medical care use and outcomes for homeless people. Health Services Research. 2000 Feb;34(6):1273–302.

Addition data collection and analyses

- Chi-square and ANOVA determined how measures differed between exiters and stayers
- Recursive partitioning identified which combination of measures and corresponding scores best differentiated these two groups
  - Uses "decision trees" to predict outcomes from independent variables
- Individual interviews with Veterans, staff, and leadership → thematic analyses
  - Focused on unmet service needs in the program and Veteran behaviors that contributed to housing loss

Sample Characteristics *(selected)*

	Stayers (n=85)	Exiters (n=85)	Total (N=170)
Age (mean)	54.0	53.4	53.7
Gender (% male)*	91.8%	97.7%	94.7%
Homelessness chronicity*			
Acute	43.5%	23.5%	33.5%
Chronic	56.5%	76.5%	66.5%
Income (mean/month)	$938.90	$995.60	$967.20
Serious mental illness*	23.5%	35.3%	29.4%
Alcohol use disorder	57.6%	62.4%	60.0%
Drug use disorder	54.1%	68.2%	61.2%
ER visits (mean/past year)*	0.5	1.2	0.9
Primary care engagement*	67.1%	51.8%	59.4%
Mental health engagement	34.1%	41.2%	37.6%

*$p<0.05$; engagement = 2+ visits/past year

"Decision rules" for classifying Veterans as stayers vs. exiters

N = 170 participants and 11 potential predictor variables

C = % of participants correctly classified

Total C = 85.9% of stayers and 48.2% of exiters

Qualitative Themes

- Veteran and staff (providers/leadership) narratives highlighted:

Domain	Factor
Enabling	Motivation
Needs (unmet)	Mental health Symptoms Substance use disorders Independent living skills Social skills Money management

Veterans thought motivation was important for VASH retention

- Veterans described "personal accountability" as more important than any unmet need
  - *"I think the Veterans have to have it in themselves that they want to stick to [the housing program] instead of taking advantage of it and drifting off."*

- Very few staff narratives described motivation as important, they more commonly described unmet needs as salient in VASH retention

Unmet mental health and substance use disorder needs were prevalent in narratives

- Psychiatric symptoms necessitated a more gradual transition into HUD-VASH from institutional environments
  - *"There was no support [in HUD-VASH] for my schizophrenia. I [had been] in a program where everything was dictated to you…to be thrown into 100% freedom [in my apartment] was culture shock really for me.*
- Stayers and exiters both highlighted a role of substance use disorders
  - *"I had a lot of idle time [in my apartment] and I was depressed…people were coming by asking me where they can buy weed. People were drinking…I was lonely and I was looking for companionship so I started using."*
- Many exiters wanted treatment mandates
  - *"…If they could do some kind of drug testing, and go over there and check up on [people who test positive]…they would have the chance to seek help."*

Many Veterans had profound deficits in independent living skills

- One exiter lost his apartment after assaulting his apartment manager who was trying to collect his rent
  - *"I was mentally unstable…I came from a prison-based program…my social circle is all prisoners. No one taught me 'you're not in prison [anymore]."*
- Stayers knew to turn to staff when they encountered money problems
  - *"…I got a job making less money. I could never catch up. [My landlord] talked to my case worker…we worked things out so I didn't get evicted."*
- Exiters' financial problems often escalated to apartment loss
  - "The case managers ultimately didn't say, 'Well, what's your budget going to look like? You get such amount of money and the rent is going to be prorated to this amount'"
- Like with mental health, Veterans wanted mandates related to financial management

Diverse and interrelated factors were associated with VASH exits

- In identifying "high risk" Veterans, these data suggest the importance of:

Domain	Factor
Predisposing	Homelessness chronicity
Enabling	Motivation
Needs	Mental health care Independent living skills
Health service utilization behaviors	Primary care engagement Emergency Department utilization Inpatient mental health admissions

- Veterans and staff alike desired program mandates, which differs from the crux of the Housing First philosophy

Implications

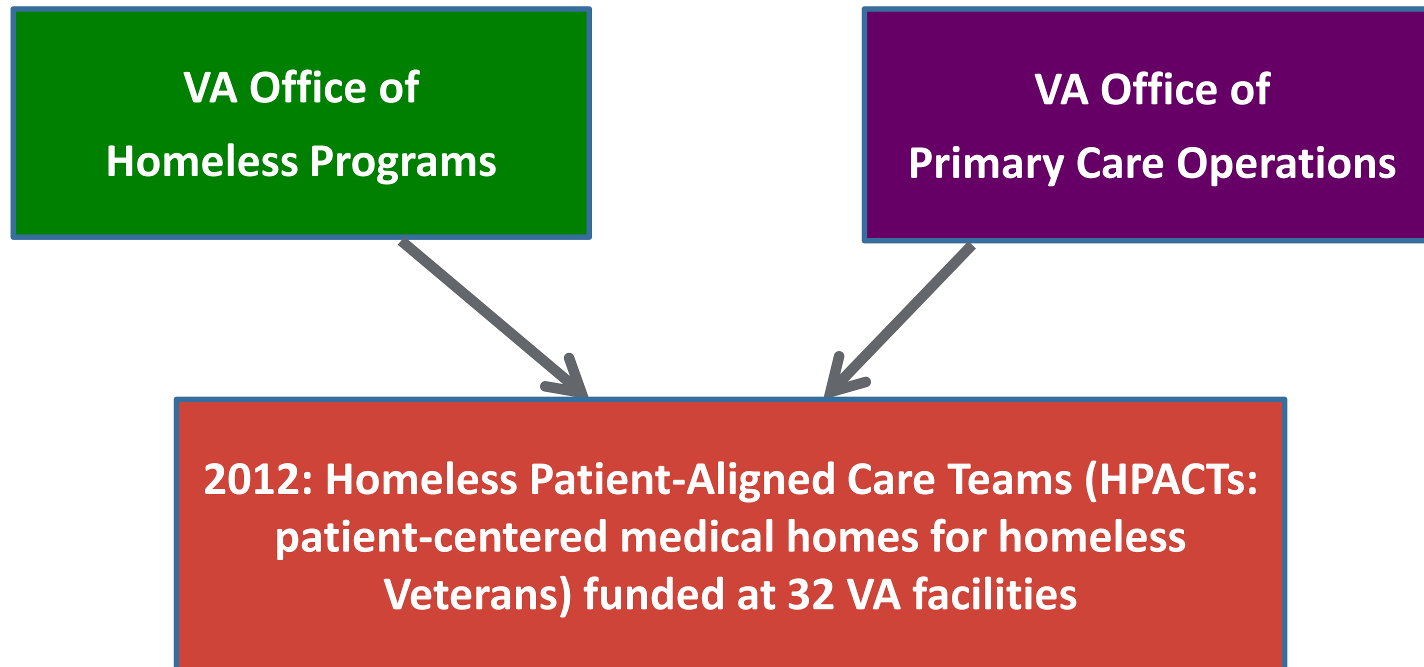
- Though this pilot work was limited to cross-sectional assessments in Los Angeles, it suggests future research and quality improvement ideas within HUD-VASH:
  - Provision of personalized budgets / money management training
  - Social/interpersonal skills training
  - Development of algorithms to use at HUD-VASH entry to identify high-risk Veterans who need more intensive services

Agenda

- Integrated care for homeless Veterans
  - Healthcare services

Until recently, the VA lacked a homeless-focused primary care initiative

- The Health Care for Homeless Veterans (HCHV) program offered many services for homeless Veterans, but there was no focused primary care program for this population



HPACT roll-out

- Three core principles guided HPACT implementation across VA
  - Establish processes to identify and refer the highest risk and highest need homeless Veterans who cannot get care through traditional channels
  - Provide high-intensity, integrated services that incorporate social determinants of health
  - Expedite housing placement

- Local contextual factors resulted in varying HPACT models at different VA facilities
  - Los Angeles as the largest HPACT in the nation, serving ~4,000 Veterans across 3 facilities

National HPACT outcomes

Acute care use (vs. historical controls)	Cost (vs. homeless Veterans in traditional PACT)	Housing (vs. homeless Veterans in traditional PACT)
• 19% reduction in Emergency Department use • 35% reduction in inpatient admissions	• Average costs are $9,379/year less	• Average time to housing is 81.1 days faster

O'Toole, et al. Prev Chronic Dis. 2016 Mar 31;13:E44
O'Toole. HSR&D SDR 11-230
O'Toole. IIR 07-184

Case Example: West Los Angeles HPACT

Idealized HPACT Team

Teamlet A
-Primary Care (MD)
-RN Care Manager
-LVN
-Medical Support Assistant

Teamlet B
-Primary Care (NP)
-RN Care Manager
-LVN
- Medical Support Assistant

Team MH/SW
-Psychiatrist or Psych NP
-Psychologist
-Social Worker and/or Substance Abuse Specialist Social Worker
-1/2 FTE Pharmacist

West Los Angeles HPACT:
Facts and Figures

- Panel Size: 2,612
  - 11% are "super-utilizers"
  - 10% are OEF/OIF/OND era
  - Team same-day access: 91%

	Average # of visits/12 months
Primary care providers	3.8
Emergency Department	5.0
Mental health visits	18.2
Homeless service encounters	11.3

George Bowen

- 49-year-old man with depression and alcohol use disorder
  - Presented to ED for detox and housing services.
  - Had spent most of his life drinking heavily, and had had multiple attempts at sobriety
- Seen as a walk-in for a new visit
  - PCP referred for detox and social work planned after care.
  - Veteran engaged in services over next 18 months, in DOM, HPACT and GPD programs
- Ultimately, the patient maintained sobriety and moved across country to rent an apartment from his aunt.

West Los Angeles VA
Inter-professional Academic HPACT

- VA Center of Excellence (COE) in Primary Care Education (PCE)
  - Trainees in internal medicine, psychiatry, psychology, nursing, clinical pharmacy, and social work learn how to care for vulnerable Veteran subpopulations in integrated care settings

- Only COE in PCE based in an HPACT

Inter-professional Academic HPACT Composition

- 2 Teams, each with:
  - MD
    - 14 UCLA Primary Care Internal Medicine residents
    - 1 Psychiatry resident
  - NP: 4 residents and 1 student
  - Psychology: 1 fellow
  - Pharmacy: 1 resident

Inter-professional Academic HPACT Curricula

- Interprofessional teamwork
- Primary Care-Mental Health Integration
- Humanism Pocket Tool for Compassionate Care
- Social Determinants of Health
- Quality Improvement and Population Management
- Well-being
- Leadership

Humanism Pocket Tool

- Helps build compassion among clinicians and trainees working with challenging populations

Core Concepts	Details
Self-talk	When frustrated, choose compassion: "Mr. X is not himself today"
Active listening	Open-ended questions, empathic remarks, restatement
Tone, touch, proximity, and synchrony	Non-verbal behavior is important, personalizing your behaviors to the patients
Vivid vignettes	Identify the patients aspirations and obstacles

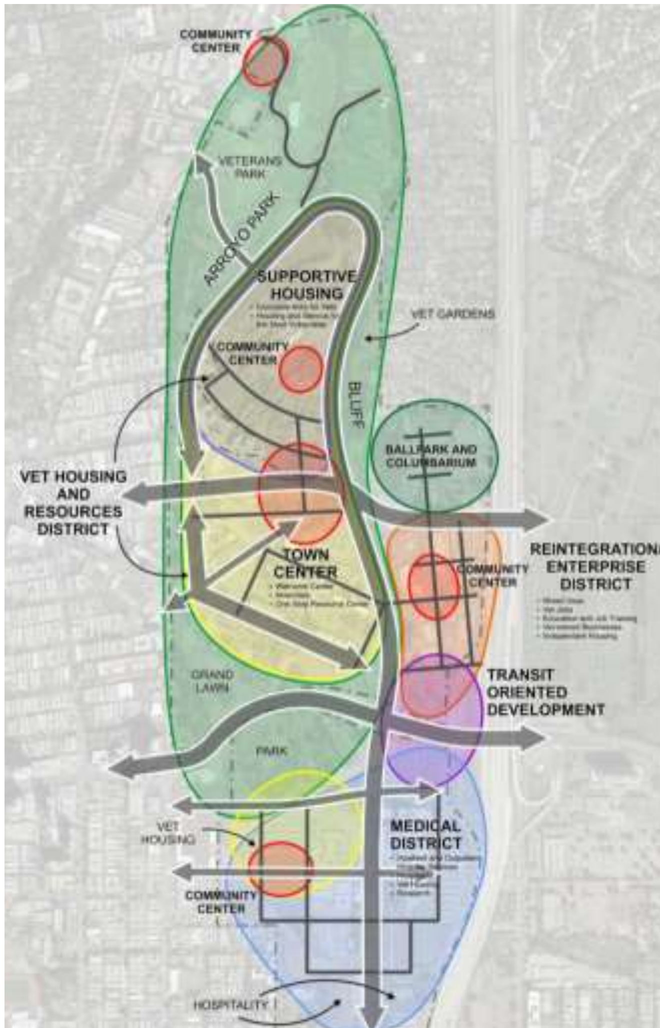
Evaluation Plans

- Patient Care and Teamwork
  - PACT and Hot spotter measures
  - Population management, quality of care
  - Cost-effectiveness analysis
  - Team function
- Education
  - All learning experiences by trainees and faculty
  - Curriculum effectiveness
  - Faculty effectiveness
- Work-life balance
  - Trainees, faculty, and HPACT teams

Agenda

- Innovations and future directions

Master Plan



- Revitalizes the 388-acre West Los Angeles campus:
  - 1,200 units of permanent supportive housing, focused on the chronically homeless, aging, disabled, and females with dependents
  - Services promoting health, vocational training, recreation, and family
  - Rehabilitation of historic structures
  - Town center and amphitheater
  - Patient care enhancements

Homeless Services Council

- To implement the Master Plan, the VA and its partners established a chartered collaboration that meets monthly
  - Incorporates community agencies, VA homeless services, VA recreational therapy, VA asset management, and more

- Ensures that services and activities on campus reflect the desires of Veterans and support homeless Veterans living on VA grounds or in the community

Whole Health

- An approach focused on well-being and complementary and integrative health approaches to optimize health and well-being – rolled out as part of the Master Plan

VA-UCLA Partnerships

- Financial commitment from UCLA to VA of over $1.65M/year
  - $300K in rent
  - $500K for a VA-UCLA Family Resource & Well-Being Center
  - $250K for a Homeless Mental Health and Addiction Center of Excellence
  - $300K for a UCLA Legal Clinic for Veterans
  - $200K for beautification and restoration of the campus

VA Homeless Programs – Vision

Mission Statement:

"To help Veterans rebuild their lives according to their goals and values, through recovery oriented health and wellness services, community partnerships, and a Housing First approach to homelessness; providing Veterans with the resources they want and need to be successful."

Guiding Principles:	
Teamwork	Continuous Improvement
Quality	Follow Through
Open & Proactive Communication	Hard Work

VA Homeless Programs – Priorities

- Collaboration
  - Across all programs
    - Examples include:
      - Hospital 2 Home (H2H) coordination between Grant Per Diem/HPACT programs
      - Hep A outbreak – across the homeless program, the VA is coordinating of resources, data, and intervention
      - VASH/HPACT collaboration to expand “teams” across program
- Continuous Improvement
  - Productivity reviews – unprecedented focus: coding workshops, time studies, monthly reports
  - Case conferences across programs
  - SOPs and policy creation and updates

Questions and Answers?

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