Addressing the Needs of Homeless Aging and Disabled Veterans

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Agenda

- Background: The Challenge of Providing Care to Aging and Disabled Homeless Veterans
- Utilization of Geriatrics and Extended Care (GEC) Services
- Engagement with Mental Health Services
- Strategies and resources to address the needs of aging homeless Veterans, including:
  - Increased Access to Geriatrics and Extended Care
  - Development of Specialized Care Settings
  - Site-based Models of Care
  - Community Collaborative Efforts
  - System Improvement Processes
- Discussion of Current and Future Directions in Homeless Programs

Background: The Challenge of Providing Care to Aging and Disabled Homeless Veterans

Poll Question #1

In your opinion, what is the most pressing need for aging and disabled homeless Veterans?

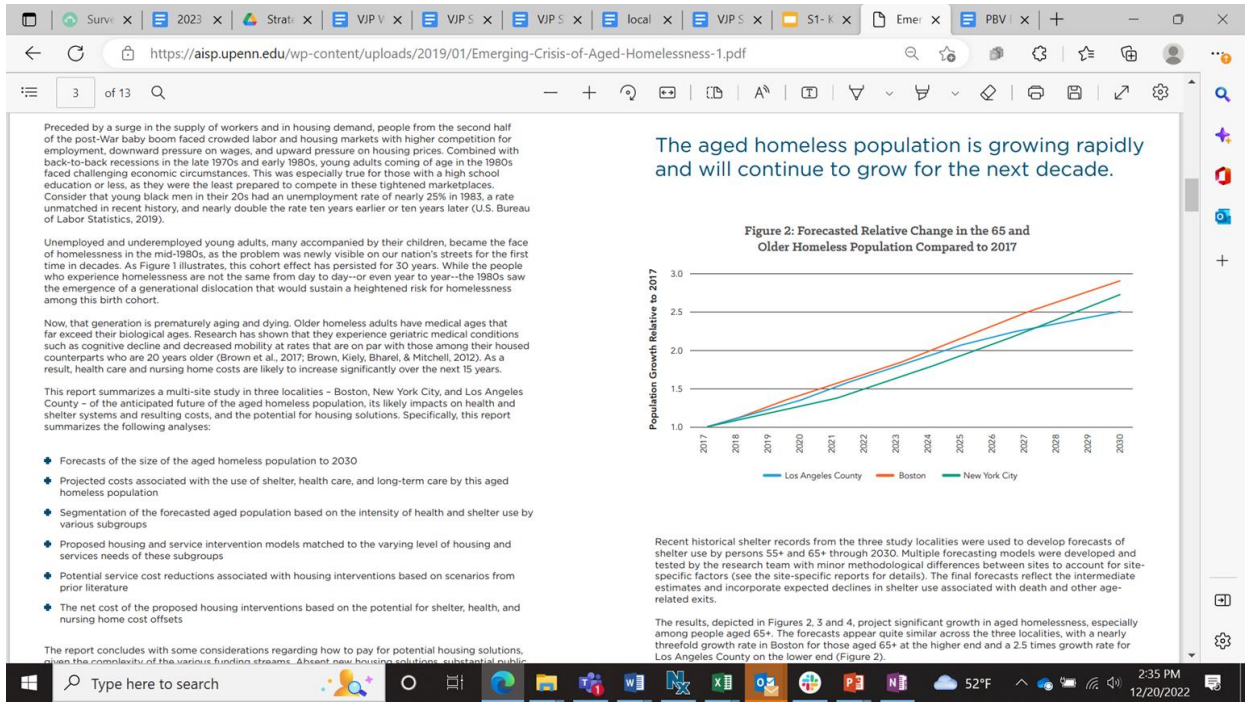
Background/The Challenge

- Almost half of Veterans enrolled with the Veterans Health Administration (VHA) are 65 or older.
- More than 60% of Veterans in the Housing and Urban Development-VA Supportive Housing (HUD-VASH) program are older than 60.
- It is expected that between fiscal year 2020 and fiscal year 2035, the subgroup of Veterans aged 85 and older is expected to increase by 66%, and specifically the subgroup of women Veterans aged 85 and older is expected to increase by 159%.
- Americans with three or more health challenges will double for populations between 65 and 75. By the age of 75, a majority of Americans have three or more chronic medical conditions.

Future Projections: A Growing Need

- Research shows the population of seniors 65+ experiencing homelessness will double or even triple 2017 levels in some places before peaking around 2030.

- Source: Dennis Culhane, Professor and Social Science Researcher at the University of Pennsylvania, https://works.bepress.com/dennis_culhane/223/



Emerging-Crisis-of-Aged-Homelessness-1.pdf (upenn.edu)

Aging Accelerated – Weathering

- Studies have suggested that prolonged exposure to economically adverse conditions such as extreme poverty and homelessness intersect with racial marginalization to age individuals faster when compared to individuals who have not experienced extreme poverty or racial marginalization.

- Sources:
  - The weathering hypothesis as an explanation for racial disparities in health: a systematic review - PubMed (nih.gov)
  - 'Weathering': The health effects of stress and discrimination (medicalnewstoday.com)
  - How poverty and racism 'weather' the body, accelerating aging and disease
  - Black Women Excluded from Critical Studies Due to ‘Weathering

UTILIZATION OF GEC SERVICES

GEC – Continuum of Care for Veterans of ALL Ages

Portfolio of GEC Programs

Ambulatory Care	Inpatient Acute	Home and Community-Based Long-Term Services and Supports	Facility Based Care	Hospice Care
Geri-PACT (Geriatric Primary Care) Geriatric Problem-Focused Clinic, Outpatient Palliative Care	Palliative Care Units, Palliative Care Consults, and Geriatric Consults	Adult Day Health Care, Home Based Primary Care, Homemaker Home Health Aide, Community Residential Care, Medical Foster Home, Respite, Skilled Home and Palliative Care, Veteran Directed Care	VA Community Living Centers, Community Nursing Homes, State Veterans Homes	Community Home Hospice and Inpatient Hospice

Equitable Access of Home and Community Based Services

Current VA Home Care Expansion

- The VA is currently undergoing one of its largest-ever multi-year expansions of Home and Community-Based Services to help Veterans remain in their home and “Age in Place” if it is safe for them to do so.

- The multi-year expansion includes:
  - Having Veteran-Directed Care (VDC) programs at all VA medical centers.
  - Having Medical Foster Home programs at all VA medical centers.
  - Adding 75 additional Home-Based Primary Care (HBPC) teams over three years.

Veteran Directed Care (VDC)

- Consumer-directed care for Veterans of all ages.
- Personal care and assistance with activities of daily living.
- Provided budget for hiring workers and for services.
  - Assistance by options counselor.
  - May hire family members.
- Must meet clinical eligibility criteria.

Home Based Primary Care

- Interdisciplinary team – Provider, Nurse, Social Worker, Dietitian, Pharmacist, Physical/Occupational Therapist, Mental Health Provider, Recreation Therapist.
- Essential care for the Veteran.
- Support to the caregiver.
- Education and training.
- Additional oversight in the home.
- Inspection process for Medical Foster Home.
- Help assess Veteran referrals to Medical Foster Home.
- Ongoing treatment planning.
- Open team communication.

Community Residential Care (CRC)

- For Veterans unable to live independently.
- Small family care homes or larger facilities.
- Inspected by a VA multidisciplinary inspection team.
- Oversight provided by Community Residential Care Coordinator.
- Social Work and/or Nurse case management to Veterans enrolled in the program.

Medical Foster Home

- Medical Foster Homes (MFH) are private homes in which a trained caregiver provides services for one to three individuals who require nursing home-level of care.
- VA inspects and approves all MFHs.
- MFH is an alternative to a nursing home. It is appropriate for Veterans who require nursing home care but prefer a non-institutional setting with fewer residents.
- The caregiver must live in the home and either own or rent the home.
- The MFH Coordinator completes monthly unannounced visits and provides oversight to ensure compliance.
- An interdisciplinary medical team (HBPC/SCI) provides care to the Veteran in the home.

Case Scenario

Orlando, FL's HUD-VASH and MFH Program

- HUD-VASH SW Leaders spearheaded a monthly call.
- Leadership from HUD VASH, GEC, and MFH met regularly to discuss the referral process.
- Identified a Veteran who was living in uninhabitable conditions with worsening symptoms.
- With some encouragement from his trusted HUD VASH team, Veteran agreed to move to MFH.
- Teams worked together to complete needed forms to develop the cost breakdown between housing and care costs.

Poll Question #2

What practices address high need/high cost for aging Veterans?

ENGAGEMENT WITH MENTAL HEALTH SERVICES

Aging Homeless Veterans/Mental Health Integration

- Shared Principles
- Likely Points of Entry
- Assessment and Evaluation
- Suicide Prevention
- Specialty Services (i.e., mental health and substance use disorder treatment)

Shared Principles

A Focus on Recovery

Whether a Veteran is facing a **mental health** concern, **substance misuse**, the effects of **military sexual trauma** or any of life's challenges, focusing on healing and recovery empowers them to take charge and live a fuller and more meaningful life. This approach builds on a Veteran's strengths and offers respect, honor and hope — to both the Veteran and the family members who support them.

Evidence-Based Treatments

VA provides mental health treatments that are proven to be effective for most Veterans. These scientifically tested and approved courses of treatment take place over defined periods of time, with a focus on helping Veterans meet their goals in recovery and in life.

To learn more, watch "'Evidence-Based' Treatment: What Does It Mean?" and other helpful videos at the **National Center for PTSD**. Explore the different types of **evidence-based therapy** available at VA.

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Shared Principles, cont.

Measurement Based Care (MBC)

- MBC provides Veterans the opportunity to take an active role in their mental health care. In MBC, the Veteran is part of their own treatment team, working with their providers to set recovery goals, develop treatment plans, establish benchmarks and monitor progress. The treatment is tailored to the individual Veteran's specific needs, and the metrics gathered along the way are used to determine whether treatment is working as planned or needs to be adjusted. VA is working to ensure that MBC is part of every one of its mental health programs.

Coordinated Care for the Whole Person

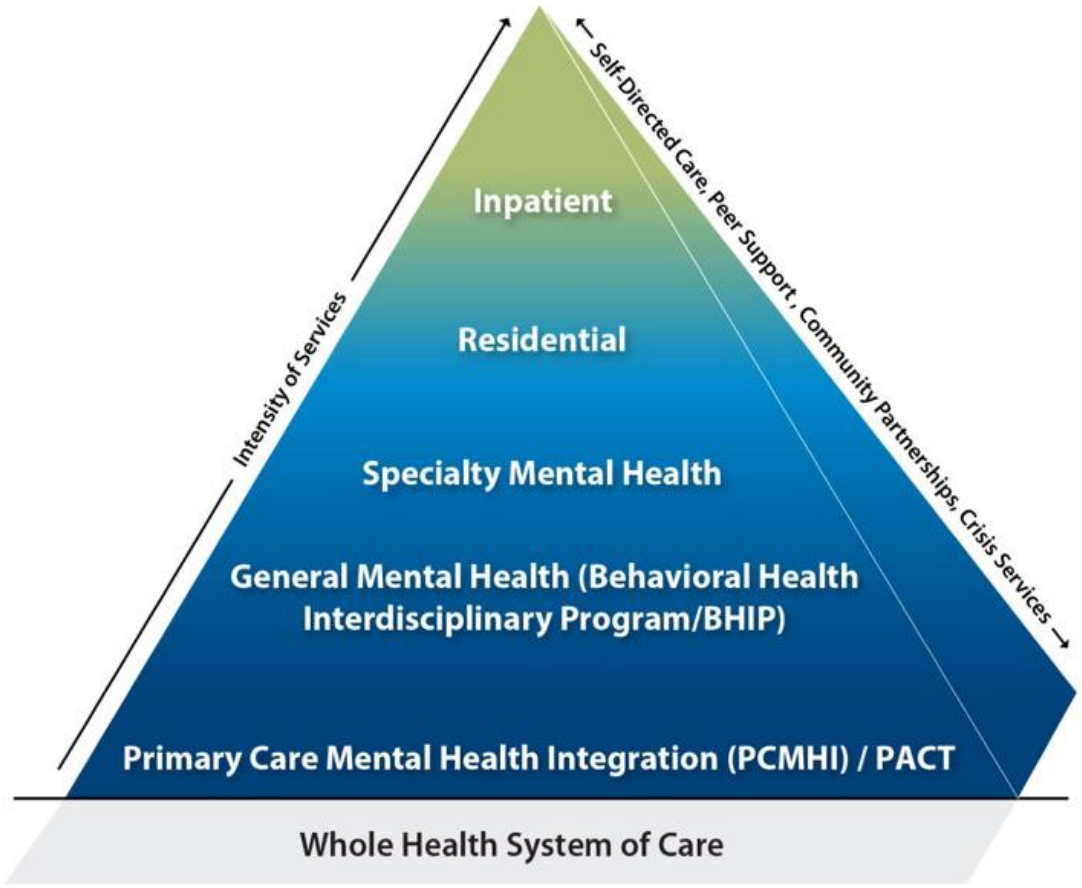
- Timely medical care, good nutrition, regular exercise, a sense of purpose and supportive family members and friends are just as important to mental health as they are to physical health. That's why VA health care professionals work together to provide safe and effective treatment for the whole person — head to toe, inside and out — using what's known as a "whole health" approach. Through VA Whole Health, Veterans take an active role in their care by partnering with their providers to achieve and maintain their optimal health and well-being. It all starts with answering a simple question: What matters most to you?

Shared Principles, cont.

Care Close to Home

- To improve Veterans' access to care, VA is adding more rural and mobile clinics and working with health care providers in smaller communities. VA also uses cutting-edge technologies — including mental health care by phone or secure video, self-directed apps for smartphones and text-based support — to deliver care to Veterans when they need it, wherever they are, even in the comfort of their own homes.

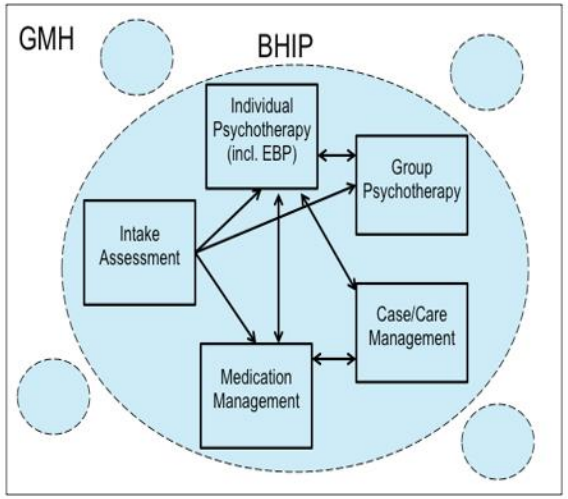
The Mental Health Continuum of Care



PRIMARY ⟷ **SECONDARY** ⟷ **TERTIARY**

General MH

- Self-Referral
- Community Referral
- Primary Care
- PC-MHI



- PCT
- SUD IOP
- Voc Rehab
- PRRC
- ICMHR
- RRTP
- Inpatient Care
- Emergent Care

Presentation and Referral

- Diagnostic Clarity
- Change in Functioning
  - After a stroke, brain injury.
  - Provider notices change in hygiene, weight.
  - Seems confused.
  - Trouble thinking in the context of known neurological disorder.
- Problems Functioning
  - Trouble managing medication.
  - Getting scammed.
  - The family or HUD-VASH Case Management Team notices home is unkempt, mail unopened.
- Concern over decision-making
  - Understanding medical treatment.
  - Ability to safely live alone, not with another family member.

Mental Health Specialty Considerations for Aging Veterans

Suicide Prevention and Older Adults

- Age distribution of the Veteran population is such that the highest number of Veteran suicides occurs among the ages 55-and-older cohort. Most Veterans are over age 54, with a median age of 65.
- Clinicians can help prevent suicide in Veterans ages 55 and older by:
  - Providing lethal means counseling, considering the role of health-related concerns and functional limitations on suicide risk
  - Utilizing integrated approaches to care that address both physical and mental health concerns
  - Making use of interventions that promote social connectedness.

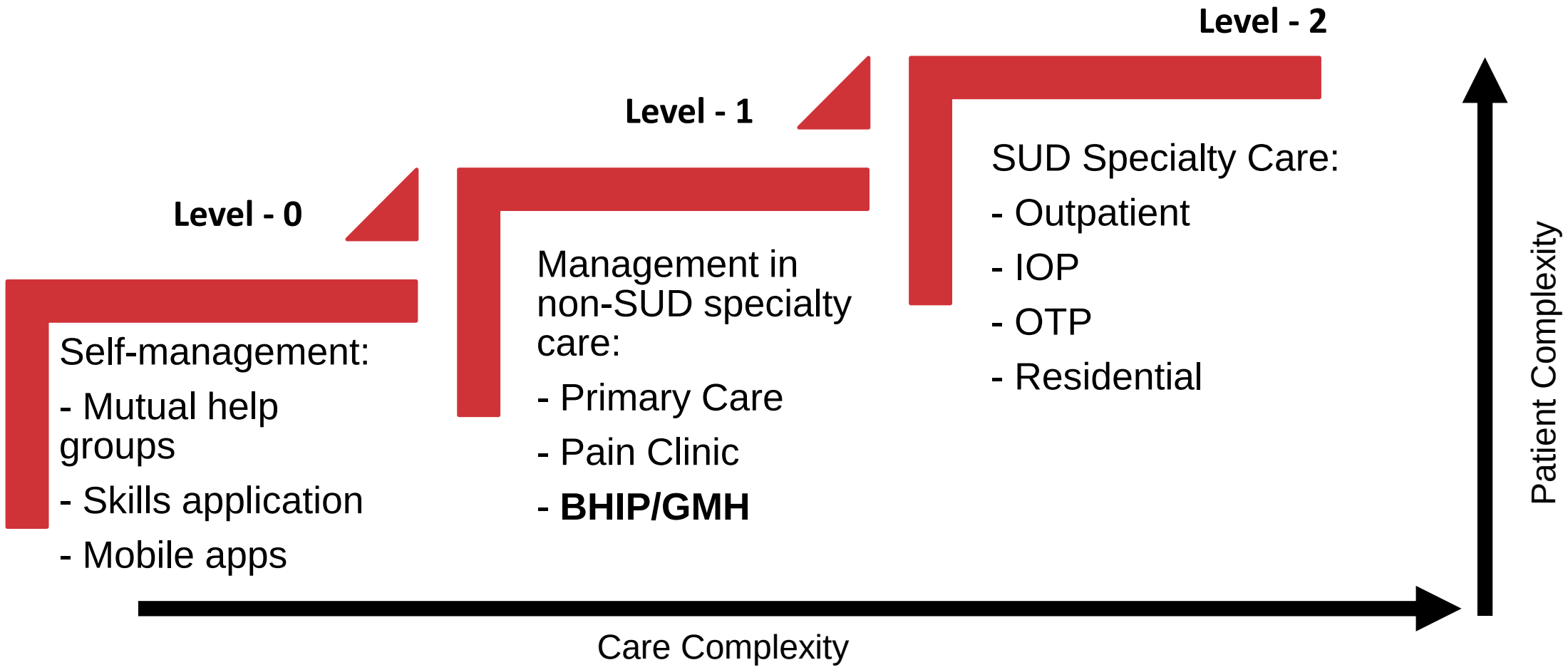
Suicide Prevention Risk ID

- Homeless Programs follow the Outpatient Mental Health screening requirements (e.g., screen at intake; screens in any MH program within 30 days waives intake screening requirement).
- Screening may occur in public settings (e.g., homeless shelter). Staff are expected to make every effort to conduct the screening in the most private area possible.
- Proactive planning even more important for this program.

Mental Health Residential Rehabilitation Treatment Programs(MHRRTP)

- Identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specific treatment of medical conditions, mental illnesses, addictive disorders, and homelessness. The residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility. Treatment intensity, environmental structures, milieu, and type of supervision vary based on population served, and need to be relevant to the diversity of the population, e.g., age, ethnicity, and culture.

Stepped Care for Substance Use Disorders

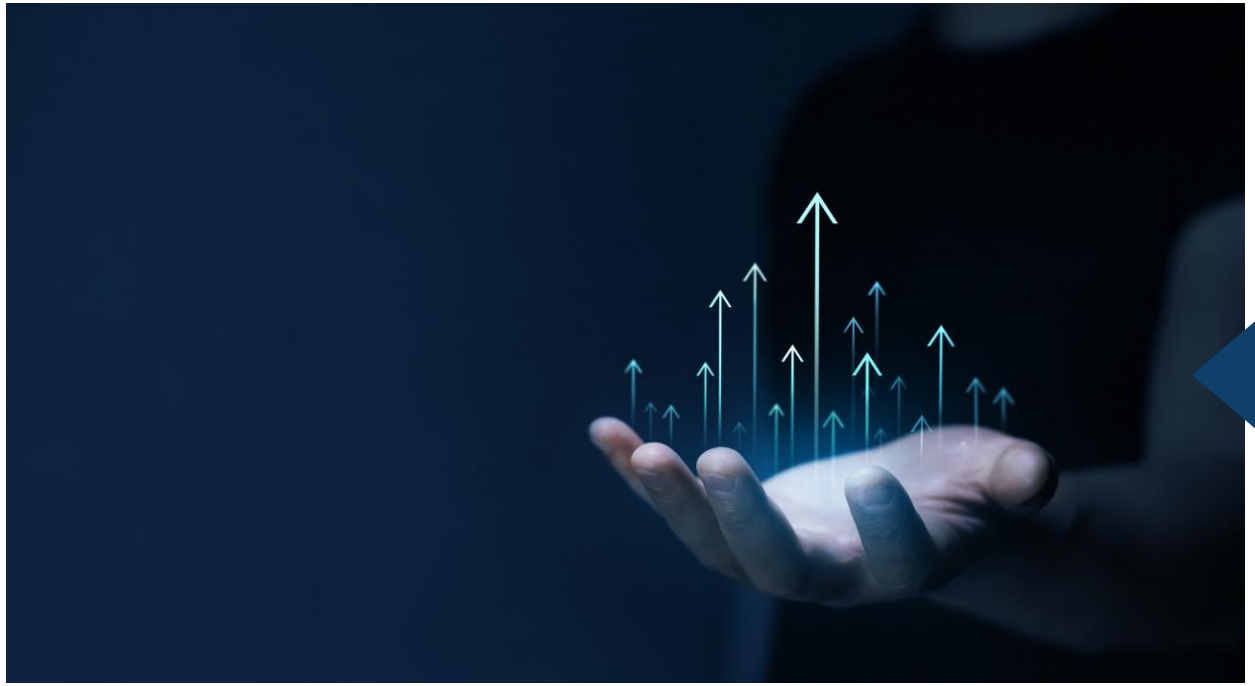


Poll Question #3

What is your level of understanding of strategies available in VA programs for aging homeless and disabled Veterans?

STRATEGIES AND RESOURCES

Strategies & Solutions (The Beginning)



- Increasing access to GEC services for Veterans experiencing homelessness.
- Developing housing options to assist with using HUD-VASH vouchers in specialized programs.
- Expanding the use of HUD-VASH project-based vouchers with intensive services that could be provided on-site.
- Proactively developing partnerships with community agencies.

Current Updates/Refinements

- Strategies and resources to address the needs of aging homeless Veterans including:

Increased access to Geriatrics and Extended Care	Focus on HBPC and Community Residential Care Programs
Special Housing Types	Development of specialized care settings
PBV Enhancement	Site-based models of care
Community Collaborative Efforts	Income Maximization (VBA, Medicare, Medicaid)
System Improvement Processes	Data Management

FUTURE DIRECTIONS

HUD-VASH Geriatric Specialists

- Provides administrative responsibility for the development of novel collaborations designed to meet the clinical and housing needs of aging and disabled homeless and/or formerly homeless Veterans.

- Accountable for clinical program effectiveness and modification of service patterns to aging homeless and/or formerly homeless Veterans with complex and chronic disabling disorders, including Veterans in advanced stages of chronic disease or nearing end of life.

- Has knowledge of screening, assessment, diagnosis, evidenced-based treatment recommendations, and systems of care for aging and/or disabled, homeless Veterans.

- Develop appropriate professional relationships with various medical center leadership and programs and community stakeholders and is responsible for communicating potential policy or protocol changes to local, VISN, and national level VA leadership where such changes would enhance the VA's ability to coordinate housing and supportive services for homeless, aging Veterans.

Communities of Practice

- VA Partnership Community of Practice:
  - HUD-VASH/GEC Community of Practice
  - Geriatric Specialist Community of Practice
  - Enhanced Project-Based Site Care Settings
  - Collaboration with Mental Health – Community of Practice Planning
  - Strategic Planning/Education
  - HBPC and Community Residential Care Focus

Project Based Voucher Development

Project-Based Housing with HUD-VASH Staffing Enhancements

- HUD-VASH is supporting PBV development to address aging and disabled Veterans through enhanced staffing models that provide site-based care provided by multidisciplinary teams.

- One such model is the development of project-based housing with enhanced on-site services for the aging population. An example of this model in action may be found in the Colma Veterans Village project discussed in this VA News article: HUD-VASH program provides comprehensive care for aging Veterans facing homelessness - VA News

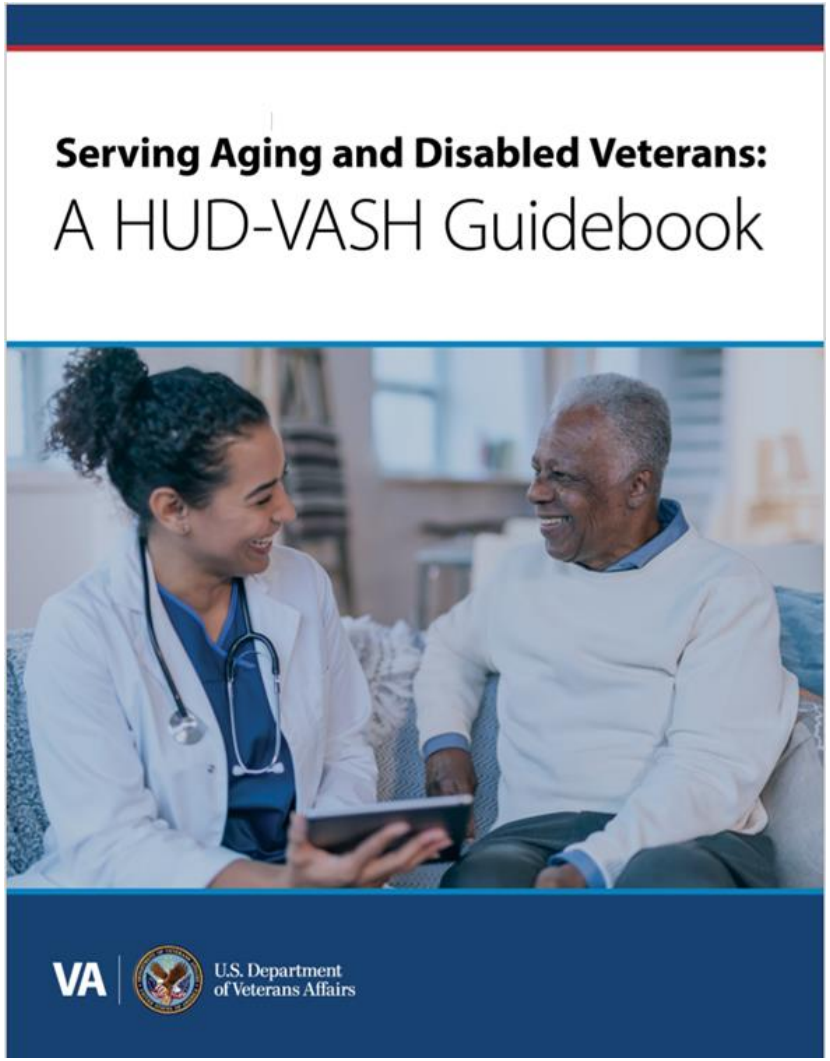
Project-Based Voucher Enhanced Sites

Health Care System	FY Funded
(V01) Bedford, MA HCS	2022
(V01) (631) Central Western Massachusetts HCS	2022
(V01) (650) Providence, RI	2022
(V02) (561) New Jersey HCS	2022
(V04) (646) Pittsburgh, PA HCS	2022
(V06) (659) Salisbury, NC HCS	2022
(V10) (541) Cleveland, OH HCS	2022
(V10) (506) Ann Arbor, MI HCS	2022
(V12) (537) Chicago, IL HCS	2022
(V12) (695) Milwaukee, WI HCS	2022
(V19) (442) Cheyenne, WY	2022
(V19) (660) Salt Lake City, UT HCS	2022
(V20) (648) Portland, OR HCS	2022
(V21) (612A4) N. California HCS	2022
(V22) (600) Long Beach, CA HCS	2022
(V22) (605) Loma Linda, CA HCS	2022
(V22) (644) Phoenix, AZ HCS	2022
(V23) (636) Nebraska -W Iowa HCS	2022

Health Care System	FY Funded
(V01) (523) Boston, MA HCS	2023
(V01) (650) Providence, RI HCS	2023
(V02) (630) New York Harbor HCS	2023
(V04) (460) Wilmington, DE HCS	2023
(V04) (642) Philadelphia, PA HCS	2023
(V07) (557) Dublin, GA HCS	2023
(V10) (757) Columbus, OH HCS	2023
(V12) (537) Chicago, IL HCS	2023
(V15) (589A4) Columbia, MO HCS	2023
(V16) (629) New Orleans, LA HCS	2023
(V20) (663) Puget Sound, WA HCS	2023
(V21) (612A4) N. California HCS	2023

Serving Aging and Disabled Veterans: A HUD-VASH Guidebook

- Released January 2023
- Located on the VHA Homeless Programs Hub and HUD-VASH Geriatric Specialist Teams Page for internal audiences
- Coming soon to VA's HUD-VASH website: U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program - VA Homeless Programs



Questions