Housing Navigator Toolkit

VA National Center on Homelessness among Veterans

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Acknowledgments

The U.S. Department of Veterans Affairs (VA) National Center on Homelessness among Veterans (the Center), through a collaboration with the Massachusetts Department of Veterans Services (DVS), and the Edith Nourse Rogers Memorial (ENRM) Veterans Hospital, is pleased to present this *Housing Navigator Toolkit,* to offer guidance to program staff, leaders, and administrators wishing to incorporate Housing Navigators into their service delivery structure, to work with homeless and formerly homeless Veterans. The Center would like to thank the Massachusetts DVS for allowing us to build from the knowledge obtained from their prior successful Navigator- and peer-based programs to further advance and structure the value of Navigators in VA homeless programs. We would like to thank Christine Croteau, Hospital Director, and Dan Berlowitz, Acting Chief of Staff of the ENRM Veterans Hospital, for their continued support, as well as Francisco Ureña, Secretary, and Matthew McKenna, Director of Communications and Intergovernmental Relations from the Massachusetts DVS, for their support of this project. We would like to especially thank Coleman Nee, President, At-Ease Strategies and former Secretary of the Massachusetts DVS, for his contributions to this project.

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We are excited to see the material included in this Toolkit be used in the field and we look forward to adding more material to this “living” document. We hope you find the information contained in this Toolkit useful in your day-to-day work with homeless and formerly homeless Veterans.

Sincerely,

Thomas P. O’Toole, M.D., Director
VA National Center on Homelessness among Veterans

Executive Summary

The United States Department of Veterans Affairs (VA) has made ending Veteran homelessness one of its top priorities, undertaking an unprecedented campaign to dramatically increase successful housing and treatment outcomes for homeless Veterans and their families, as well as for those Veterans who are at risk of becoming homeless. VA is working with a number of state and community-based partners (e.g., The 25 Cities Initiative) to ensure that every Veteran has access to permanent housing, and has embraced the use of innovative strategies aimed at identifying and engaging homeless Veterans, as well as Veterans at-risk of homelessness, in needed housing, clinical, and related social service programs.

Housing Navigator: "In collaboration with VA homeless program teams, Housing Navigators will work to prioritize Veterans' living in community-based stable housing by having a strong working knowledge of available resources (VA and non-VA) to link Veterans to needed programs, and by making warm handoffs whenever possible" (further defined in Chapter 1).

The VA National Center on Homelessness among Veterans (the Center), works to explore innovative programming and disseminate policy and best practices that can help VA and its partners end Veteran homelessness. Many different communities across the country are rolling out Housing Navigator programs to help homeless Veterans with their healthcare needs. Navigators are frequently being used to help homeless Veterans overcome barriers to housing and access needed treatment and/or support services. The initiatives described throughout this Toolkit share many of the same encouraging benefits of using Navigators as a valuable and knowledgeable resource to help with accessing healthcare and achieving positive housing outcomes. However, given the lack of clarity regarding the definition of a Navigator, in this Toolkit, we will discuss potential uses of the *Housing Navigator* for VA, drawing upon existing community and state examples, particularly examples set forth by the Commonwealth of Massachusetts Department of Veterans' Services (DVS). Within VA, Navigators will work to prioritize Veterans' living in community-based stable housing by having a strong working knowledge of available resources (VA and non-VA) to link Veterans to needed programs, and by making warm handoffs whenever possible.

This Toolkit is designed to provide Navigators, program managers, administrators, staff, and other key stakeholders working to end Veteran homelessness with a number of resources, tools, and ideas which can be used to help develop or refine local Navigator programming. The information contained in this Toolkit is intended to assist with the integration of Navigator programs into existing systems of care. This Toolkit can also be used to provide context for other provider staff (e.g., case managers, peer support specialists, healthcare providers, local

government agencies), who will likely collaborate with Navigators to help homeless Veterans overcome barriers to housing and engage in needed treatment services. Moreover, this Toolkit will become a "living" document that will be enhanced regularly to provide additional education and training for both VA and non-VA partners through the VA National Center on Homelessness among Veterans.

While this Toolkit has been tailored for policy makers and program managers at the federal, state, and local levels, the information contained herein is relevant to all stakeholders engaged in ending Veteran homelessness. This Toolkit contains a number of chapters targeted to the unique needs of different members of Navigator programs. Additionally, a number of supplementary tools and resources that can assist in the implementation of a Navigator program are included in the Appendices. Therefore, we encourage the reader to review those chapters and appendices that may be most relevant to their own collaborative efforts to better serve homeless Veterans.

Chapter 1: Overview & Background

Chapter 1 provides an introduction to VA's initiative to end homelessness. We also review some uses of Navigators in existing healthcare and housing programs, and define the potential role of Navigators in VA homeless programming.

a. VA Efforts to End Veteran Homelessness[1]

The United States (U.S.) Department of Veterans Affairs (VA) is the Nation's largest single provider of homeless treatment and benefits assistance services to Veterans, as well as their families who are also homeless or at risk of becoming homeless. VA has made ending Veteran homelessness one of its top priorities, undertaking an unprecedented campaign to dramatically increase successful housing and treatment outcomes for homeless Veterans, Veterans' families, and Veterans who are at risk of becoming homeless. As part of this campaign, VA is working with a number of state and community-based partners to ensure that every Veteran has access to permanent housing. For those Veterans who are homeless or at-risk of becoming homeless, VA has the capacity to quickly connect them to the help they need to achieve housing stability through a number of Veterans Health Administration's (VHA) homeless programs (see Appendix A). For VA, ending Veteran homelessness means that all Veterans have permanent, sustainable housing with access to high-quality healthcare and other needed support services.

In 2010, VA launched a comprehensive, evidence-based and outcome-driven strategy consistent with the United States Interagency Council on Homelessness (USICH) - *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*[2]. Since then, VA, along with its federal, state, and local partners, has made steady progress toward preventing and eliminating Veteran homelessness. The 2015 Point-in-Time (PIT) count estimated that in the United States there were 47,725 homeless Veterans on a single night in January 2015, marking a 35% reduction in Veteran homelessness between 2010 and 2015.[3] Further, VA has embraced the use of innovative strategies aimed at identifying and engaging homeless Veterans and Veterans at-risk of homelessness in housing programs, clinical care, and needed social services. Through the Homeless Programs Office (HPO), in Fiscal Year (FY) 2014, VHA provided services to more than 260,000 homeless or at-risk Veterans placing more than 53,000 Veterans in permanent housing. This number rises to over 72,000 when accompanying family members who were placed in housing are also included.

Strong interagency collaborations have resulted in the implementation of a number of successful policies and programs such as the use of Housing First principles with Veterans in the

[1] Information adapted from Programs for Homeless Veterans Fact Sheet December 2014
[2] *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* http://usich.gov/opening_doors/
[3] The 2015 Annual Homeless Assessment Report to Congress: Part 1

community, Rapid Re-Housing and Prevention services through programs such as Supportive Services for Veteran Families (SSVF), and by providing permanent housing through the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program. These programs, along with other VHA homeless programs (described in Appendix A), have been essential in reducing Veteran homelessness to date.

Moreover, the VA National Center on Homelessness among Veterans (the Center), works to explore innovative programming and disseminate policy, programs, and best practices that can help VA and its partners end Veteran homelessness. For example, the Center is assisting with the 25 Cities Initiative, a collaboration between VA, USICH, HUD, state and local governments, and community-based provider organizations. As part of this initiative, 25 communities with high concentrations of homeless Veterans are working to intensify and integrate their local efforts to end Veteran homelessness. These 25 cities are working to identify all of the remaining homeless Veterans in their respective communities by name, so they can establish and tailor permanent housing solutions for each homeless Veteran. In order to achieve the goals of the 25 Cities Initiative, VA is assisting these communities to strengthen and integrate the data systems used to end both Veteran and chronic homelessness, and also to further integrate the work and assets of the VA with the broader efforts to end chronic homelessness in these 25 cities. Many of these 25 cities have developed strategies to implement Housing Navigators in the fight against Veteran homelessness.

In this Toolkit, we will discuss potential uses of the Housing Navigator and other Navigator-type positions, drawing upon existing community and state examples, particularly those set forth by the Department of Veterans' Services (DVS) in the Commonwealth of Massachusetts, that are being used to assist Veterans in accessing housing and related healthcare services.

b. Brief introduction to Navigator Role

In this section, we provide a brief overview of some of the empirical evidence supporting the use of Navigators in both community-based and VA-specific service and treatment settings to help address the many different needs of homeless Veterans. The goal of this section is to highlight the benefits of using Navigators in treatment settings and areas where continued focus and increased use of Navigators may provide additional resources and gains for homeless Veterans.

Navigator services have been utilized among populations identified by their healthcare needs perhaps more than any other population. For example, Navigator programs developed by the American Cancer Society (ACS) have been used to assist low-income cancer patients overcome

several barriers to accessing care[3]. These included financial barriers, lack of available services for low-income patients, lack of transportation, distance from treatment services, lack of communication tools, lack of treatment and disease education, and lack of social support. For the ACS program, patient navigation was defined as a "barrier-focused" intervention that provided individualized services based on the unique needs of individuals who otherwise would face barriers to accessing needed screening, diagnosis, and treatment services. Although limited in the extent of its generalizability, efficacy of research investigating Navigator services in the field of cancer treatment indicated that navigation services helped improve screening and adherence to follow up treatment. However, there were limited and mixed results regarding the impact on disease development and timeliness of treatment initiation[4].

Over the past several years, there has been a growth of literature investigating the use of Navigators with similar results indicating that Navigator and/or Navigator-type programs have the greatest impact on increased screening (or entry into service). Additionally, a more recent review of the efficacy of patient navigation programs highlights the unique needs of individual patients as well as among communities of patients[5]. Other data have also suggested that regardless of whether or not patient navigation is directly linked to improved treatment outcomes, Navigator services are effective at linking patients to healthcare systems, and perhaps more importantly, patients themselves view Navigators as effective in providing emotional, informational, and logistical support, information, and problem-solving assistance[6]. Therefore, if a clinician or healthcare organization is considering the implementation of a Navigator program, it is important to assess the needs of the population to be served by that organization, and tailor the intervention to the specific needs of each patient.

Other healthcare navigation services have looked at enhanced case management services in increasing service engagement in HIV-positive communities. These studies suggest potential benefits of case management or patient navigation services, including increased therapy adherence[7], treatment engagement, and reduced HIV retroviral cell count[8]. As a result, best

[3] Matthews, B., Baldwin, L.M., Hannon, P., & Harris, J. (2007, September). The American Cancer Society's Cancer Resource Navigation Program: Clients' Program Use and Perceptions of Program Effectiveness https://depts.washington.edu/hprc/docs/acsnav1.pdf

[4] Wells, K.J., Battaglia, T.A., Dudley, D.J… & Raich, P.C. (2008). Patient navigation: State of the art or is it science? *Cancer, 113*(8):1999–2010.

[5] Paskett, E.D., Harrop, J.P., & Wells, K.J. (2011). Patient navigation: an update on the state of the science. *CA: A Cancer Journal for Clinicians, 61*(4), 237-249.

[6] Carrol, J.K., Humiston, S.G., Meldrum, S.C… & Fiscella, K. (2010). Patients' experiences with navigation for cancer care. *Patient Education and Counseling, 80*(2), 241-247.

[7] Kushel, M.B., Colfax, G., Ragland, K… & Bangsberg, D.R. (2006). Case management is associated with improved antiretroviral adherence and CD4+ cell counts in homeless and marginally housed individuals with HIV infection. *Clinical Infectious Diseases, 43*(2):234-42.

practice guidelines for increasing access and engagement to healthcare services in this population includes the use of Navigators, as well as case managers focusing on addressing a number of psychosocial barriers including housing, food, and transportation needs[9].

Similar results of increased access to care and improvement in health outcomes have been found in other healthcare areas including colorectal care[10], primary care[11], diabetes[12], and chronic illness among the elderly[13]. Similar findings have also been reported among mental health populations. In Georgia, a Navigator program was designed to reduce re-hospitalization and crisis team contact among individuals with Serious Mental Illness (SMI). In this project, Navigators could be mental health workers, a family member of someone in recovery, and/or peers in recovery who were "committed to providing extensive community-based, wraparound navigation services for consumers being discharged from inpatient care who have a history of recidivism"[14]. Although no outcome data are available to date, the program's developers did demonstrate increased knowledge and perceived self-efficacy among Navigators being trained as part of the program[15]. Other research has looked at the addition of a *Systems Navigator* in the delivery of comprehensive depression care among individuals with complex health needs, and found that overall, the intervention group had significant decreases in depression scores as

[8] Bradford, J.B., Coleman, S., & Cunningham, W. (2007). HIV System Navigation: an emerging model to improve HIV care access. *AIDS, Patient Care and STDs 21*(Suppl 1), S49-S58.

[9] Thompson, M.A., Mugavero, M.J., Amico, K.R… & Nachega, J.B. (2012). Guidelines for improving entry into and retention in care and antiretroviral adherence for persons with HIV: evidence-based recommendations from an International Association of Physicians in AIDS Care panel. *Annals of Internal Medicine, 156*(11):817-833.

[10] Lebwohl, B., Neugut, A.I., Stavsky, E… & Rosenberg R. (2011). Effect of a patient navigator program on the volume and quality of colonoscopy. *Journal of Clinical Gastroenterology, 45*, 47-53.

[11] Ferrante, JM, Cohen, DJ, & Crosson, JC. (2010). Translating the patient navigator approach to meet the needs of primary care. *Journal of the American Board of Family Medicine, 23*(6), 736-44.

[12] Ell, K., Katon,W., Xie, B… & Chou, C.P. (2010). Collaborative care management of major depression among low-income, predominantly Hispanic subjects with diabetes: a randomized controlled trial. *Diabetes Care, 33*(4), 706-713.

[13] Manderson, B., McMurray, J., Piraino, E., & Stolee, P. (2012). Navigation roles support chronically ill older adults through healthcare transitions: a systematic review of the literature. *Health and Social Care in the Community, 20*(2), 113-127

[14] Compton, M.T., Hankerson-Dyson, D., Broussard, B…& Thomas, G.V. (2011). Opening doors to recovery: a novel community navigation service for people with serious mental illnesses. *Psychiatric Services, (62)*11, 1270-1272.

[15] Compton, M.T., Reed, T., Broussard, B… & Haynes, N. (2014). Development, implementation, and preliminary evaluation of a recovery-based curriculum for community navigation specialists working with individuals with serious mental illnesses and repeated hospitalizations. *Community Mental Health Journal, 50*(4), 383-387.

well as improved health outcomes[16]. However, the use of Navigators among mental health client populations needs to also assist clients in accessing general medical services[17].

c. Use of Navigator Services among Homeless Client Populations

In addition to their use in healthcare settings, Navigators are also frequently used in helping homeless individuals overcome barriers to housing and in accessing needed treatment and/or support services. Many different communities are rolling out Navigator programs to help homeless populations with their housing and healthcare needs. These include programs in San Diego, Connecticut, San Francisco, Florida, and North Carolina, among other states. Many of these programs are built upon partnerships among cities, counties, and government as well as private partners, including VA. One of the most promising examples of a housing Navigator program is the H3 program in Maricopa County, Arizona[18]. H3 initially began as prioritizing the 50 neediest homeless individuals in the county (successfully housing 49 of those individuals), with a 95% housing retention rate. In addition to these promising housing numbers, results from an impact study conducted by Arizona State University found a drastic reduction in arrests, ER visits, substance use disorders, and homelessness.

The H3 program, through strategic partnerships with the Carl T. Hayden VA Medical Center in Phoenix, used Navigators to reduce the number of Veterans in transitional housing thereby allowing for a number of HUD-VASH housing vouchers to be used specifically for unsheltered chronically homeless Veterans. H3 Navigators then assisted other Veterans in obtaining permanent housing by working with other local partners also engaged in the initiative. H3 defines the role of the Navigator as being characterized by outreach, engagement, case management, and natural support. However, it is important to note that in a number of instances, Navigators are peers who are in their own recovery (typically from substance use and/or mental illness) and are employed by a community-based behavioral health system.

Phoenix is one of the cities participating in the 25 Cities Initiative to end Veteran and chronic homelessness described earlier in this chapter. The initiative is part of the VA's Five Year Plan to End Homelessness among Veterans and focuses on intensifying efforts to find housing in those cities with high concentrations of homeless Veterans. One primary goal of the initiative is to enhance integration of federal, state, and community stakeholders in this mission, and form

[16] Ell, K., Katon, W., Xie, B., Lee, P.J., Kapetanovic, S., Guterman, J., & Chou, C.P. (2010). Collaborative care management of major depression among low-income, predominantly Hispanic subjects with diabetes: a randomized controlled trial. *Diabetes Care, 33*(4), 706-713.

[17] Kelly, E, Fulginiti, A, Pahwa, R, Tallen, L, Duan, L, & Brekke, JS (2014). A pilot test of a peer navigator intervention for improving the health of individuals with serious mental illness. *Community Mental Health Journal, 50*(4), 435-436.

[18] Bean, KF, Shafer MS, & Glennon M. (2013). The impact of housing first and peer support on people who are medically vulnerable and homeless. *Psychiatric Rehabilitation Journal, 36*(1), 48-50.

or strengthen the continuum of care within each participating city by integrating the resources of multiple agencies, when possible. This is done through a variety of assessment and tracking tools, as well as through coordinated efforts to staff programs across the continuum of care of these different communities. In many of the participating communities of the 25 Cities Initiative, one nexus of such integration is use of a *Housing Navigator*.

Many cities participating in the 25 Cities Initiative are using Navigators as key staff working towards meeting housing goals. Most of the cities utilize matching systems like the Coordinated Assessment and Housing Placement System (CAHP) and Homeless Management Information System (HMIS), and their Navigators typically meet weekly for case conferences. For example, Baltimore has over 70 Navigators participating from over 30 different agency partners with 175 of the most vulnerable clients being matched to a Navigator. In New Orleans, 116 high need individuals are being assisted through a housing navigation group, in which multiple community organizations participate. In New York City, over 100 partners and stakeholders participated in the 25 Cities Initiative launch, and in Tampa, 261 Veterans have been paired with a Navigator.

In order to avoid confusion of roles, this Toolkit draws upon the following definition of Navigator:

In collaboration with VA homeless program teams, Housing Navigators will work to prioritize Veterans' living in community-based stable housing, by having a strong working knowledge of available resources (VA and non-VA) to link Veterans to needed programs, and by making warm handoffs whenever possible.

Navigators will have a comprehensive knowledge of VA, state, county, city, and community resources including not only housing options, locations, and availability, but also services including health, mental health, benefits, employment, and transportation, etc. The Navigator will use this knowledge to facilitate 'active' linkages before, during, and/or after permanent housing has been established as well as work with Veterans to enhance their skills in utilizing these various resources, which are critical to the maintenance of permanent housing.

The Navigator will be responsible to follow assigned Veterans to and among these services throughout the path to permanency. In collaboration with the VA homeless program team, they will understand each Veteran's individual needs and develop a plan that identifies the unique services and referrals necessary to meet those needs. These paths to permanency may require that the Navigator work as an advocate, a referral agent, a coordinator or facilitator with VA, other government agencies, and community partners' systems.

Chapter 2: The Role of Navigators in Addressing Homelessness among Veterans

Chapter 2 focuses on the role of Navigators in ending Veteran homelessness and identifies the broad array of organizations, systems, and services which Navigators must be familiar with in order to best serve their Veteran clients. Special attention is paid to the multitude of challenges homeless Veterans may face in their everyday lives, including mental health, substance use, financial, and family issues, as well as issues surrounding the criminal justice system. This chapter defines the Housing Navigator's role and distinguishes it from the role of case managers and peer support specialists who may also be helping the homeless Veteran.

a. Introduction

For many chronically homeless Veterans, the pathway to homelessness was complex. Therefore, the transition from homelessness to stable housing is similarly winding, and at times indirect. Transitioning into housing requires engaging with a wide variety of agencies and organizations, each with its own practices and cultures. Individuals with limited resources can easily be discouraged or overwhelmed by the sheer volume of paperwork and time it may take to meet the requirements of each organization with which they will come into contact. Any roadblocks on the path to stable housing could lead to an unnecessary detour from the final goal. The use of Navigators with homeless Veterans to assist in accessing housing and needed support services is one promising tool that has recently emerged within systems providing services to homeless Veterans.

In order to assist Veterans with successfully finding stable housing, the Navigator must be able to work across the many organizations with which the Veteran needs to become engaged. Chronically homeless Veterans may face health, mental health, and/or substance use problems that either preceded their homelessness or developed while homeless. Further, since some Veterans are not eligible for VA healthcare services, they could be engaged with community health and mental healthcare providers. Outside of the healthcare system, Veterans may come into contact with representatives from the local Public Housing Authority (PHA), housing providers organized under the HUD Continuum of Care (CoC), the criminal justice system, substance abuse treatment providers, and service providers funded by the U.S. Department of Labor (DOL), which assists homeless Veterans through the Homeless Veterans' Reintegration Program (HVRP).

Navigators must be prepared to address barriers to stable housing that may arise from a multitude of areas and be familiar with available VA and non-VA resources. This chapter reviews some of the challenges homeless Veterans face; provides an overview of relevant resources; and introduces the role of the Navigator in addressing housing-specific issues, as well as health, mental health, and substance use disorder (SUD) treatment, economic and

justice needs; and provides examples of specific tasks for which a Navigator may be responsible.

b. Health, Mental Health, and Substance Use

The healthcare needs of homeless Veterans are complex and often poorly managed while living on the streets and/or in temporary shelters. In a survey of homeless Veterans, conducted by the 100,000 Homes campaign, 27.3% of Veterans reported tri-morbid health conditions (concurrent physical illness, mental illness, and substance abuse conditions). The same survey also found that over 20% of Veterans had used the Emergency Department (ED) over three times in the past year[19]. Permanent supportive housing has been shown to be effective at reducing the high costs of public and emergency health services among homeless individuals with serious mental illness (SMI).[20] Housing provides the stability to address health, mental health, and SUD treatment needs. However, without a network of ongoing, intensive, and integrated support services, many Veterans are unable to maintain housing, once placed. Overall, Veteran and non-Veteran homeless populations have similar rates of alcohol and substance abuse, but studies have not shown a consistent relationship between Veteran status and rates of mental illness or health status. However, Veterans do face unique health and mental health challenges related to their service, such as Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBIs), combat injuries, and Military Sexual Trauma (MST).[21] Thus, Veteran-centric care is often appropriate for homeless Veterans.

<u>Health, Mental Health and Substance Use Resources</u>

If enrolled, the primary source of health and mental health care should be the local VA Medical Center (VAMC) and/or Community Based Outpatient Clinics (CBOC). If a Veteran is not enrolled in VA healthcare, the Navigator should work with the homeless program team and assist the Veteran in this effort. There will be many portals for enrolling the Veteran, through existing methods developed by the local VA's homeless program, the Homeless Patient Aligned Care Team (HPACT), or if not currently working directly with VA homeless programs, the Navigator can assist with a referral to a VAMC representative in the eligibility office. Most often, this person is located in VA's Medical, or Health Administrative Service (MAS or HAS) office. The healthcare of the Veteran will be coordinated by the VA homeless program team and ancillary providers. The Navigator should assist in this role by ensuring the Veteran is able to seek, access, and coordinate care.

[19] National Survey of Homeless Veterans in 100,000 Homes Campaign Communities. (2011): 100,000 Homes Campaign. https://100khomes.org/sites/default/files/images/NationalSurveyofHomelessVeterans.pdf

[20] Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate, 13*(1), 107-163.

[21] Balshem, Howard, Christensen, Vivian, & Tuepker, Anais. (2011). *A critical review of the literature regarding homelessness among Veterans*. Department of Veterans Affairs.

Various options exist for the treatment for alcohol and/or drug use through the VAMC and in coordination with VA homeless programs and/or in the community. Many VA homeless programs coordinate this treatment with local VAMCs to assist the Veteran in receiving the most appropriate care, based on his/her enrollment in the program. For example, transitional/bridge housing programs under contract with VA provide supportive services, while VAMCs may provide more intensive inpatient or outpatient SUD treatment. Treatment in the community may be an option for a Veteran. For those community options, treatment should be evidence-based. The U.S. Substance Abuse and Mental Health Services Administration (SAMSHA) provides a comprehensive overview of Evidence-Based Practices.[22] During treatment for alcohol or SUD, it is important that Relapse Prevention be part of any strategy. The Navigator should provide assistance to VA homeless program staff to ensure care is coordinated and follow-up is provided.

Role of Navigator in the Healthcare System

One of the primary tasks that Navigators can assist with is connecting Veterans with healthcare benefits and available providers. Housing offers the foundation needed to address healthcare needs, but it must be combined with support services that enable Veterans to access the care necessary to manage health and mental health conditions. Along with case managers and peer specialists, Navigators are tasked with linking homeless Veterans to needed healthcare services while addressing barriers to accessing that care, all while preparing the Veteran for housing. While the Navigator does not have the clinical skills of professionals in hospitals or clinics, s/he is uniquely positioned to act as a bridge between the Veteran and clinicians, and advocate on behalf of the Veteran to obtain housing and 'navigate' health systems.

The Navigator is particularly important during the transition from inpatient care to a community setting. A warm hand-off facilitated by a Navigator could make a difference between ongoing homelessness and maintaining stable housing. While there are no existing studies on Navigators, similar interventions have been investigated. In a study of a Brief-Critical Time Intervention (B-CTI) for Veterans with SMI, a nurse or social worker was tasked with engaging a Veteran before discharge and for three months after discharge. Similar to a Navigator, in B-CTI the nurse or social worker "builds rapport, develops individualized treatment goals, identifies barriers to treatment, and establishes a case management plan."

The study found that those randomly assigned to the B-CTI were more likely to engage with outpatient services and to experience continuity of care. [23]

[22] See: http://www.samhsa.gov/ebp-web-guide

The Navigator's role in health, mental health, and SUD treatment will be specific to each individual Veteran, but will always be focused on ensuring that the Veteran has the resources he or she needs to overcome barriers to care and ensure that system fragmentation does not prevent continuity of care. Below are a few examples of potential health-related challenges and tasks that the Navigator may perform.

Within the healthcare system, Navigators may be responsible for:

- Assisting Veterans with transportation to appointments and group meetings (e.g. AA/NA, outpatient SUD treatment, primary care appointments);
- Engaging with Veterans who are hospitalized or in inpatient treatment to help facilitate continuity of care;
- Assisting Veterans with applications for health insurance and other related benefits;
- Modeling healthy living for Veterans and providing encouragement and support; and
- Assisting Veterans with finding appropriate community supports, social activities, and spiritual supports to encourage sobriety and health.

Potential Healthcare System Challenges and Navigator Responses	
Potential Challenge	Potential Navigator Tasks
Scenario #1: A chronically homeless Veteran drinks every day and is worried that if he goes into shelter, he will be forced to stop drinking. He suffers from multiple health conditions related to his alcoholism and living on the streets. If he does not move into housing soon he may succumb to his illness.	• Administer comprehensive housing assessment to determine his vulnerability and prioritize him for supportive housing. • Make repeat visits to develop a rapport with the Veteran and explain that the Housing-First model embraced by the VA and its providers does not require sobriety. • Provide assistance with obtaining necessary documents and completing a housing application. • Reach out to local healthcare workers who work with chronically homeless individuals to begin to address urgent healthcare needs.
Scenario #2: A formerly homeless Veteran has poorly controlled diabetes. He has trouble monitoring his insulin levels and is not eating well. He ends up in the ER.	• Be present at the discharge from the hospital and provide reminders and transportation for follow-up medical appointments. • Ensure that the Veteran has prescriptions and remind the Veteran to monitor his insulin and take necessary medications. • Connect the Veteran to a diabetes educator or diabetes support group in the community. • Provide transportation to a grocery store so that the Veteran can eat healthier options.
Scenario #3: A formerly homeless Veteran with a co-occurring mental health and substance-use disorder has recently left outpatient treatment and has moved into	• Assist Veteran with transportation to AA/NA meetings by driving the Veteran to meetings or taking public transit with the Veteran the first meeting(s). • Assist the Veteran with obtaining public transit passes.

an apartment using a HUD-VASH voucher, but does not have a car and does not know the local transportation system.	

c. Economic

A key component of homelessness is poverty. Many homeless Veterans are among the working poor, or are disabled and unable to work. A recent study found that for many homeless Veterans, community-based employment is a goal, but homeless Veterans have experienced high rates of unemployment, and have been particularly hard-hit by the recent recession.[23] Employment challenges are often entangled with histories of substance use, mental health disorders, disability, and criminal records. Challenges with employment may arise both as Veterans search for and begin employment. Maintaining a job can be as challenging as finding work.

For parents with young children, childcare is essential in sustaining employment, however affordable childcare is often difficult to secure and for those without fixed schedules or who work outside of traditional hours, coordinating childcare can be difficult. Transportation can also be a challenge, particularly in areas that are not served by public transportation. In addition, despite higher rates of education than their non-Veteran homeless counterparts and the skills they acquired in the military, Veterans often have difficulty translating their military-based skillset to the civilian job market.

<u>Economic Resources</u>

Essential to maintaining housing is a reliable source of income. In order to assist Veterans interested in employment, Navigators should be aware of VA and community-based employment programs available to the Veterans they serve. Therapeutic and Supported Employment Services (TSES) programs commonly referred to as Compensated Work Therapy (CWT) and Vocational Rehabilitation and Employment (VR&E), may be particularly appropriate for homeless Veterans who need specific or intensive services and support to achieve the goal of community-based employment. To be eligible for VR&E, Veterans must be VA eligible and have a service-connected disability rating. Veterans are paired with a Vocational Rehabilitation Counselor who in conjunction with input from the Veteran, develops an individualized rehabilitation plan. The plan clearly states independent living and/or employment goals and also identifies the resources and steps needed to achieve those goals. In addition to VA employment programs, the Navigator should be aware of local and state employment services as eligibility for CWT and VR&E programs is limited.

[23] O'Connor, K., Kline, A., Sawh, L… & Smelson, D. (2013). Unemployment and Co-occurring Disorders Among Homeless Veterans. *Journal of Dual Diagnosis*, *9*(2), 134-138.

For homeless Veterans, the Department of Labor's (DOL) Homeless Veterans' Reintegration Program (HVRP) and the VA's Supportive Services for Veteran Families (SSVF) program are additional resources. HVRP provides grants to non-profit organizations to deliver case management and peer support to homeless Veterans seeking community-based employment. Services may include job placement, training, job development, career counseling, resume preparation, and assistance with transportation. Though focused on rapid re-housing and homeless prevention, community-based non-profit organizations funded through the SSVF program are also able to assist Veterans with job search costs. In the course of assisting Veterans in staying housed or finding stable housing, SSVF providers are able to help Veterans with transportation, childcare, budgeting, and other activities of daily living. In many instances, non-profit organizations may receive grants through both HVRP and SSVF. When this is not the case, strong relationships between local HVRP and SSVF providers can benefit to Veterans who seek community-based employment.

For some Veterans, the path to economic stability may involve taking advantage of educational benefits and acquiring new skills at a community college or university. Commonly known as the GI Bill, depending on the nature of service, many Veterans have access to federal assistance with paying for higher education. In addition, the VR&E program can assist in paying for education for eligible Veterans. In addition to paying tuition, the VA will assist with housing and living expenses while the Veteran is in school.

Role of Navigator in Economic Systems

For nearly every homeless Veteran, it will be essential to address the economic challenges that have contributed to their homelessness. Navigators must be prepared to assist Veterans with completing applications for a range of benefits that can provide income while they are unable to work. For those who are able to work, the Navigator can provide essential logistical support and encouragement during the job search and while establishing employment. For those who are unable to work due to disability, Veterans may be able to access specific benefits through VA or Social Security. In addition, some states offer complementary programs. Access to benefits could mean the difference between being able to make a regular rent payment or returning to homelessness. Veterans may be unaware of these programs or overwhelmed by the process of obtaining assistance. Thus, Navigators should be knowledgeable of the resources and assist Veterans in accessing these benefits.

Some of the essential tasks of the Navigator include:

- Advising the Veteran of available employment and education support programs and assisting with applications.

- Advising the Veteran of available income support programs and assisting with applications.
- Providing transportation to job interviews and assisting the Veteran with developing strategies for getting to work on-time.
- Assisting the Veteran with finding childcare.
- Assisting the Veteran with budgeting and establishing necessary financial skills (e.g., opening a savings account).
- Assisting the Veteran with job search skills (e.g., resume writing, interview skills).

Potential Economic and Employment Challenges and Navigator Responses	
Potential Challenges	Potential Navigator Tasks
Scenario #1 A single-mother Veteran has recently moved from shelter to an apartment with a HUD-VASH voucher. She would like to work, but needs childcare.	• Assist Veteran with application for Head Start and/or voucher for childcare. • Connect Veteran to the local HVRP service provider. • Assist Veteran with locating childcare providers in the area that accept vouchers.
Scenario #2 A Veteran with a service-connected disability is currently unemployed, but would like to work in the community.	• Connect Veteran with the VA VR&E program. • Assist Veterans with writing a resume and practicing interview skills. • Ensure that the Veteran is receiving all applicable income supports from the VA and Social Security.

d. Housing

By definition, a primary challenge for every homeless Veteran is finding affordable housing. In 2014, 11% of homeless adults, or 49,933 individuals, were Veterans.[24] In addition, many Veterans live with extreme rent burdens. A recent report by the National Low Income Housing Coalition estimated that over 1.5 million Veteran households pay more than 50% of their income for housing. Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND) Veterans were more likely than Veterans of prior eras to experience severe housing cost burdens.[25] In addition, Veterans who are racial minorities, women, and disabled Veterans were more likely to experience extreme housing cost burdens. Solving the problem of Veteran homelessness will require finding affordable housing for homeless individuals and families who are homeless today and also ensuring that those who are facing severe housing cost burdens stay housed. The HUD-VASH program is focused on targeting chronically homeless Veterans who need intensive case management, while the SSVF program targets resources to prevent homelessness and rapidly rehouse Veterans and families. While

[24] Henry, Meghan, Cortes, Alvaro, Shivji, Azim, & Buck, Katherine. (2014). *The 2014 Annual Homeless Assessment Report to Congress*. Retrieved from https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf.
[25] Arnold, Althea, Bolton, Megan, & Crowley, Sheila. (2013). Housing instability among our nation's Veterans. Washington, D.C.: National Low Income Housing Coalition.

these resources are valuable, the Navigator may also need to look beyond these two programs for some Veterans.

Housing Resources

Local public housing agencies (PHA's) are an important piece of the puzzle in ending Veteran homelessness. Local PHA's are key gatekeepers to affordable housing in many communities. PHA's operate public housing programs and administer the Housing Choice Voucher program, also known as Section 8. In addition, in partnership with the local VAMC, PHA's also administer the HUD-VASH program for chronically homeless Veterans.

Community providers funded under the VA's Grant and Per Diem program (GPD) may offer transitional, bridge, and safe haven housing for Veterans. Local GPD programs can serve as a transition to permanent housing. Additionally, VAMCs contract in many areas with providers to offer community-based residential care, including low demand programs designs, through VA's Health Care for Homeless Veterans (HCHV) Programs. Navigators can assist Veterans' 'transition' by utilizing these programs if additional time is needed to secure permanent housing.

Many community organizations receive funding through VA's Supportive Services for Veteran Families (SSVF) program. Providers that have developed SSVF programs are able to assist Veterans and their families in transitioning to permanent housing by offering rapid re-housing options as well as various wraparound services. Navigators should coordinate with these providers as they offer services valuable in assisting Veterans move to permanency.

Depending on funding streams and program goals Veterans may be given preference in housing assistance through programs that are not Veteran specific. Again, the Navigator must have knowledge of affordable housing providers and supportive housing programs in the community. Permanent housing, transitional housing, and homeless assistance providers that receive assistance from HUD are organized through local CoCs. The Navigator should be well connected to the local CoC administration and its members, and attend scheduled CoC meetings when possible.

Role of Navigator in Housing Systems

In cities like New Orleans and Los Angeles, the primary goal of the Navigator has been to conduct outreach to identify homeless Veterans and then ensure that the Veteran completes the application for appropriate housing assistance, typically a HUD-VASH voucher. In addition to the essential work of obtaining housing, we propose a model utilizing the Navigator, in which the Navigator remains engaged with the Veteran so that when barriers arise, the Navigator is able to assist the Veteran**.**

Essential responsibilities of the Navigator include:

- Identifying homeless Veterans living in the community;
- Conducting a comprehensive housing assessment using a Vulnerability Index[26] (e.g., Vulnerability Index-Service Prioritization Decision Assistance Tool ,VI-SPIDAT);
- Assisting the Veteran with obtaining the necessary documentation to prove Veteran status (DD-214), identification, and other documentation to apply for housing;
- Assisting the Veteran with completing the housing application;
- Constant communication with housing providers and landlords to identify potential apartments for Veterans;
- Working with the Veteran to determine the appropriate type of housing;
- Working with the Veteran to obtain furnishings; and
- Checking in with the Veteran regularly after housing is secured to address any barriers that arise.

Potential Housing Challenges and Navigator Responses	
Potential Challenge	Potential Navigator Tasks
Scenario #1 Veteran who has been living on the streets for months does not have necessary identification and documentation for HUD-VASH application.	• Assist Veteran with obtaining DD-214, obtaining license, documentation of income sources, and other documents necessary for HUD-VASH application.
Scenario #2 Veteran who has been in housing for a few months is at risk for eviction because she has not been properly maintaining the apartment.	• Engage with the Veteran to understand the root cause of the problem. • Connect the Veteran to appropriate clinical staff to address any underlying mental health issues. • Connect Veteran with training on maintaining a home.

e. Justice Involved Veterans

A 2007 Bureau of Justice Statistics Report found that as of 2004 about 10% of prisoners in Federal and State prisons were Veterans.[27] Compared to the general population, Veterans are actually less likely to be involved in the criminal justice system, but for those who do become involved it can pose a barrier to obtaining stable housing. Landlords and employers conduct criminal background checks on potential tenants and employees. A history of incarceration or justice involvement can prevent a Veteran from being housed or becoming employed. In addition, the fines and fees that come with involvement in the system often create a barrier to making rent payments and becoming financially secure.

[26] For more information on the Vulnerability Index, please see http://usich.gov/usich_resources/solutions/explore/vulnerability_index

[27] Noonan, M. E., & Mumola, C. J. (2007). *Veterans in state and federal prison, 2004*. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Resources for Justice-Involved Veterans

Recognizing that service-related conditions, such as PTSD or substance abuse used to self-medicate service-connected conditions, may contribute to criminal behavior, some communities have established Veterans Treatment Courts (VTCs) to help divert Veterans from costly jail and prison time towards alternatives to incarceration. Adult Drug Courts and Mental Health Courts are more widely established and have been used to direct individuals towards treatment rather than jail and prison. In recent years, VTCs have expanded, and integrate key components of each model including a focus on public safety, the integration of treatment through community partnerships, monitoring abstinence through regular alcohol and drug testing, and regular judicial interaction, with a conscious awareness of the Veteran's experiences and needs.[28]

Role of Navigator in the Justice System

Just as discharge planning is important for hospital stays, it is also essential for individuals in jail and prison. For justice-involved Veterans, a Navigator can help to ensure that a jail stay or an arrest does not automatically lead to a lost apartment or job. The Navigator should be able to work with criminal justice staff to ensure that the Veteran experiences as smooth a transition as possible from jail/prison to the community. For those with ongoing monitoring in the community, a Navigator should be able to assist Veterans with attending meetings with probation officers, ensure that Veterans attend all required court appearances, and that the Veteran complies with court-imposed treatment and community services. In addition, a Navigator may be able to use his/her social network and relationship with landlords or potential employers to assist those with criminal records in finding suitable housing and employment. Ideally, formerly incarcerated Veterans will not reenter the system, but the majority of individuals leaving jail and prison will return either for new offenses or for technical violations of parole or probation.[29] Having a Navigator to assist with the difficult transition from jail or prison to the community could make a difference in preventing future recidivism by ensuring that justice-involved Veterans with mental health needs and/or substance use disorders are quickly connected with services, and that a short stay in jail does not result in a new episode of homelessness. Furthermore, a Navigator can assist the Veteran with proactively reviewing criminal background checks, addressing any inaccuracies, and working with the Veteran to create strategies to discuss their record with a potential employer or landlord.

When working with justice-involved Veterans, a Navigator must be prepared to:

- Request and review any criminal record with the Veteran;

[28] Russell, R. T. (2009). Veterans treatment court: A proactive approach. *New Eng. J. on Crim. & Civ. Confinement*, 35, 357.

[29] Roman, C. G., & Travis, J. . (2006). Where will I sleep tomorrow? Housing, homelessness, and the returning prisoner. Housing Policy Debate, 17(2), 389-418.

- Support the Veteran to ensure he/she attends any meetings or hearings required as part of his/her parole, probation, or involvement in a specialty court;
- To the extent possible, be present to assist the Veteran with discharge from prison or jail; and
- Advocate on behalf of the Veteran for reasonable accommodations for employment and housing.

Potential Justice Challenges and Navigator Responses	
Potential Challenge	Potential Navigator Tasks
Scenario #1: Veteran is looking for housing, but has a criminal record related to his abuse of prescription painkillers.	• Coach the Veteran on how to discuss the record and describe the ways in which he/she is actively in recovery and working towards. • Access his/her network of landlords to locate appropriate vacancies. • Arrange a meeting with the landlord so that the Veteran may demonstrate his/her commitment to keeping housing and getting his/her life back on track.
Scenario #2: Veteran with a HUD-VASH voucher is arrested for a misdemeanor related to his substance abuse. He spends the night in jail and his employer is ready to fire him for not showing up to work.	• Reach out on the behalf of the Veteran to explain the absence. • Develop a plan to recommit to sobriety, including drug treatment if necessary. • Advocates for the Veteran in court to ensure that he/she has the option to engage with treatment court.

f. Conclusions

In this chapter we have begun to outline the complex systems that a Navigator will be required to understand. The complexity of the challenges facing homeless Veterans cannot be addressed by a single individual, but a single individual can make a difference in ensuring that the Veteran does not get lost in the system. Successful navigation will require a strong effort on the part of the Veteran to communicate with the Navigator about his or her needs, hopes, and fears. The inclusion of a Navigator on the service team, acknowledges that there will be multiple barriers to achieve the goal of stable housing, but together the Navigator and Veteran will be better able to achieve the goal of permanent housing. Permanent housing requires not only case management and peer support services, but also knowledge of the systems and resources available to Veterans within a specific community.

Chapter 3: Introduction of Navigators into an Organization

Chapter 3 focuses on how to integrate Navigators into an organization or homeless program once hired. Special emphasis is placed on providing clear definitions of both the Navigator role within the organization, as well as in relation to the Veteran who will be receiving services from the Navigator. Efforts to assess the Navigator's fit within the existing organization, as well as supervision considerations are also discussed. This chapter also provides a practical outline of how to hire, fund, and evaluate Navigators for VA Homeless Programs.

a. Introduction

As described in Chapter 1, Navigators are relatively new to the healthcare field. Most recently, a number of Navigators were hired and used to help citizens negotiate the Affordable Health Care Act, linking citizens to health insurance programs provided under this new legislation. Additionally, Navigators have been used over the past several years in other healthcare settings to help patients negotiate and gain access to palliative care and rehabilitative care services. Navigators in such settings may be paid by the host organization, but at other times are volunteers.

Use of Navigators in homeless programs, both in VA and community-based homeless programs is even more recent. It is very important to carefully define the roles, duties, responsibilities and the professional expectations of the Navigator and their role within the agency itself, in working with patients/clients, with community partners, and more importantly, with those staff occupying the Navigator role. As described in this Toolkit, the (potential) roles of Navigators are detailed in this chapter, as well as chapters two, six, and also, in the sample position description found in Appendix B. Thus, the roles and responsibilities of the homeless Navigator are not repeated in this chapter.

b. Defining/Introducing the role of the Navigator within the Organization

Although many Navigators in homeless programs can be categorized as peer providers of care, that is, an individual who has shared relatively similar experiences as the client being served, it is important to note that in some community-based programs, such as those participating in the 25 Cities Initiative, Navigators have very specific and defined goals, and thus, are hired because of their prior professional experience and/or advanced credentials. When Navigators are hired with more advanced credentials, it is especially important to define and communicate their role on the team, especially in cases of potential overlap in responsibilities with clinical staff (e.g., case managers, social workers), or peers who are also on staff. Thus, program managers should discuss the role of the Navigator with any existing staff so that their duties are distinguished from those of existing clinical staff. More specifically, if Navigators are brought onto a team and are working alongside peers, the program manager should distinguish the roles and responsibilities of these two positions and how each will work to further the goals of the program.

Upon hiring the Navigator, the program manager should introduce the Navigator to the homeless program team, VA medical center ancillary staff (those staff in departments or services that provide direct referrals to and from other homeless programs), and VA medical center program management and leadership. Additionally, introductions should be made to relevant community partners and local agencies. These introductions should be structured and include an overview of the role, responsibilities of the Navigator, who in the organization the Navigator will be working with and supervised by, and how they will function as an integral member of the existing team in assisting homeless Veterans. During the initial months of employment, it is important to closely review and monitor these relationships to ensure tasks are aligned with the duties assigned in the position description. Please see Appendix B for a sample Navigator position description.

As with all new hires, Navigators should be oriented to all local and national VA policies and procedures. Navigators may be new to the VA system and unfamiliar with health and mental healthcare as provided through VA. As such, in addition to established orientation and training provided by the local VA Medical Center (VAMC), Navigators should be provided with an overview and have working knowledge of homeless populations (especially the local homeless population), current VA and community programs for the homeless, policy and procedures of the national VA Homeless Program Office, homeless program interventions and program designs (e.g., Housing First), as well as role-specific orientation on maintaining professional boundaries, client confidentiality, and ensuring both personal safety and the safety of the Veteran.

c. Helping the Veteran Consumer Understand the Role of the Navigator in Homeless Programs

Homeless Veterans will encounter a host of VA- and community-based staff as they negotiate the wide array of needed services to end their homelessness. While the roles of some staff, for example a HUD-VASH case manager, are more obvious, the roles of other staff can be less obvious. When used within VA homeless programs, the role of the Navigator, and how that role relates to the responsibilities of other professionals on the team, should be carefully explained to the Veteran. The supportive assistance that they will be getting from the Navigator should be carefully explained to the Veteran by both existing staff and the Navigator in the same session or meeting. Although Navigators often are often in a position to mentor and guide clients while negotiating the homeless service maze, they should be cautioned about providing advice and counsel typically provided by specialized clinical staff (i.e., psychiatrists, psychologists, social workers, etc.).

d. Hiring Procedures for Navigators

Navigators can be acquired to provide services for VA Homeless Programs in 3 different ways:

1 *Direct hire under temporary or permanent hiring authority*
When Navigators are hired directly by VA Homeless Programs, a position description must be developed and approved, clearly detailing the knowledge, skills, abilities, and other qualifications required for the position, and if applicable, the duration of the funding secured to support the position. Please see the sample position description in Appendix B for an example.

2 *Acquisition of Navigators by Contract*
Navigators can also be acquired by contract with a local- or state- agency that provides homeless services to Veterans. To acquire Navigators by contract, a Statement of Work (SOW) must be completed. For guidance on contracting procedures and developing a SOW, please contact your local Contract Office for an overview of the process.

3 *Acquiring Navigators through collaborative relationships with community providers or the local Continuum of Care Office.*
Services of Navigators can sometimes be secured via sharing agreements, collaborative agreements with community providers, and/or collaborative grants. For more information on this method, please contact VA National Center on Homelessness among Veterans for technical assistance.

e. Funding Navigators

Navigators can be funded from staffing resources designated for management of local HUD-VASH Programs. These funds would typically be requested during the cycle when new vouchers and staff are being allocated to local programs. The request must be justified and specific to Navigator positions. While the request would be facilitated by the local VA homeless program, it should also be made to the National VA Homeless Program Office. Out of cycle requests can sometimes be made to this office when additional program funds are available. However, requests to convert existing positions to Navigator positions must also be made to that office.

Services of Navigators can also be obtained by application for grants in collaboration with community providers eligible to receive grants. For more information on this method of acquiring Navigators, please contact the VA National Center on Homelessness among Veterans for technical assistance.

f. Evaluating Navigators

1 Performance Monitors for Navigators

Navigators typically play a very important role in ensuring that homeless Veterans are connected to a number of service packages that will end their homelessness. To ensure that these services are delivered in a manner that meets the Veterans' need, it is recommended that the following key aspects of Navigator performance be regularly monitored:

- Timeliness of service delivery
- Rates in which Veterans are connected to the requested service
- Veteran satisfaction with services received from the Navigator
- Basic workload measures
- Navigator communication regarding service delivery to the homeless team

2 Outcomes Measurement

Measuring the outcomes of the Navigator can quickly become onerous or burdensome if made too complicated. It is suggested that sampling techniques or focus groups be used to evaluate the routine performance of the Navigator after clear performance goals are described. Fidelity sheets can also be used to assist with ensuring that the Navigator is meeting the roles and responsibilities of the position. For a sample *Navigator Program Integration Tool*, please see Appendix C.. However, workload goals and performance should be evaluated separately and workload evaluation should be conducted at least monthly and discussed with the Navigator by his/her supervisor.

g. Supervision and Accountability

It is recommended that all Navigators employed by the agency be a part of the local homeless team and included in all the daily or weekly communication huddles. It is recommended that Navigators receive weekly, but no less than monthly, supervision from a senior member of the housing team (e.g., local homeless program manager).

Navigators often conduct much of their activities in private with the client and many of the visits may occur in the community. Balancing supervision and accountability in that environment becomes a delicate affair where trusting relationships, good communication, forums for working through problems, and opportunities to obtain supervisory assistance, must be given high priority by the program manager. Supervisors must develop a strategy that involves strong partnering, mentoring, and ensuring that they ae readily available to provide day-to-day supervision to the Navigator.

Chapter 4: Federal & State-Community Partnerships: A Critical Component to Ending Veteran Homelessness

Chapter 4 focuses on the specific examples set forth by the Massachusetts Department of Veterans' Services in its efforts to end Veteran homelessness. Emphasis is placed on how Massachusetts defined its various stakeholders, and also how these stakeholders collaborated to fund Navigator positions and provided a comprehensive continuum of care for Veterans. The planning and execution of these programs are presented as a model program to which other organizations and state agencies can refer to in the development and/or enhancement of their own Navigator programming.

Combined, Chapters 4 and 5 provide a case study on the development and implementation of a specialized Navigator program, as well as a discussion of challenges and lessons learned, to assist other sites in designing and/or revising their own programs.

a. Introduction

When the VA released its plan to end Veteran homelessness and challenged other federal agencies, state partners and Veteran service providers to identify priorities and join the national effort, then Massachusetts Governor Deval Patrick, accepted this challenge and announced that the Commonwealth of Massachusetts would coordinate all relevant state, municipal and non-governmental organizations to link with the federal effort to end Veteran homelessness. In December 2011, then Lt. Governor Timothy P. Murray charged the Massachusetts Interagency Council on Housing and Homelessness (ICHH) and the Department of Veterans' Services (DVS) with drafting the first statewide plan to prevent and end homelessness among Veterans.[30] This action built upon several existing activities in Massachusetts that had already fostered a number of emerging partnerships, between federal, state, and community partners, but also set the stage for a new way of approaching the challenge of ending Veterans' homelessness in a targeted and collaborative fashion.

This chapter uses specific examples of innovative programming from the Commonwealth of Massachusetts and highlights its localized efforts to end Veteran homelessness to illustrate the importance of strong local programming and federal and state-community partnerships. Programming local to Massachusetts is described throughout this chapter to also provide the reader with background on how localized programming was established, and how partners have been included in the Commonwealth's plan to end Veteran homelessness by the end of 2015.

[30]The Massachusetts Integrated Plan to Prevent and End Homelessness Among Veterans, MA Department of Housing and Community Development 2012
http://www.tacinc.org/media/31041/MA%20Plan%20on%20Vet%20Homelessness.pdf

b. The Massachusetts Plan to End Veterans' Homelessness

At the start of the Civil War in 1861, the Massachusetts state legislature formalized the assistance provided to Veterans by establishing Massachusetts General Laws Chapter 115 and the Department of Veterans' Services (DVS). Offices of Director of Veterans' Services, Burial Agent, and Graves Officer opened in every city and town in the Commonwealth.[31] Today, state and local government leaders continue to recognize service in the armed forces by providing certain essential benefits to men and women (both living and deceased) who had borne the burden of military duty—and to their families. A 2012 analysis conducted by the Massachusetts Legislative Committee on Veterans and Federal Affairs concluded that the Commonwealth spends more per capita on Veterans' services than any state in the nation.[32] Massachusetts General Laws Chapter 115 makes available to all residents, the services of either an exclusive or district, Veterans' Service Officer (VSO) through every city and town in the Commonwealth. Chapter 115 enables every eligible Massachusetts Veteran to receive certain financial, medical, educational, employment, and other benefits earned by military service. Veterans, their dependents, and surviving spouses have been singled out to receive counsel and assistance dispensed through the 351 municipal Veterans' Services offices in Massachusetts. Further, it is the job of the VSO to provide Veterans (living and deceased), and their dependents, access to every federal, state, and local benefit and service to which they are entitled—including funeral assistance and honoring them on Memorial Day and Veterans' Day.[33]

Federal Partnerships

While VA is the primary agency for providing Veterans benefits at the federal level, Massachusetts also relies on support from other Federal agencies in supporting Veterans, including HUD, USICH, and SAMHSA. There are ample VA resources in Massachusetts, including five VA Medical Centers (VAMC), 14 Community Based Outpatient Clinics (CBOC), and six Vet Centers. Additionally, the Veterans Benefits Administration (VBA) operates a regional office in Boston for all of New England and maintains an active partnership with DVS to support VSOs who assist Veterans, and their families, with claims and benefits access. These are all key entry points for Veterans, especially homeless Veterans, and their families, for accessing the resources made available to them. As described in earlier chapters of this Toolkit, VAMCs in Massachusetts also partner with HUD to administer supportive permanent housing and case management through the HUD-VASH program. HUD-VASH rental subsidies are provided through Housing Choice, tenant based vouchers, or location-specific project based vouchers awarded to local housing authorities throughout the Commonwealth. Other federal agencies also provide services to assist homeless Veterans, including the Department of Labor, which has

[31] Veterans Laws and Benefits, Secretary of Commonwealth of Massachusetts http://www.mass.gov/veterans/

[32] MA Joint Committee on Veterans and Federal Affairs, November 7, 2012

[33] *Veterans Laws and Benefits*, Secretary of the Commonwealth of Massachusetts

employment programs to assist homeless Veterans in identifying employment opportunities. A full description of the actions and partnerships with federal agencies in ending Veteran homelessness can be found in USICH's *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*[34].

Coordinating State & Municipal Efforts

At the state level, there are many other benefits access points for Veterans and, in particular, homeless Veterans. Access points are identified by working with partners included in the *Massachusetts Integrated Plan to End Homelessness*[35] such as the MA Department of Housing & Community Development (DHCD), Local Housing Authorities, Regional Homeless Networks, as well as a number of providers who comprise the Massachusetts Continuum of Care (MA CoC).

The MA CoC[36] represents a key system designed to improve the coordination of services for homeless populations located throughout the Commonwealth. The CoC uses state funding combined with federal funding (obtained from HUD through an annual competitive application), to provide homeless assistance services and supportive housing programs for long-term homeless individuals and families with one or multiple disabilities. Across Massachusetts, there are 19 CoCs eligible to apply for HUD Homeless Assistance Funds. CoC membership is open to anyone interested in ending homelessness in the CoC's geographic area. Members include other state agencies, many local, private, non-profit homeless service provider organizations, other private non-profit organizations and individuals, and local VA homeless program staff.

Within the MA CoC, there is an increased focus on ending Veteran homelessness. For example, the City of Boston – partnering with VA, DVS, DHCD, the Boston Housing Authority, and a number of community-based, non-profit agencies who work with homeless Veterans – participated in a national campaign to house 100 Veterans in 100 Days in various communities located throughout the U.S. Through this initiative, partner agencies created a registry of homeless Veterans looking for housing and have identified housing resources for many of those Veterans and pledged to provide each and every Veteran with support services to meet their ongoing needs, including stabilization services to maintain their housing after they move in.[37] In addition, DVS manages and administers a unique system of community entry points on the municipal level, which has the authority and funding to specifically target and address the

[34] Opening Doors: Federal Strategic Plan to Prevent and End Homelessness http://usich.gov/opening_doors/
[35] MA ICHH http://www.mass.gov/eohhs/docs/eohhs/cyf/ichh-initiativeoverview.pdf
[36] MA Continuum of Care Programs http://www.mass.gov/hed/housing/stabilization/continuum-of-care-programs.html
[37] http://homesforthebrave.boston.gov/

housing/financial needs of homeless Veterans and provides needed case management services, including guidance relative to the federal benefits available through the VA.

As described earlier in this chapter, every city and town in MA is represented by a VSO who is an employee of that municipality. The primary responsibility of the VSO is to administer to the Veteran, financial assistance made available through the Commonwealth via Chapter 115. Qualifying Veterans and their dependents receive necessary financial assistance for food, shelter, clothing, housing supplies, and medical care in accordance with a formula which takes into account the Veteran's dependents and income level. Eligible dependents of deceased Veterans are provided with the same benefits as they would were the Veteran still living. Funding for Chapter 115 is unique to MA. Chapter 115 is a partnership between the state and municipal government. While all benefits are initially paid for by the individual municipality, the Commonwealth then reimburses the municipalities at least 75% of those costs. On average, the Commonwealth spends $65M with the state contributing 75% and the municipalities contributing 25%. Since 2011, the Commonwealth has reimbursed the municipalities 100% of their expenditures for those Veterans considered to be homeless, which accounts for close to $800K in additional state spending each year.

VSOs function as Navigators for all resources that may be available to Veterans and their families, working in partnership with DVS's Statewide Advocacy for Veterans' Empowerment (SAVE) special population Navigator/peer outreach teams (for more information, see Chapter 5 of this Toolkit) to provide specific benefits to targeted groups of Veterans. The VSO provides assistance with all benefits associated with the VA. However, the VSO also provides assistance with any resource or benefit that may be offered by the Commonwealth or a non-government community provider. Throughout Massachusetts, VSOs are the front line resource or first responder for Veterans and their families at the community-level for any resource provided by a federal, state, municipal government, or non-government provider agency.

<u>Working with Community Service Providers and other local partners</u>

Massachusetts relies on numerous Veteran-centric and community service providers to support homeless Veterans through outreach, improved access to care, shelter, as well as a number of transitional and permanent supportive housing options. Currently, Massachusetts provides financial resources to 20 Veteran-centric and community service providers located throughout the Commonwealth, for the maintenance and operation of homeless shelters and transitional housing totaling approximately $8.6M annually. Thus, these service providers play a critical role in navigating available services for Veterans and their families throughout the Commonwealth. These organizations , which provide housing services to eligible Veterans

including Emergency Homeless Shelters, group residences, Single Room Occupancy (SRO) quarters, and the only Homeless Veterans' Hospice in New England.

There are several other state and non-profit agencies that, while not specifically focused on delivering services to the Veteran population, do include specific Veteran-focused initiatives in their missions and operating budgets. These include:

- The MA Judicial System which funds peer support and resource navigators in MA Veterans Treatment Courts and through the Department of Mental Health which funds the MISSION Direct Vet[38] jail diversion program, which strategically placed case management and peer navigator staff in specific municipal courts.
- The MA Department of Public Health's Suicide Prevention Bureau funds the DVS Statewide Advocacy for Veterans' Empowerment (S.A.V.E.) team and supports the clinical oversight of the team in the form of two dedicated clinicians who work with the team as mental health experts and self-care specialists.
- The MA Housing and Shelter Alliance partnered with DVS to launch a pilot program for homeless Veterans. By bringing peer and navigator systems support into shelters and community-based organizations that do not exclusively serve Veterans, the Veterans Homeless In-Reach Peer Project reaches a population who may not have access to specialized supports for post-traumatic stress disorder, undesirable service discharges and other significant barriers that Veterans face.[39]

c. Massachusetts's Commitment to Ending Homelessness among Veterans

Buy-in from Leadership

The efforts to impact any major social issue can only be effectively solved if there is "buy-in" from the political and governmental leadership of the state and/or city. In Massachusetts, former Governor Patrick, former Lt. Governor Murray, former Boston Mayor Tom Menino and his successor, Mayor Marty Walsh publicly committed to ending homelessness among Veterans, which positioned the Commonwealth to move forward with a full array of state/city resources to end Veteran homelessness.

Interagency Council on Housing and Homelessness Strategic Plan

On November 18, 2007, Governor Patrick signed Executive Order #492 establishing the Massachusetts Interagency Council on Housing and Homelessness (MA ICHH). Since then, the ICHH has served as the body responsible for implementing the state's plan to prevent and end homelessness, which was released by the Special Commission Relative to Ending Homelessness

[38] MISSION Direct-Vet http://www.mass.gov/veterans/benefits-and-services/mission-direct-vet.html
[39] Massachusetts Housing and Shelter Alliance http://www.mhsa.net/about-us/Veterans

in the Commonwealth. MA ICHH works on several initiatives to increase effectiveness and collaboration among state agencies and with community partners. All of this work is organized around the goal of ensuring all of our neighbors have a safe, affordable place to call home. The ICHH meets monthly and has five active committees focusing on ending homelessness for Veterans, youth, individuals experiencing chronic homelessness, older adults, and survivors of sexual and domestic violence.

In 2012, former Governor Patrick established the ICHH Steering Committee to End Veterans Homelessness. This Committee met quarterly to provide solutions to ongoing systemic barriers to ending Veterans' homelessness. In 2013, the MA ICHH Steering Committee to End Veterans Homelessness published The Massachusetts Integrated Plan to Prevent and End Homelessness among Veterans[40]. The vision of this Plan was to ensure that all Veterans in MA had a stable place to call home and set the bold goal of reducing the number of homeless Veterans in the Commonwealth by 1,000 as determined by the January 2016 Point-in-Time (PIT) count.

The Steering Committee to End Veterans' Homelessness sought significant input into the development of the guiding principles, goals, targets, and strategies detailed below. Plans from VA, USICH, Arizona, New Hampshire, and Washington states, and King County, Washington were reviewed, and the Steering Committee spoke to the implementing bodies of these plans to learn from their experiences. Additionally, the Steering Committee engaged well over 200 stakeholders from across the Commonwealth to identify barriers, opportunities, and best practices. Finally, the Steering Committee reviewed emerging best practices in preventing and ending homelessness among Veterans, including a number of local efforts being used throughout Massachusetts, as well as those occurring in other parts of the country.

Goals

Stemming from an environmental scan and needs assessment, the Steering Committee organized its goals within a Four Pillar framework. This framework should be considered by stakeholders for implementation of future strategies to end Veteran homelessness. These Pillars and Goals are illustrated in the Table below.

MA Steering Committee to End Veterans' Homelessness: Four Pillar Framework	
Pillar	**Goal**
***1.** Housing*	Veterans who become homeless are rehoused and stabilized
***2.** Prevention*	Veterans most at-risk of homelessness remain housed
***3.** Intervention*	Veterans have increased access to benefits and resources
***4.** Partnership*	Federal, state, and community resources are aligned and integrated to support Veterans

[40] MA Integrated Plan to Prevent and End Homelessness
http://www.tacinc.org/media/31041/MA%20Plan%20on%20Vet%20Homelessness.pdf

The goals outlined in the framework are accomplished by utilizing the following strategies and practices:

- Focus on results and evidence-based practices
- Prioritize prevention and rapid rehousing (divert and use shallower resources for non-chronically homeless Veterans)
- Prioritize chronically homeless Veterans, the most at-risk, and frequent utilizers of emergency care
- Focus deep subsidy resources and services on chronically homeless Veterans
- Address the needs of all men and women who served in the military regardless of the type of discharge they received
- Build partnerships

The *Signature initiatives* of the Plan to Prevent and End Homelessness among Veterans are listed below:

1. Reduce the 2011 homeless Veterans PIT count by 1,000 by the end of 2015 (as determined by the January 2016 PIT count).
2. End chronic homelessness among Veterans, going from 450 to 0, by the end of 2015.
3. Access 1,000 units of permanent housing with access to Navigators/peer support/case management to meet plan goals by end of 2015, including:
    a. New HUD-VASH vouchers or additional state resources to house Veterans;
    b. 250 new units of housing through DHCD initiatives for chronically homeless Veterans, including at least 25 for non-VA eligible chronically homeless Veterans; and
    c. 50 housing subsidies through DHCD initiatives to access existing housing units for non-VA eligible homeless Veterans.
4. Support the VA's efforts to build community capacity to serve Veterans where they live by seeking a contract to provide case management, peer support and other services with DVS and community-based non-profits.
    a. Expand partnerships between VA, MA ICHH, DVS (Chapter 115), DHCD, the MA CoC, VSO's, local Housing Authorities, Regional Homeless Networks, and the Regional Housing Network.
    b. This partnership is the key to: accessing existing housing; new housing production; providing comprehensive and integrated wraparound services; ensuring access to income supports such as benefits and other income supports, including employment services, and prevention of Veteran homelessness.
5. Develop regional lists of homeless Veterans in partnership with CoCs, Regional Networks to End Homelessness, local VSO's in order to prioritize resources and support services, to track progress and outcomes for specific individuals, and to understand the scope of Veterans who are newly homeless and accessing systems of care.

6. Launch a demonstration project in Year 1 of this plan to test the feasibility of conversion strategies that allow providers to utilize existing Veteran's emergency and transitional housing resources for permanent housing and community-based supports.
7. Improve research and data to better inform policy and target resources.

The 25 Cities Initiative

Mayor Walsh committed the City of Boston to the 25 Cities Initiative[41], a key Federal strategy through which 25 communities are receiving technical assistance and are mobilizing local planning efforts and partnerships to create effective systems for aligning housing and service interventions through coordinated systems to end homelessness. One of the staples of concerted effort has been to develop a Coordinated Assessment and Housing Placement (CAHP) System in each participating community, allowing communities to strengthen identification and prioritization, ensuring that Veterans experiencing homelessness can be paired with the best available services (most importantly systems navigation and peer support services) to meet their needs. The implementation of a CAHP system in these communities has led to an increase in HUD-VASH utilization, housing units, and vouchers. Led by VA, in partnership with HUD and the USICH, the aim of this initiative is to assist 25 communities in accelerating and aligning their existing efforts toward the creation of coordinated assessment and entry systems, laying the foundation for ending all homelessness, but specifically targeting homeless Veterans in these communities.

The City of Boston and DVS joined the 25 Cities Initiative in June 2014 and the following initiatives are being pursued by the Boston team:

1. Implementation by the Boston Housing Authority, DVS and the provider network of The Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT). The VI-SPDAT is a "supertool" that combines the strengths of two widely used existing assessments:
    a. The Vulnerability Index (VI), developed by Community Solutions, is a street outreach tool currently in use in more than 100 communities.
    b. The Service Prioritization Decision Assistance Tool (SPDAT) is an intake and case management tool in use in more than 70 communities. Based on a wide body of social science research and extensive field testing, the tool helps service providers allocate resources in a logical, targeted way.[42]
2. A Housing First approach, which removes barriers to help Veterans obtain permanent housing as quickly as possible without unnecessary prerequisites.

[41] 25 Cities Initiative http://www.25cities.com/

[42] http://100khomes.org/blog/introducing-the-vi-spdat-pre-screen-survey

3. Prioritizing the most vulnerable Veterans especially those experiencing chronic homelessness for permanent supportive housing opportunities, including those created through the HUD VASH program.
4. Coordination of outreach efforts to identify, engage, and provide outreach to every Veteran experiencing homelessness in order to achieve desired housing outcomes.
5. Targeting rapid re-housing interventions including those made possible through the VA's Supportive Services for Veteran Families (SSVF) program who need shorter term rental subsidies and services in order to be reintegrated back into their communities.
6. Leveraging housing and services that can help Veterans who are ineligible for some of the VA's programs get into stable housing.
7. Increasing early detection and access to preventive services so at risk Veterans and their families remain stably housed.

d. Challenges & Lessons Learned

Systems Navigation

Throughout their quest to end Veteran homelessness, the Commonwealth of Massachusetts has learned a great deal from its efforts. Below are some lessons learned, as well as plans to improve processes and outcomes that will better serve homeless Veterans and ultimately end Veterans' homelessness in Massachusetts.

There are a number of resources available to Veterans and their families residing in Massachusetts. Services are administered by a variety of entities including federal, state and, municipal agencies, as well as a myriad of community-based and non-government providers. This network of resources is extremely vast and can be confusing and overwhelming for Veterans and/or their family members, who may find themselves in a crisis situation, or in a time of hardship.

Through its efforts, the Commonwealth of Massachusetts has found that the key to successful access and utilization of all resources is *systems navigation*. The ability and persistence to navigate the necessary administrative processes for housing and services can be the difference between success and failure as many systems include cumbersome application processes, at a number of agencies, as well as varied and locally defined operating procedures. The key is to make the system work for the Veteran rather than having the Veteran work within the system. With that in mind, MA has adopted systems and services to assist in the navigation process.

Apartment and Unit Identification

Massachusetts is heavily populated in the Eastern and Central portions of the state. The cost of living in many cities and towns in these areas are prohibitive for working class families and those living at or below poverty. Additionally, the availability of affordable housing stock is very low. While the Western counties of MA are more affordable and offer greater availability of housing options, lack of reliable, wide-spread public transportation and employment opportunities creates significant barriers to re-establishing economic self-sufficiency and or accessing healthcare services. Identification of available housing stock at the local level has also posed challenges. Very rarely are there up-to-date lists of available units in these areas. Thus, clients are often forced to look for housing on their own and local housing authorities often have long wait lists. Further, private landlords didn't know where to list their available units. Additionally, many units are not inspected and approved for voucher programs, resulting in delays to occupancy.

To address these issues, partners in this effort have created a registry of homeless Veterans looking for housing and have identified housing resources for many of those Veterans. Utilizing a website[43], local real estate community and business leaders are being urged to register their units online. This site also has the capability to track available units as well as pre-approved units, thereby offering a quicker solution, which all providers can use to rapidly re-house Veterans.

Data Collection, Tracking, & Reporting

One of the most significant challenges in working with homeless populations is often the lack of accurate data on individuals, as well as populations and sub-populations. This can be very challenging when it comes to homeless Veterans as they may either be reluctant to share their military background with providers for fear of shame, loss of benefits, or characterizations of discharges less than honorable. Also data on homeless Veterans come from multiple sources, making it difficult to create a single report for any one homeless Veteran, thus tracking that individual through the system can be challenging. Additionally, reporting requirements tend to focus on capacity temporary facilities and head counts of Veterans, rather than focus on the results of the each Veteran client. As mentioned before, the VI-SPDAT system and other coordinated efforts set forth through the City of Boston's participation in the 25 Cities Initiative, are helping to coordinate the data being collected among homeless Veterans and all homeless individuals in the in the city more effectively. Use of standard data collection tools and assessments instruments are helping to address inconsistencies, as Navigators often deliver

[43] http://homesforthebrave.boston.gov/

services across various agencies and service providers. Such an approach allows for data collection and storage of Veteran housing information/preferences in a central bank that otherwise may not have been shared or stored in a central repository. Therefore, it is essential these data collection efforts continue to be coordinated across all local agencies and service providers working to end Veteran homelessness across the CoC.

e. Conclusions

As stated throughout this chapter, a key element of successful Navigators is each Navigator's ability to analyze and map key access points for their Veteran clients in their particular geographic regions of MA, tailoring housing and wraparound support services to each Veteran's specific needs, rather than funneling all homeless Veterans through the same process. As services are multi-pronged, funded through different mechanisms, and not always well aligned, the role of the Navigator should be to identify and categorize these multiple entry points and understand how they operate and with what level of success.

With a large number of medical centers and community-based clinics throughout the nation, VA offers a significant amount of resources that can positively impact a Veteran's mission to become self-sufficient and address their physical and behavioral problems in highly coordinated system of care. However, navigating the VA network of financial benefits, healthcare, rehabilitation services, educational support, housing, etc. can be challenging for Veterans, and has the potential to discourage homeless persons not engaged in care from utilizing their benefits. Thus, there is a need to better integrate Navigators into VA, creating strategic community partnerships between VA, state, and community-based Veteran-centric social service agencies.

Chapter 5: Peer Support – The Massachusetts Case Example

Chapter 5 extends the information provided in Chapter 4 by describing how the Commonwealth of Massachusetts was able to leverage the collaborations forged by federal, state, and municipal agencies into programs that work effectively and efficiently to end Veteran homelessness. Three different Massachusetts Navigator-oriented programs are described, as well as a merger of efforts between two of these programs to provide Veterans with more comprehensive services. This information is contextualized within a CoC framework targeting the needs of homeless Veterans. Combined, Chapters 4 and 5 provide a case study on the development and implementation of a specialized Navigator program, as well as a discussion of challenges and lessons learned, to assist other sites in designing and/or revising their own programs.

a. Introduction

As detailed in Chapter 4, The Massachusetts Department of Veterans' Services (DVS) is one of the oldest and most active Veteran outreach and navigation service providers in the Nation. Utilizing elements of a peer-to-peer Navigator model, Massachusetts General Laws Chapter 115 requires every city and town in MA to employ a Veteran as a Veterans' Service Officer (VSO), whose job is to provide local Veterans (living and deceased) and their dependents access to every federal, state, and local service/benefit to which they are entitled.

DVS utilizes Navigators in a variety of different ways to most effectively serve its Veteran residents. In addition to VSOs, Navigators are also hired in specific programs (described later in this chapter) to work with Veterans to assist them in obtaining benefits and other entitlements. For example, one of the keys to Massachusetts' successes serving returning Veterans has been the use of Navigators to assist with accessing benefits at the community-level.

Navigators also work with VSOs to assist Veterans with obtaining VA benefits through the Veterans Benefits Administration (VBA), and also in accessing available local, and state benefits. Navigators help make a meaningful difference in the lives of Veterans, especially those with serious impediments to achieving self-sufficiency such as serious mental illness (SMI), including PTSD, TBI, and substance abuse issues. Many of the Veterans DVS Navigators work with may have had difficulties navigating the benefits system when left on their own in the past. Thus, the Navigator role is critical, given that Navigators serve as the main link between the Veteran and a number of different health/benefit program staff. In addition to these responsibilities, Navigators may also be charged with additional responsibilities described in the Table below.

Various Responsibilities of MA Navigators
• Assess the needs of the Veteran • Work with counselors, social workers, and/or family members to communicate issues affecting the Veteran • Assist in the collection of needed documentation and completing paperwork • Develop benefits plan based on which and when benefits get accessed according to the Veteran's needs/abilities • Provide supportive coaching and encouragement during and after the period of time the Veteran receives services

This chapter will illustrate how Massachusetts' use of Navigators is an integral part of three signature MA Veterans outreach programs. These programs specialize in: 1) helping Veterans to access federal/state benefits, 2) preventing suicide, and 3) ending chronic homelessness. We will also demonstrate why Navigators are a critical component to the success of these programs and provide guidance on how to implement peer-to-peer Navigator programs elsewhere, including tips for training and structuring staff to ensure that programs are navigating Veterans through the system in the most efficient way possible.

b. MA Navigator Types

Local Veterans Service Officers (VSOs)

The Massachusetts VSO program is, at its core, a peer-to-peer Navigator program insofar as VSOs are trained and charged with using their Veteran status to establish common connections with their Veteran clients. VSOs rely upon their extensive knowledge of the range of available benefits and services to which Veterans are entitled. VSOs not only promote engagement in available services, but also provide the most accurate referrals to needed services. As mentioned in chapter four, per program guidelines, all cities and towns in Massachusetts must employ a Veteran as a VSO. This position operates out of City/Town Halls and VSOs serve as an invaluable resource to Veterans providing guidance on accessing an array of federal, state, and local benefits to which the Veteran and/or their dependents may be entitled. His/her job is to help Veterans in the community learn about, apply for, and in some cases, receive benefits.

Massachusetts offers a need-based program of financial and medical assistance for qualifying Veterans and their dependents. If eligible, qualifying Veterans and their dependents receive financial assistance for food, shelter, clothing, fuel, and medical care according to a formula which takes into account income and number of dependents. Eligible dependents of deceased Veterans are provided with the same benefits as if the Veteran were still living. The VSO also helps Veterans and their dependents apply for a range of other programs including VA, Social Security, and Supplemental Nutrition Assistance Program (SNAP). As these benefits are complex and not always connected systematically, the VSO plays the critical role of Navigator in

assessing the Veteran's needs, developing a benefits plan, and helping them to access those services in the most efficient way possible.

Statewide Advocacy for Veterans' Empowerment (S.A.V.E.)

In 2008, DVS leadership recognized that Veterans, and especially newly returned Veterans, were still facing challenges in accessing services and navigating the healthcare/benefits network at the local level. Nationally, and also in Massachusetts, Veterans were dealing with several issues as a result of their deployments, including higher than average unemployment rates, long wait times for medical care, financial insecurity, and mental health/readjustment needs not being met. The following tragic example personified this struggle.

Jeffrey Lucey of Belchertown, MA was a 23 year-old Marine Veteran of Iraq. He came home and suffered with post-traumatic stress and depression. Despite intense love and support from his family, he could not see a path to overcoming all that he was dealing with and committed suicide in 2004. In meeting with DVS, Jeffrey's parents shared their thoughts and feelings about what would have helped their son and what we could still do to support those men and women who were currently out there trying to seek help and resources in an attempt to heal and reintegrate successfully back to civilian life.

This was the genesis for establishing the Statewide Advocacy for Veterans' Empowerment (S.A.V.E.) program. S.A.V.E. outreach coordinators focus on community advocacy, suicide prevention, mental health awareness, responding to, and providing referrals, to more adequately meet the multifaceted needs of Veterans and their families.

Also, DVS recognized that in addition to the many Veteran-specific benefits and services that are offered at all governmental levels and in the non-profit sector, there are many other benefits and services that are available to all MA residents, especially those who are low-income and/or suffering from mental illness, such as MassHealth, the Commonwealth's Medicaid program. However, working one's way through that delivery system, in addition to the Veteran-specific benefits network can be highly challenging. The use of Navigators in these situations can ensure that the Veteran follows a pathway and benefits plan that is going to help them in the quickest and most efficient manner with access to the most beneficial services.

S.A.V.E. is a community-based, peer support program that uses Navigators to provide link and referral services, as well as more comprehensive peer support and case management services to Veterans and their families. It is important to note however, that S.A.V.E. is a non-clinical team and does not provide any clinical or medical services. However, S.A.V.E. team members work with all generations of Veterans, but place an emphasis on those considered to be high-risk due to suicidal ideations and actions, TBI, PTSD, substance abuse and/or mental health

issues, or medical problems. Once the Veteran or family member is identified, a S.A.V.E. outreach coordinator will go through an in-depth intake form to assist the Veteran in identifying what barriers and challenges they are facing and then link or refer them to the appropriate services. S.A.V.E.'s screening assessment for suicide risk is modeled after the World Health Organization, Centers for Disease Control and Prevention, and the Air Force's suicide assessments. The TBI assessment is taken from the MA Statewide Head Injury Program head injury assessment, and the PTSD assessment was constructed from the VA's Vet Center mental health questionnaire.

RESPONSIBILITIES OF SAVE PEER NAVIGATORS	
Community Outreach	Assisting Veterans in Navigating Benefit Systems
Attending Community Events	Supportive Coaching for Struggling Veterans
Developing a regional network of advocates and community leaders	On-Going Follow Up with Clients
Assessing Veterans for Benefits and Services	Educating civilian providers on Veterans Culture and Benefits

S.A.V.E. Navigators provide ongoing systems navigation, following-up with the Veteran and his/her family to ensure that the link or referral was successful, and also to assess any other needs of the Veteran and/or family members. If ongoing support is needed, S.A.V.E. Navigators can then set up an Individual Action Plan (IAP), which identifies specific goals, and the activities needed to be complete in order to meet those goals. They will then work with the Veteran and/or family member to complete the activities and meet established goals.

In addition to providing ongoing Peer Support and referrals to needed services, the S.A.V.E. program has an extensive community outreach component. The goal of the community outreach component of S.A.V.E. is to not only identify those Veterans and families who are unaware of available benefits and services, but also to provide education and resources to communities. For example, by coordinating with various community-based housing providers, S.A.V.E. Navigators received assistance requests from many Veterans in need of housing and homeless services, which was instinctive in the development of DVS' housing outreach program, *SHARP* (described in detail later in this chapter). These services also include, but are not limited to, educational facilities, local first responders, private and non-profit organizations, medical staff within community facilities, senior homes, the court system, Gold Star Families, Blue Star Families, military organizations including the Reserve and Guard, and any community members expressing a desire to learn more about Veterans issues, and more importantly, what services are available to Veterans. By having such strong relationships with community-level

providers, S.A.V.E. Navigators are able to help the Veterans they serve utilize benefits, services, and the expertise of local governments, while at the same time, assisting Veterans and their families with successful reintegration back into the community.

Given that only 1% of the Nation serves in the military, there is a significant military-civilian knowledge gap that exists within the Commonwealth. Thus, S.A.V.E. offers *BattleMind* trainings[44], which are designed to help individuals understand how minds are trained to go into battle and how if not transitioned properly, the BattleMind can create many challenges and obstacles for the Veteran and their families upon returning home. By having a better understanding of military culture, training, and the mindset of a service member, it will allow the community to better understand our Veterans and ultimately help them support Veterans and their families throughout their transition to civilian life. The DVS version of *BattleMind* is a personal perspective of training by the United States Army that focuses on the skills used in military service for survival, and how those skills, while helpful during military service, may cause conflicts upon return home. The *BattleMind* presentation is included in the MA Human Resource Managers and Diversity Officers training with a focus on educating hiring managers and Human Resources Staff about military culture and the emerging issues of reintegrating Veterans and their families. S.A.V.E. also delivers *BattleMind* presentations to varied audiences such as First Responders, clinicians, as part of the University of Massachusetts Medical School clerkship, Service Providers, Corrections Staff, Probation Officers, and District Attorneys. This presentation has been filmed by the MA Department of Mental Health for continued use in the training of clinicians, first responders, service providers, corrections staff and court personnel.[45]

In its six years of service, the S.A.V.E. team (which is entirely funded by the Commonwealth of Massachusetts through a partnership with DVS and the MA Department of Public Health's Suicide Prevention Bureau) has interacted with thousands of Veterans and their families. S.A.V.E. Navigators are selected for their ability to interact and relate to the Veterans they meet based on shared experiences of military service and reintegration.

Training and Staffing Structure

The S.A.V.E. Team is structured in a tiered manner. Oversight is provided by senior staff at DVS. The team structure consists of a Director, Team Leaders and Peer Navigators with additional specialized support in clinical expertise and administrative duties. The Director functions as the overall manager providing administrative, case management and operational guidance. The Team Leaders report to the Director and have geographic responsibilities to provide navigation services as well as management of the Peer Navigators assigned to their area. Peer Navigators

[44] http://www.armyg1.army.mil/dcs/docs/Post-Deployment%20Battlemind%20training%20for%20Soldiers.pdf

[45] https://www.youtube.com/watch?v=3zwJTQwk-9U

report to the Team Leaders and are assigned geographically. All staff from the Director, to Peer Navigators, are cross-trained in peer support and can provide any/all services the S.A.V.E. team offers. The team also has an in-house clinician that supports staff with self-care as well as guidance on specific cases. Additionally, the team contracts with a local behavioral health services provider to deliver clinical consultations for more difficult cases as well as after-hours consult for cases that present on nights and weekends. The S.A.V.E. team handles a wide variety of cases, ranging from link and referral assistance, resource navigation, peer support, critical case management, jail diversion, and general outreach services. At any given time, S.A.V.E. team members are working on approximately 200 active cases.

New members to the S.A.V.E. team are required to fulfill a 90-day probationary period. During this time, under the supervision of their assigned team leader, new team members work out of a main office and also work closely with senior team members on various case and database issues. They also shadow team members during outreach events, provider meetings, interventions, and other day to day activities that are scheduled to place throughout the Commonwealth. The 90-day probationary period was put in place to ensure that every facet of case management and outreach work has been covered and understood by all new Peer Navigators. Once the probation period is over and the team leader decides that new Peer Navigators are ready to take on their new roles with minimal guidance and oversight, they will take on full responsibility for cases in their outreach area, which is geographically based and determined by the S.A.V.E. workers background and place of residence. The table below provides a list of trainings that new S.A.V.E. team members must attend:

Mandatory Trainings for S.A.V.E. staff
• Initial database training, to include submission of all intake forms • *Question Persuade Refer* (QPR) Certification • Attends all offered VA Mental Illness Research, Education and Clinical Centers (MIRECC) • Obtains Peer Certification (if possible) • DVS Peer Support Training • Community Outreach Work with a Team Leader/Outreach Coordinator • In-depth overview of DVS' mission and protocols • Suicide Prevention Training - Veterans Administration • Crisis intervention/community - services • Traumatic Brain Injury • PTSD/Mental health overview • Self-Care

Additionally, all S.A.V.E. team members must participate in regularly scheduled trainings, continuing education courses, professional development courses, and have monthly meetings

with outside providers to continue to learn about the new benefits and services within their assigned communities.

S.A.V.E. Program Results

As an indication of its success, we will now examine S.A.V.E. program results from Fiscal Year 2014 (see Appendix D) to highlight the unique impact that Navigators have had on MA Veterans/military families. During FY14, over 200 Veterans received direct referral and linkage services and over 190 Veterans received active case management, with 12 of those involving critical incidents (i.e., a suicide attempt or self-destructive action). Additionally, during FY14, S.A.V.E. refined its partnership with the Massachusetts National Guard and provided peer Navigator services on site at National Guard Armories and at the Otis Air National Guard Base/Camp Edwards. These efforts also marked the beginning stages of embedding S.A.V.E. with the Guard's Military Police and Engineering units, which have been struggling recently with increased suicide completions. S.A.V.E. has also recently received training from the National Guard to have better knowledge of Guard specific benefits for soldiers who have not had the minimum requirement for most Veteran benefits.[46]

S.A.V.E. is a cost-effective model, since the model strives to link the Veteran to the appropriate service at the right time, thereby cutting down on emergency, duplicative, or unnecessary treatments. It also produces better utilization rates for the already comprehensive network of programs and services made available to our Veterans and their families. Further, by virtue of being community-based and the program's mission to integrate into their local regions, S.A.V.E. workers have become vital contacts for organizations like local healthcare providers and law enforcement personnel when working with Veterans-in-crisis in their systems. S.A.V.E. has been recognized by the Massachusetts Coalition for Suicide Prevention with a Leadership in Suicide Prevention Award and was the 2014 Recipient of the Manuel Carballo Governor's Award for Excellence in Public Service by the Commonwealth of Massachusetts.

Statewide Housing Advocacy Reintegration and Prevention (SHARP)

As described in Chapter 4, the Commonwealth of Massachusetts aligned itself with the federal mandate to end chronic homelessness among Veterans. MA drafted its first plan ever to end Veteran Homelessness in partnership with local VA medical centers, community-based providers, and other stakeholders. This plan focused on five key goals: 1) *Housing,* 2) *Prevention,* 3) *Intervention,* 4) *Partnership, and* 5) *Stabilization*, and called for the development of intentional and strategic relationships with partners across many systems, including VA, the CoC, public housing agencies, and 32 leading service providers throughout the Commonwealth. These collaborative relationships allowed for the sharing of evidence-based practices, program

[46] http://www.wbur.org/2014/09/18/massachusetts-national-guard-suicide

data, and client assessments, to better assess available programs and roles across the Commonwealth, so as not to duplicate efforts since all the collaborative partners are working for and serving the same population, and also, to develop integrated and innovative programs that could use available resources more efficiently.

Concurrently with this effort, during the spring of 2011, the VA National Center on Homelessness among Veterans (the Center), collaborated with DVS to create a federal/state partnership in the Metro-Boston area to provide enhanced services to 50 chronically homeless Veterans. This pilot project was modeled after the already established and successful peer-to-peer Navigator S.A.V.E. program described earlier in this chapter. In response to this request, a one-year pilot program, referred to as Statewide Housing Advocacy of Reintegration and Prevention (SHARP), was established. The contract to carry out SHARP programming was facilitated through a sole source agreement procured by the Center to the Commonwealth of Massachusetts through the local VA Veterans Integrated Services Network 1, providing funding for a team of Peer Navigators, a psychiatrist, and substance abuse specialist, as well as an in-house clinician.

DVS recognized that Peer Navigator elements should have a pivotal role in any initiative the agency chose to undertake, particularly any efforts to end chronic homelessness among Veterans. SHARP adapted the S.A.V.E. Peer Navigator model with the goal of reaching the most vulnerable Veterans experiencing chronic homelessness and immediately connecting them to permanent housing and wraparound services as prescribed in the Housing First framework. Through the SHARP program, VA provided homeless Veterans in the Boston area with HUD-VASH vouchers, and paired the recipients with a DVS SHARP Peer Navigator to augment their VA case management, increasing the likelihood for success during the transition from homelessness to housing. SHARP Navigators also coordinated access to all available state- and community-based Veteran benefits and resource programs.

The pilot SHARP program was comprised of six staff: four Peer Navigators, one substance abuse counselor, and one psychiatrist, who were all supported by a 24/7 hotline. Two VA social workers also worked closely with the SHARP Peer Navigators. SHARP Navigators performed outreach and provided peer support services to complement VA's HUD-VASH case managers. SHARP Navigators were also embedded within local public housing authorities (PHA) to assist Veterans in completing paperwork, obtaining needed documentation, and with housing searches, decreasing the Veteran's wait for housing.

SHARP team members were trained through many of the same protocols as the SAVE team described earlier in this chapter, including best practices for mental health, outreach

techniques, and training on available federal/state/local benefits and services. Within the first six months of the SHARP pilot program, the model contributed to a 21% reduction of Veterans' homelessness from the previous year in Massachusetts with 450 of the Veterans served during this period meeting HUD criteria for chronic homelessness.

One example of the work done in the pilot program by a SHARP Peer Navigator can be evidenced by the case studies below.

Scenario #1
A SHARP Peer Navigator was able to build rapport with a male Veteran who had lived unsheltered for the better part of 20 years. He had been approached many times in the past and always adamantly refused shelter and other services. The Peer Navigator was able to reach him by building trust, by talking to him about shared experiences, and by offering help to the Veteran on his terms. This gave the Veteran the confidence he needed to finally access permanent housing and sustain his housing long-term.
Scenario #2
A SHARP Peer Navigator brought an elderly female Veteran who had significant physical and mental health issues to a local VAMC. The SHARP Navigator was able to act on the Veteran's behalf, working with the VA worker to facilitate the VA's "no wrong door" approach to help the Veteran in need get an immediate appointment in this case. By being persistent and acting as an advocate for the Veteran, they were able to get the Veteran an appointment and the care she needed. [47]

The SHARP program was highlighted as a national model appearing in the VA National Center on Homelessness among Veterans (the Center) 2012 Annual Report. The Center has also featured the team at workshops in Washington, Chicago, Baltimore, and New Orleans. Due to its early successes, the Center facilitated an additional sole source contract with the Commonwealth for three more years to scale the program for statewide implementation.

While follow up data are currently being collected, there is strong early anecdotal evidence to suggest that those formerly homeless Veterans who were enrolled in HUD-VASH, and received support from both a SHARP Peer Navigator and HUD-VASH case manager, had higher rates of program retention and housing stability than those who had only case management. Highlights from the SHARP program are highlighted in the table below.

[47] US Interagency Council on Housing and Homelessness. http://usich.gov/population/veterans/veterans_homelessness_in_focus/pilot_program_in_massachusetts/

SHARP Program Results (Through FY14)
• 715 VASH vouchers issued in Massachusetts since 2008 • 900 cases of direct care services using a Peer Navigator intervention • Participation in 100 Days 100 Homes 100 Veterans Metro-Boston Initiative (8/2013-6/2014) • 306 Veterans Housed (192 Chronically homeless)

c. SAVE/SHARP Integration

In October of 2014, the SHARP pilot program ended with reallocation of funding to community-based homeless Veteran service providers for contracted Peer Navigator services. The success of the SHARP pilot program demonstrated the critical role that Peer Navigators could play in the effort to provide outreach and service coordination to homeless Veterans. The SHARP team had also established many valuable partnerships with a number of community resources and other Federal/State/Municipal governmental agencies including Police departments and other first responders.

Given its track record, as well as the numerous hours of training DVS had put into its Peer Navigator programs, DVS decided to keep the team in place and merged SHARP and S.A.V.E. program staff responsibilities to better serve special populations of Veterans such as homeless, recently incarcerated Veterans, Veterans in jail diversion programs, and Veterans struggling with substance abuse issues, mental health issues, including PTSD and TBI, or at-risk of suicide.

As SHARP and S.A.V.E. shared a common chain of command and many of the same training protocols, the integration of the teams was seamless. Cross-training on issues such as rapid re-housing and suicide prevention actually complemented both sets of Peer Navigators' capabilities and allowed for more robust and comprehensive service provision for all DVS clients.

d. Future of Veteran-Veteran Navigator Support Services in Massachusetts

The anecdotal results of Peer Navigator programs for Veterans in Massachusetts have demonstrated to Federal/State policy makers and social service agencies that these models are not only beneficial to serving Veterans, but also critical to ensuring that Veterans are able to relate to providers. Further, Navigators ensure that Veterans receive assistance with navigating and accessing the myriad of benefits and services for which they are qualified, or need. The SAVE/SHARP model has been expanded or duplicated by other agencies and branches of government, as well as several not-for-profit organizations, in their efforts to serve their respective Veterans/ military family client base. Below is a list of other programs in Massachusetts using Navigator-type models to deliver services to Veterans.

The Massachusetts General Hospital and Red Sox Foundation Home Base Program

The Red Sox Foundation and Massachusetts General Hospital Home Base Program provides clinical care and support services to Iraq and Afghanistan service members, Veterans, and their families throughout New England, who are affected by deployment– or combat–related stress or TBI. The organization employs an outreach team made up of individuals who have served in Iraq or Afghanistan since 2001, including some who have had their own experience with combat–related stress and can relate to the stigma of seeking help, unease about the healthcare system, anxiety about managing a return to school or a job, and family stresses.[48]

Massachusetts Housing and Shelter Alliance

The Massachusetts Housing and Shelter Alliance (MHSA) is a non-profit public policy advocacy organization with the singular mission of ending homelessness in the Commonwealth. Supported by a grant from the Highland Street Foundation, MHSA has partnered with the MA DVS on a pilot program designed to better meet the needs of homeless Veterans. The Veterans Homeless In-Reach Peer Project is an expansion of the SHARP model in which Veterans serve other Veterans. By bringing Peer Navigator models into shelters and community-based organizations that do not exclusively serve Veterans; the Veterans Homeless In-Reach Peer Project reaches a population who may not have access to specialized supports for PTSD, undesirable service discharges, and other significant barriers that Veterans face.[49]

MISSION Direct-Vet/Veterans Treatment Courts

MISSION Direct-Vet started as a federally-funded court based jail diversion program with priority to Veterans. This project was funded through a five-year SAMHSA grant, awarded to the MA Department of Mental Health (MA DMH), in partnership with faculty at the University of Massachusetts Medical School, and the VA, along with numerous state agencies. In November of 2009, MISSION Direct-Vet began accepting referrals for the pilot phase of the program in the City of Worcester and throughout Worcester County. A year later, MISSION Direct-Vet opened a second site based in the Lawrence District Court which accepts referrals from all over Essex County. In July 2011, MDV opened a third site at Brockton District Court and has also expanded to include sites in Plymouth County near the Cape and Hampden County in the Western part of the Commonwealth. Although federal funding ended in 2014, MA DMH provided internal funds to sustain the project.

The jail diversion component of the project sought to provide services and treatment to Veterans as an alternative to incarceration. For 12 months, individuals regularly met with a

[48] http://www.homebaseprogram.org/general-information.aspx
[49] http://www.mhsa.net/about-us/veterans

treatment team to address mental health and substance abuse issues. Throughout the program, a peer support specialist and case manager worked with the individual to not only deliver mental health and substance abuse treatment sessions directly to the Veteran, but also to connect them to additional services as needed. Referral services included medical care, additional mental health and substance abuse treatment, Veterans' services, vocational programming, transitional residence programs, and family support.

The success of the MISSION Direct-Vet and the opening of three Veterans' Treatment Courts (designed to handle criminal cases involving defendants who have a history of military service through a coordinated effort among the Veterans services delivery system, community-based providers, and the court) led to a budgetary line item in the FY14 MA State Budget that allows DMH to partner with the S.A.V.E. team to support 2.5 FTE Veterans Justice Peer Support Specialists, whose goal is to assist Veterans in the justice system through peer support.[50] In FY14, over 200 Veterans were diverted resulting in some form of treatment other than adjudication through the courts.

[50] http://dedham.wickedlocal.com/article/20140324/News/140329920

Chapter 6: The Policy Framework of VA's Homeless Programs

Chapter 6 discusses the importance of fostering the intergovernmental and intra-community partnerships required for the delivery of effective Navigator services within and outside of VA. Special attention is paid to the unique challenges faced when integrating VA and community services to address homelessness. Policy implications of intergovernmental partnerships to end Veteran homelessness are also discussed.

a. Introduction

As addressed in earlier chapters, VA has developed a comprehensive network of homeless programs across the country, with a commitment to ending homelessness among our nation's Veterans. The National VA Homeless Program Office and the VA National Center on Homelessness among Veterans (the Center) utilizes a number of evidence-based approaches to formulate key policy decisions, as well as an implementation science framework to guide program development and dissemination within VA's national homeless program. Use of Implementation Science frameworks provides a uniform way of evaluating new interventions, programs, and strategies to end homelessness among Veterans, such as the VA Enhanced Navigator Program described in this chapter.

This chapter provides Navigators and program managers working within, or alongside VA Homeless Programs with information on the policy framework of VA's national homeless program as it relates to the Enhanced Navigator program. In the first section of this chapter, we provide policy guidance for use of VA Navigators that serve homeless Veterans and their families, followed by the training and support needs of VA Navigators.

b. Permanent Supportive Housing vs. Temporary Placement

Although placement of homeless Veterans in shelters and temporary settings is sometimes necessitated by a lack of immediately available and affordable permanent housing, VA Homeless Programs supports routine placement in permanent supportive housing as the desired approach (Housing First) to end Veteran homelessness, especially for chronically homeless Veterans who have a need for long term supportive services. Further, VA has prioritized permanent supportive housing placement of chronically homeless Veterans. Chronically homeless Veterans have significantly higher incidence of mental illness, substance use, PTSD, TBIs, and complex service needs that necessitate use of permanent supportive housing to end their homelessness. Use of permanent supportive housing should always be pursued first when the Veteran has a need for longer term supportive services to sustain their ability to stay housed.

VA also recognizes that the homelessness of many Veterans can be addressed by transitional supportive housing or residential treatment services, especially when the Veteran has not been chronically homeless and their homelessness can be addressed with briefer interventions. Although at one time, transitional supportive housing as provided in programs such as VA Grant and Per Diem (GPD) and residential treatment services provided through VA's Domiciliary and Residential Treatment Programs was VA's primary option to addressing homelessness among Veterans, VA has now developed a robust permanent supportive housing program utilizing a Housing First framework that is provided through the HUD-VA Supportive Housing (HUD-VASH) program, making the transitional and residential options more useful for their intended target: Veterans whose needs can be addressed on a short term basis. In addition, VA's Supportive Services for Veteran Families (SSVF) Program uses a rapid rehousing approach and provides brief services and interventions for Veterans who are at risk of becoming homeless or who experience brief episodes of homelessness. Providing the housing option that best meets the Veteran's need is always the goal of VA Homeless Programs.

c. Housing First Approach as Policy

VA Homeless Programs has adopted the evidence-based Housing First[51] approach in all of its homeless programs. Housing First is an evidence-based, cost-effective approach to ending homelessness for the most vulnerable and chronically homeless individuals. Within VA Homeless Programs, the Housing First model prioritizes housing, and then assists the Veteran with access to healthcare and other supports that promote stable housing and improved quality of life. The model does not try to determine who is "housing ready" or demand treatment prior to housing. Instead, treatment and other support services are wrapped around Veterans as they obtain and maintain permanent housing.

The approach has the following defining characteristics:

- Treatment and supportive services are made available, but are not a requirement for participation or remaining in housing.
- Assertive community outreach is used to engage people who are homeless with mental illness and substance use problems, and place them in permanent housing as quickly as possible.
- A low demand approach is used to accommodate people who cannot remain clean and sober, and be fully compliant with mental health treatment, in order to sustain the formerly homeless person in stable permanent housing.
- A commitment is made to offer permanent housing for vulnerable people who are chronically homeless, not requiring a period of stabilization, sobriety, or commitment to treatment to demonstrate housing readiness.

[51] Housing First is Ending Veteran Homelessness https://pathwaystohousing.org/housing-first-model/ending-veteran-homelessness

Comprehensive Supportive Service Package

VHA's Homeless Programs have been aligned for many years with the Veterans Health Administration and have a strong tradition of directly providing healthcare, including mental healthcare and substance use services to all Veterans enrolled in VHA homeless programs. In addition, the Programs have developed strong collaborative relationships with community partners across the country to provide uniform supportive services to end the Veteran's homelessness. Each Veteran receives a detailed assessment upon intake to VHA homeless programs, and the supportive service package is individualized to meet the needs of the Veteran based on the initial assessment. A list and brief description of VHA's homeless programs can be found in Appendix A.

A Low Demand/Harm Reduction Approach

The primary focus of the Veteran's care in a low demand/harm reduction model program is housing stability. Most VA Homeless Programs utilize a low demand/harm reduction approach in many of their programs, especially in its permanent supportive housing programs for homeless Veterans. The low demand/harm reduction model does not require sobriety or full compliance with treatment for admission or continued stay in the program. Many individuals experiencing homelessness cannot be fully compliant with traditional requirements, and consequently have repeated failures, resulting in chronic homelessness. Low demand/harm reduction models attempt to reverse that trend by continuously engaging the Veteran, using state-of-the art, evidence-based therapies, but do not discharge the Veteran for noncompliance. The low demand approach is a cornerstone of Housing First.

Community Partnerships

Many of the services VA provides to homeless Veterans and their families are provided through collaborative relationships with local community agencies, grantees, Veterans Service Organizations, and faith based and charitable organizations. This requires careful coordination of services and monitoring to ensure that needed services are provided in a timely manner, services are not duplicated, and important communication channels are established to ensure that the needs of homeless Veterans' are being met. Thus, it is important for Navigators to be knowledgeable of community agencies and the services they can provide to homeless Veterans.

Recovery Focus

The Recovery Model is a treatment concept wherein services are designed in such a way that program participants have primary control over decisions about their own care. This is in contrast to many traditional models of service delivery, in which program participants are instructed in what to do, or simply have things done for them with minimal, if any, consultation regarding their opinions. The Recovery Model is based on the concepts of strengths and

empowerment; it is rooted in the principle that when individuals who have been homeless or have histories of mental illnesses and substance use problems have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives.

d. The Mission and Scope of the Navigator - *When to Use a Navigator?*

People who are homeless often find it a daunting task to negotiate assistance from the services that can help them. Finding the right services to address their individual needs requires special knowledge, may require transportation to the agency, documentation of their status, and sometimes negotiation of barriers that may prevent them from getting the assistance they need. To address this issue, many local Continuums of Care (CoC) and agencies that serve the homeless have developed the Navigator position to assist homeless populations negotiate the services they need. Some Navigators operate under very limited scopes, assisting homeless populations with negotiating employment or housing. However, VA envisions the scope of the Navigator more broadly, involving the linking of Veterans to a broad range of housing medical, employment, mental health, income support, legal, and community services designed to address their homelessness and other assessed needs.

Below we define in detail, the mission and scope of Navigators, and suggest polices for their use in the care of homeless Veterans.

<u>Navigators and Outreach</u>

The process of linking homeless Veterans with services begins with the assessment and the establishment of the relationships that occur at outreach. Many of the *Combined Assessment Centers* used in the 25 Cities Initiative have successfully integrated Navigators into their outreach operations. Navigators are also used in VA's Community Resource and Referral Centers (CRRCs) that provide "one stop" outreach services to homeless Veterans from community-based urban store front centers in collaboration with other local community partners. Navigators who work with the Outreach teams and in the community outreach and assessment centers can play an important role in connecting clients with a wide variety of services rapidly, and help the homeless Veteran build confidence that assistance can be provided to end their homelessness. Basic services such as showers, clean clothes, meals and nutrition programs, and connecting Veterans with other needed services like childcare, medical, and mental health care, and temporary and permanent housing services, are all roles that Navigators should have when working with outreach teams.

Helping homeless Veterans navigate the system goes beyond making needed referrals for housing and services. Navigators ensure that connections with needed services are made by following up to see that the Veteran connects with all identified services, and checking back

with both the Veteran and the service provider. Navigators routinely must ensure that the Veteran has the transportation and means to get to the service provider, any paper work required for the requested service, and follow-up to ensure that the Veterans' service needs will be met by the service provider, and provide alternative linkages if needed. Homeless Veterans sometimes "fall through the cracks" during the early intervention phase. Navigators can play a key role in staying continuously engaged through close frequent contact with the Veteran and careful follow-up to ensure that Veteran's needs are met.

Navigating Housing Search and Housing Systems

Securing safe, affordable, permanent housing is one of the key functions of the Navigator in VA's homeless programs. Due to the fact that immediate access to permanent housing is not available in many parts of the country, the process usually begins with direct intervention to secure shelter, temporary, or bridge housing, assuring the client that they will be rapidly housed in safe, affordable, permanent housing as rapidly as possible. Navigators and team members assisting with this process must always listen and respect the homeless Veteran's preferences with regard to securing housing. Respecting the preferences of Veterans helps build trust, which is critical to the success of any new Navigator-Veteran relationship.

Navigators typically have a number of important roles in assisting the Veteran in securing safe, affordable housing:

- Participating in the housing needs assessment and assessing the Veteran's housing preferences
- Assist with landlord and Public Housing Authority (PHA) applications for permanent housing
- Assisting the Veteran with necessary documentation
- Guiding and supporting the Veteran with the housing search
- Mitigating issues with credit reports, utility arrears, and unfavorable landlord references
- Assisting Veterans with acquisition of furniture and move-in essentials
- Negotiating with PHA officials for timely inspections and landlord corrective action
- Assisting the Veteran with expanded housing searches when necessary to ensure timely permanent housing
- Connecting Veterans with the Supportive Service Package

The Navigator also typically plays a key role in working with the team to assist the Veteran to acquire a wide variety of supportive services to successfully end his or her homelessness:

- Medical, mental health, dental, and substance use care
- Income supports
- Employment, vocational, education, and leisure services
- Legal services

- Supportive services such as AA, NA, NAMI, special needs support groups, and connections with churches, synagogues, mosques, and avenues of spiritual support
- Food stamps, Food pantries, meals on wheels, and food programs
- Parks, recreation, and leisure time programs
- Federal, State and County benefit programs
- Programs that address the Veterans special needs
- Coordination with VA and Community Homeless Teams

Navigators work most effectively when they are part of a larger homeless team where daily meetings are conducted to coordinate and communicate about the plan of care and the services being provided to the team's Veteran clients. While assisting with the negotiation of services, Navigators typically acquire information about the Veteran that is invaluable for providing tailored and ongoing assistance. Navigators often accompany or transport Veterans to appointments, and in the course of their close contact have opportunities to observe responses to the interventions, and acquire information about need for any additional services. When Navigators work in teams that regularly conduct a "huddle", the information can be quickly shared and the Navigator in collaboration with the team, can respond, refine, and make adjustments that will improve services to the Veteran.

The Navigator Role in Teaching Veterans System Negotiation Skills

One of the key roles of the Navigator is to serve as a role model and mentor to the Veterans they work both within and throughout homeless programs. Navigators both teach and mentor as they negotiate service systems, helping the homeless Veteran practice their personal negotiation skills. The Navigator provides pointers on where services are likely to be obtained, guidance on access issues, and offers support for the Veteran while they are negotiating for needed services. Navigators should always endeavor to provide the supports necessary to help the Veteran be as independent as possible, with the Veteran being the driving force in directing their own service plan, consistent with the Recovery Model approach described earlier in this chapter.

The Navigator Role in Sustaining Veterans in Permanent Housing

The services of the Navigator should be continued well into the Veteran's adjustment to living in permanent housing. Valuable relationships between the Veteran and the Navigator are built up as services for the Veteran are negotiated. These relationships should be sustained by use of Navigators in the task of helping Veterans stay housed. Some of the roles that Navigators can play in the sustainment process are as follows:

- Assisting Veterans with negotiating local transportation systems
- Connecting with local Veterans service programs
- Negotiating low cost entertainment and assistance with leisure pursuits

- Building social support systems in their new area of residence
- Continued role in monitoring and maintaining their usage of the supportive service package

For a detailed description of the duties, responsibilities, and scope of Navigators employed in VA Homeless Programs, please refer to the Sample Navigator Position Description in Appendix B.

e. Training and Support Needs of Homeless Navigators

Navigators should be provided with training and information on the following subjects to carry out their duties and responsibilities:

- Working knowledge of the VA and community based homeless programs
- Working knowledge and assistance with acquisition of working relationships with a wide range of service providers with whom they are expected to conduct business
- The basics of the do's and don'ts of helping relationships
- The Recovery Model
- Veterans, Federal, State and County benefit programs
- Working knowledge of housing programs, landlord requirements, and lease-up process and requirements
- Local social, leisure time, spiritual, mental health, and substance use support systems
- Emergency service systems used for support of Veterans in crisis

Navigators should always work with the support of homeless teams and have the ability to communicate daily with other providers/members of the homeless team. Navigators should also be provided a minimum of one hour per week supervision from a senior homeless team staff member similar to clinical case staff.

Contributing Authors

(in alphabetical order)

- Roger Casey, VA National Center on Homelessness among Veterans
- Stephanie George, University of Southern California
- Matthew McKenna, Massachusetts Department of Veterans' Services
- Coleman Nee, President of At-Ease Strategies, LLC, and former Secretary of Veterans' Services for the Commonwealth of Massachusetts
- Thomas O'Toole, VA National Center on Homelessness among Veterans
- Leon Sawh, VA National Center on Homelessness among Veterans
- David Smelson, VA National Center on Homelessness among Veterans and University of Massachusetts Medical School
- Paul Smits, VA National Center on Homelessness among Veterans and University of South Florida
- Kerry Spitzer, Massachusetts Institute of Technology
- Matthew Stimmel, VA Palo Alto Health Care System
- Susan Vieira , VA National Center on Homelessness among Veterans

Appendices

The Appendices to the Toolkit contain:

- Appendix A: A Brief Review of Current VA Homeless Programs
- Appendix B: A Sample Navigator Job Description
- Appendix C: A Navigator Program Integration Fidelity Tool - to assess the incorporation of Navigators into existing program structures
- Appendix D: Excerpts from the Standard Operating Procedures - used for the Massachusetts' SAVE/SHARP programs described in Chapters 4 and 5.

Appendix A: Description of VA Homeless Programs

1. Housing and Urban Development - Veterans Affairs Supportive Housing (HUD- VASH) Program: A collaborative program between HUD and VA where eligible homeless Veterans receive a Housing Choice rental voucher from HUD, paired with VA providing case management and supportive services to sustain housing stability and recovery from physical and mental health problems, substance use disorders, and functional concerns contributing to or resulting from homelessness. HUD-VASH subscribes to the principles of the "Housing First" model of care. Housing First is an evidence based practice model that has demonstrated rapidly moving individuals into housing, and then wrapping supportive services around them as needed, helps homeless individuals exit from homelessness, remain stable in housing, and thus improving ability and motivation to engage in treatment strategies. Program goals include housing stability while promoting maximum Veteran recovery and independence in the community for the Veteran and the Veteran's family.
2. Supportive Services for Veteran Families (SSVF): This program was authorized by Public Law 110-387 and provides supportive services to very low-income Veteran families in or transitioning to permanent housing. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability.
3. Homeless Providers Grant and Per Diem Program (GPD): The GPD program allows VA to award grants to community-based agencies to create transitional housing programs and offer per diem payments. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VA medical centers (VAMC) by augmenting or supplementing care.
4. Health Care for Homeless Veterans (HCHV): The central goal of HCHV programs is to reduce homelessness among Veterans by engaging and connecting homeless Veterans with healthcare and other needed services. HCHV programs provide outreach, case management and HCHV Contract Residential Services ensuring that chronically homeless Veterans, especially those with serious mental health diagnoses and/or substance use disorders, can be placed in VA or community-based programs that provide quality housing and services that meet the needs of these special populations.
5. Health Care for Reentry Veterans Services (HCRV): The HCRV program is designed to address the community re-entry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community re-adjustment, and decrease the likelihood of re-incarceration for those leaving prison.

6. Veteran Justice Outreach (VJO): The purpose of the Veteran Justice Outreach (VJO) Program is to prevent homelessness, and avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans. This is accomplished by ensuring that eligible justice-involved Veterans encountered by police, and in jails or courts, have timely access to VHA mental health, substance abuse, and homeless services when clinically indicated, and other VA services and benefits as appropriate.

7. Homeless Veteran Community Employment Services (HVCES): In order to help improve employment outcomes and reach the most difficult to serve homeless Veterans, in the third quarter of FY 2014 each VA medical center (VAMC) received funding to hire new Vocational Development Specialists (VDS) who will serve as Community Employment Coordinators (CEC) within the Homeless Veteran Community Employment Services (HVCES) framework. The new CECs are responsible for the ongoing orientation and training of the Homeless Services continuum and for providing direct assistance in connecting Veterans to the most appropriate and least restrictive VA and/or community-based employment service leading to competitive employment with appropriate supports.

8. National Call Center for Homeless Veterans (NCCHV): The NCCHV was founded to ensure that homeless Veterans or Veterans at-risk for homelessness have free, 24/7 access to VA staff. The hotline is intended to assist homeless and at-risk Veterans and their families, VAMCs, Federal, state and local partners, community agencies, service providers and others in the community. The phone number is **1-877-4AID VET (1-877-424-3838).**

9. Domiciliary Care for Homeless Veterans (DCHV): The DCHV program provides time-limited residential treatment to homeless Veterans with mental health and substance use disorders, co-occurring medical concerns, and psychosocial needs including homelessness and unemployment. DCHV programs provide homeless Veterans access to medical, mental health, and substance use disorder treatment in addition to psychosocial and vocational rehabilitation treatment programs.

10. Homeless Patient Aligned Care Teams (H-PACT): H-PACT provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans. At selected VA facilities, Veterans are assigned to an H-PACT care team that includes a primary care provider, nurse, social worker, homeless program staff and others who provide medical care, case management, housing and social services assistance, to provide and coordinate the healthcare they may need while assisting them in obtaining and staying in permanent housing.

11. Community Resource and Referral Centers (CRRC): CRRCs are a collaborative effort of VA, the community, service providers, and agency partners. The CRRCs are located in strategically selected areas to provide both a refuge from the streets and a central location to engage homeless Veterans in services. Veterans will be referred to health and mental healthcare resources, job development programs, housing options, and other VA and non-VA benefits.

12. Safe Havens: Safe Havens provide a transitional residence for hard to reach homeless persons with mental illness and substance use problems who have failed in traditional programs. The low-demand, non-intrusive environment is designed to establish trust and eventually engage the homeless Veteran in needed treatment services and transitional or permanent housing options.
13. Homeless Veterans Dental Program (HVDP): The Homeless Veteran Dental Program helps increase the accessibility of quality dental care to homeless and certain other Veteran patients enrolled in VA-sponsored and VA partnership homeless rehabilitation programs throughout the U.S.
14. Stand Downs: Stand Downs are typically one to three day events providing services to homeless Veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment. Stand Downs are collaborative events, coordinated between local VAs, other government agencies, and community agencies who serve the homeless.
15. VA National Center on Homelessness among Veterans (the Center): The VA National Center on Homelessness among Veterans (the Center) works to promote recovery-oriented care for Veterans who are homeless or at-risk for homelessness by developing and disseminating evidence-based policies, programs, and best practices. The Center was active this year in research, model development, and education.
16. Project CHALENG (Community Homelessness Assessment, Local Educations and Networking Groups) for Veterans: This program unites consumers, providers, advocates, local officials and other concerned citizens to identify the needs of homeless Veterans and work to meet those needs through planning and cooperative action. CHALENG is designed to be an ongoing assessment process that describes the needs of homeless Veterans and identifies the barriers they face to successful community reentry. This process has helped build thousands of relationships with community agencies, Veterans groups, law enforcement agencies, and Federal, state, and local government. Local CHALENG meetings represent important opportunities for VA and public and private agency representatives to meet and develop meaningful partnerships to better serve homeless Veterans.

Appendix B: Sample Navigator Position Description

DISCLAIMER: ANY POSITION DESCRIPTION MUST BE APPROVED BY VA FACILITY/PROGRAM LEADERSHIP. THE POSITION DESCRIPTION BELOW IS ONLY A SAMPLE INTENDED FOR INFORMATIONAL PURPOSES.

WHAT DOES A HOUSING NAVIGATOR DO?

Navigators work as part of a team to prioritize Veterans' living in community-based stable housing, by having a strong working knowledge of available resources (VA and non-VA) to link Veterans to needed programs, and by making warm handoffs to needed services/providers whenever possible. Navigators facilitate 'active' linkages before, during, and/or after permanent housing has been established, consistent with the Housing First model. Navigators will then work closely with Veterans to help develop the skills required to utilize the necessary resources to support their permanent housing. Navigators have many roles often working as advocates, referral agents, and/or facilitators with VA, other government agencies, and community partners' systems on behalf of the Veteran.

DUTIES

- Guide and support Veterans through the housing search process
- Mitigate any issues with credit reports, utility arrears, criminal records, and/or unfavorable landlord references
- Participate in the housing needs assessment process to identify the Veteran's housing preferences
- Assist with landlord and Public Housing Authority (PHA) applications for permanent housing and in preparing/obtaining any needed documentation
- Negotiate with PHA officials for timely inspections and landlord corrective action requests
- Assist Veteran with expanded housing searches when necessary to ensure timely permanent housing
- Assist with facilitating a wide variety of support services including health, mental health, substance abuse treatment, benefits, employment, transportation, etc.
- Monitor each Veteran's individual needs and contribute to the development of a plan designed to appropriately respond to the Veteran's needs
- Develop strong working relationships, through active outreach, with a wide range of service providers and related stakeholders such as landlords, service providers, property management companies, employers, etc.

- Work as part of a team including the Veteran's case manager to address any emerging issues related to housing and community adjustment
- Regularly document updates in clinical charts for each Veteran on caseload
- Actively participate in staff meetings and complete trainings as assigned
- Assist Veterans with acquisition of furniture and other move-in essentials (kitchen utensils, cleaning supplies, etc.)
- Help Veterans build social support systems in their new area of residence
- Continued monitoring of the Veterans' engagement with needed services in their new communities

QUALIFICATIONS

- Should have comprehensive knowledge of VA, state, county, city, and community resources
- Working knowledge of current housing practices for homeless populations including *Housing First*, landlord requirements, lease-up processes, and use of emergency service systems to support Veterans in crisis
- Demonstrated prior experience working in, or familiarity with, the field of homelessness
- Effective written and communication skills
- Ability to cope/resolve conflicts and crisis situations
- Proficient in use of computers, including Microsoft Office software package, and familiarity with database platforms to efficiently track service delivery
- Ability to develop relationships with a wide variety of stakeholders
- Valid driver's license and clean driving record

Appendix C: Navigator Program Integration Fidelity Tool

This fidelity tool is designed to help program managers assess the integration of Navigators into existing services. It can also be modified to be better meet the local needs of your program. ***If an individual is incarcerated or is in inpatient treatment during a particular time period, or if no service was needed or necessary, mark 'N/A' for relevant questions. Additionally, if a function listed below is the role of another team member, and the Navigator is not expected to function in this role, mark 'N/A'. An explanation in the comment section would be helpful in this regard.*

1. Team Cohesion

A) Do Navigators have a strong working knowledge of available resources (VA and non-VA) to link Veterans to needed programs, prioritizing permanent supportive housing for the Veteran?	Always	Frequently	Sometimes
	Seldom	Not Observed	N/A
B) Do Navigators work with others on team to monitor each Veteran's individual needs and contribute to the development of a housing plan designed to appropriately respond to the Veteran's needs?	Always	Frequently	Sometimes
	Seldom	Not Observed	N/A
C) Do Navigators develop strong working relationships, through active outreach, with a wide range of VA and non-VA service providers and related stakeholders such as landlords, service providers, property management companies, employers, etc.?	Always	Frequently	Sometimes
	Seldom	Not Observed	N/A
D) Do Navigators actively participate in staff meetings with program manager, case managers, social workers, and other clinical staff, which may also include peers, to address any emerging issues related to housing and community adjustment?	Always	Frequently	Sometimes
	Seldom	Not Observed	N/A
E) Do Navigators have many diverse roles and functions - often working as advocates, referral agents, and/or facilitators with VA, other government agencies, and community partner' systems on behalf of the Veteran?	Always	Frequently	Sometimes
	Seldom	Not Observed	N/A
F) Are Navigators provided with the opportunity to document or contribute clinician's documentation regarding updates in charts for each Veteran on caseload?	Always	Frequently	Sometimes
	Seldom	Not Observed	N/A

2. Engagement with Services

A)	Do program staff ensure that Veterans have social support systems in place in their new communities?	Always Frequently Sometimes Seldom Not Observed N/A
B)	Do program staff monitor the Veterans' engagement with needed services in their new communities?	Always Frequently Sometimes Seldom Not Observed N/A
C)	Do Navigators facilitate a wide variety of support services including health, mental health, substance abuse treatment, benefits, employment, transportation, etc.?	Always Frequently Sometimes Seldom Not Observed N/A

3. Housing Supports

A)	Are Navigators a part of the housing needs/preferences assessment process?	Always Frequently Sometimes Seldom Not Observed N/A
B)	Do Navigators assist with landlord and Public Housing Authority (PHA) applications for permanent housing and in preparing/obtaining any needed documentation from Veterans?	Always Frequently Sometimes Seldom Not Observed N/A
C)	Are Navigators in a position on the team to facilitate with PHA officials for timely inspections and landlord corrective action requests?	Always Frequently Sometimes Seldom Not Observed N/A
D)	Can Navigators intervene regarding issues related to credit reports, utility arrears, criminal records, and/or unfavorable landlord references?	Always Frequently Sometimes Seldom Not Observed N/A
E)	Do Navigators conduct housing searches when necessary to ensure timely permanent housing of Veterans?	Always Frequently Sometimes Seldom Not Observed N/A

Comments

Appendix D: MA Resource Documents

i. Executive Summary of the Massachusetts Plan to Prevent and End Homelessness
ii. S.A.V.E. Program Standard Operating Procedures (SOP)
iii. S.A.V.E. FY14 Annual Report

i. Executive Summary of the Massachusetts Plan to Prevent and End Homelessness

The Massachusetts Plan to Prevent and End Homelessness among Veterans has a compelling vision: all Massachusetts Veterans will have a stable place to call home. Its overall goal is bold: reduce the number of homeless Veterans in the Commonwealth by 1,000 point in time by the end of 2015. Massachusetts Veterans deserve nothing less.

According to the 2011 Point-in-Time (PIT) count there were 1,268 homeless Veterans on a given night across Massachusetts, which represents 7.6% of the total homeless population in the state. This PIT count has been trending downward in recent years, with the 2011 count 20.6% lower than that of the previous year. We also estimate that 450 of those individuals meet the U.S. Department of Housing and Urban Development's (HUD) definition of chronically homeless.

The Steering Committee to End Veterans' Homelessness sought significant input into the development of the guiding principles, goals, targets, and strategies contained herein. Plans from the U.S. Department of Veterans' Affairs (VA), the United States Interagency Council on Homelessness (USICH), Arizona, New Hampshire, King County, Washington and Washington State were reviewed and the Steering Committee spoke to the authors and implementing bodies to learn from their experiences. Additionally, the Steering Committee engaged well over 200 stakeholders from across the Commonwealth to identify barriers, opportunities, and best practices. Finally, the Steering Committee reviewed emerging best practices in preventing and ending homelessness among Veterans from here in Massachusetts, as well as other parts of the country.

Stemming from this environmental scan and needs assessment, the Steering Committee identified five guiding principles that form the basis of this plan, and should be considered by stakeholders for all future implementation strategies.

1. Focus on results and evidence-based practices
2. Prioritize prevention and rapid rehousing
    - Divert and use shallower resources for non-chronically homeless Veterans
3. Prioritize chronically homeless Veterans, the most at-risk, and frequent utilizers of emergency care
    - Focus deep subsidy resources and services on chronically homeless Veterans
4. Address the needs of all men and women who served in the military regardless of the type of discharge they received
5. Build partnerships

Further, in an effort to integrate federal, state, and local resources and to align with the VA's Plan to End Homelessness among Veterans and the USICH plan *Opening Doors*, the Steering

Committee has organized its goals within a Four Pillar framework of (1) Housing, (2) Prevention, (3) Intervention, and (4) Partnerships. The specific goals addressed by this plan include:

- Goal 1: Veterans who become homeless are rehoused and stabilized
- Goal 2: Veterans most at risk of homelessness remain housed.
- Goal 3: Veterans have increased access to benefits and resources
- Goal 4: Federal, state, and community resources are aligned and integrated to support Veterans.

The following are signature initiatives of the Plan to Prevent and End Homelessness among Veterans, details of which are provided in the following pages.

1. Reduce the 2011 homeless Veterans PIT count by 1,000 by the end of 2015.
2. End chronic homelessness among Veterans, going from 450 to 0, by the end of 2015.
3. Access 1,000 units of permanent housing to meet plan goals by end of 2015, including:
    - 700 new HUD-VASH vouchers
    - 250 new units of housing through DHCD initiatives for chronically homeless Veterans, including at least 25 for non-VA eligible chronically homeless Veterans
    - 50 housing subsidies through DHCD initiatives to access existing housing units for non-VA eligible homeless Veterans
4. Support the VA's efforts to build community capacity to serve Veterans where they live by contracting for HUD VASH case management, peer support and other services with DVS and community-based non-profits.
5. Expand partnerships between local VA Medical Centers as well as the VA National Center on Homelessness among Veterans, MA ICHH, DVS (Chapter 115), DHCD, Continua of Care (CoC), VSO's, Housing Authorities, Regional Homeless Networks, and the Regional Housing Network. This partnership is the key to:
    - Accessing existing housing
    - New housing production
    - Providing comprehensive wrap around services
    - Ensuring access to benefits and income supports
    - Prevention
6. Develop regional lists of homeless Veterans in partnership with CoCs, Regional Networks to End Homelessness, and city and town Veteran's Services Officers (VSO's) in order to prioritize resources and support services, to track progress and outcomes for specific individuals, and to understand the scope of Veterans who are newly homeless and accessing systems of care.
7. Launch a demonstration project in Year 1 of this plan to test the feasibility of conversion strategies that allow providers to utilize existing Veteran's emergency and transitional housing resources for permanent housing and community-based supports.
8. Improve research and data to better inform policy and target resources.

ii. **S.A.V.E. Program Standard Operating Procedures (SOP)**

Standard Operating Procedures
Massachusetts Department of Veterans' Services
S.A.V.E. Team
Kevin Lambert, Director
(November 2013)

Purpose of this manual

The Operations Manual brings together the detailed requirements, instructions and guidelines for performance of members of the Massachusetts Department of Veteran Services S.A.V.E. Team. The purpose of the Operations Manual is to assist all members of the S.A.V.E. Team and service providers working with the S.A.V.E. Team to successfully help the Veterans and family members of Veterans of the Commonwealth.

This manual was designed to be a reference or guide **ONLY**. This manual will not answer all questions that may arise in the day-to-day operations of the S.A.V.E. Team; however, the rules and policies in this manual shall be used in conjunction with the Standard Operating Procedures of the Massachusetts Department of Veteran Services when formulating answers to questions.

Terms Used

There are several key terms and abbreviations that appear throughout this manual. Once a term has been used once in the manual an abbreviation will appear in place of the full term. Below is a list of commonly used terms and their abbreviations:

- Director of Save (DS)
- Team Leader (TL)
- Operations Specialist or (OS)
- Outreach Coordinator or (OC)
- Department of Veteran Services or (DVS)
- Statewide Advocacy for Veterans Empowerment or (S.A.V.E.)
- Department of Public Health or (DPH)
- Point of Contact or (POC)
- Traumatic Brain Injury or (TBI)
- Post-Traumatic Stress Disorder or (PTSD)
- Critical Incident Report or (CIR)

S.A.V.E. Mission Statement

The S.A.V.E. program is a one-of-a-kind peer outreach program within the Massachusetts Department of Veterans' Services. The fundamental principle of the S.A.V.E. program is to advocate for Veterans who are not able to obtain the benefits they have earned due to institutional or personal barriers. The program's primary mission is to prevent suicide and mental health distress in Veterans returning from military service. The program also proactively provides them with access to benefits and services that may address these issues and result in positive transitions back to civilian life.

The outreach team is comprised of Veterans and family members of Veterans who have overcome many of the same obstacles Veterans and families may be facing now. Through their own shared stories and extensive knowledge of the benefits and services available we are able to offer hope, empowerment, and more importantly meet the needs of our Veterans and Families and not make them meet the needs of our system

"When your service ends, our mission begins!"

Demographics S.A.V.E works with

The S.A.V.E. program is a community based peer support program who offer simple link and referral services as well as peer support and case management services to Veterans and their families. SAVE in a non-clinical team and does not provide any clinical or medical services. The S.A.V.E. team works with all generations of Veterans but focuses on those who are high risk due to suicide ideations and actions, TBI, PTSD, Substance Abuse, Medical issues, and mental health issues. Once the Veteran or family member is identified an outreach coordinator will go through an in depth intake form to assist in identifying what barriers and challenges they are facing and then link or refer them to the appropriate services. The OC can provide ongoing peer support and system navigation or will simply follow-up to ensure the link or referrals was successful and see if the Veteran or family member needs anything else. If ongoing support is needed the OC can then set up an Individual Action Plan (IAP) which will help identify goals and the activities needed to be completed in order to meet those goals. They will then work with the Veteran and/or family member to complete the activities and meet those goals.

The screening assessment for suicide risk is modeled after the WHO (World Health Organization), CDC (Center for Disease Control). and the Air Force's suicide assessments, the TBI assessment is taken from The S.H.I.P.'s (Statewide Head Injury Program) head injury assessment, and the PTSD assessment is constructed from the Veterans Administration Vet Center's mental health questionnaire.

In addition to Peer Support and link and referral services, the S.A.V.E. program also has an extensive community outreach program. The goal of the community outreach program is to not only identify those Veterans and families who are unaware of the benefits and services available to them but to also provide education and resources to the communities. This includes but is not limited to educational facilities, local first responders, private and non-profit organizations, medical staff within community facilities, senior homes , court system, Gold Star families, Blue Star Families, military organizations to include Reserve and Guard, and any community members looking to learn about Veterans issues and more importantly what is available to those Veterans. By having this relationship with community level providers we are able to utilize the benefits, services, and expertise of the government while at the same time assisting the Veterans and their families reintegrate back into the community.

Another facet of the outreach program is training. To date, the S.A.V.E Program provides an adapted version of Q.P.R. training (a gatekeeper training for suicide prevention) for persons working in the Veterans' service community, as well as DVS 101 which goes over the benefits and services available to Veterans and their families.

Additionally, S.A.V.E. also offers BattleMind training, which helps individuals understand how our mind is trained to go into battle and how if not transitioned properly the BattleMind can create many challenges and obstacles for the Veteran and their family once back home. By having a better understanding of the military culture, training, and mindset of a service member it will allow the community to better understand our Veterans and ultimately help them support our Veterans and families throughout their transition.

Team Responsibilities by Position

Director of S.A.V.E.:

- Reports to Manager assigned to S.A.V.E.
- Delivers year-end reports to Department of Public Health (DPH).
- Coordinates any database changes or updates.
- Staffs highly visible public events and fulfills interview/media requests.
- Main point of contact for potential partners or contributors to S.A.V.E.
- Responsible for ensuring that the overall S.A.V.E. mission is accomplished.
- Assists in strategic development of objectives and their implementation.
- Over see's all Team Leaders and Operations Specialist

Team Leader - S.A.V.E.:

- Works in collaboration with and under the guidance of the Director and other team leaders of S.A.V.E.
- Briefs Director of S.A.V.E. on all issues that may arise, as needed
- Submits weekly reports to Operations Specialist
- Oversees day-to-day operations of S.A.V.E. (i.e. manages daily outreach and case management effort's, tracking the OC's in the field, monitor the level of cases each OC is carrying).
- Oversees and schedules the On-Call phone rotation with other team leaders.
- Conduct, schedules and track's all S.A.V.E. team training.
- Solves any scheduling conflicts that may arise.
- Staffs any high visibility public events and covers interview requests.
- Reports directly to the Director of S.A.V.E.
- Attends weekly team leader meetings with the Director and other Team Leaders.

Outreach Coordinators:

- Conduct in-person visits with Veterans and administer a Form 1 (initial intake form) and a Form 2 (initial interview form) if needed.
- Link and refer Veterans and family members as needed.
- Follows up with Veteran or family member within 2 weeks of initial contact.
- Responsible for conducting community outreach in their areas (i.e. hanging posters, placing S.A.V.E. brochures) to keep a presence in local communities around the Commonwealth.
- All community outreach mapped and tracked using the 'Outreach Tracking Log'.(i.e. name and type of business, address and POC where posters and brochures are placed)
- Responsible for setting up appointments with Veterans that are received from the S.A.V.E. phone and email address via the OS.
- Works closely with service providers to monitor and help individual Veterans and family members.
- Reports directly to their assigned Team Leader.
- Responsible for all aspects of active case management of Veterans that are referred to them.
- Responsible for creating an Individual Action Plan (IAP) for each Veteran.
- Link Veterans to various service providers to help meet and sustain IAP goals.
- Act as the main liaison between their Veterans and the service providers.
- Submits weekly reports to TL and OS.
- Report directly to the assigned Team Leader – S.A.V.E.

Operations Specialist:

- Routes and tracks incoming calls and refers to the appropriate S.A.V.E. team member or provide a direct referral to the Veterans or family member.
- Follow up with those Veterans and/or families that were provided with a referral.
- Offers every person they have contact with a in person visit with one of the OC's.
- Routes incoming complex or potentially active cases to the appropriate OC via email, with a CC to assigned Team Leader
- Maintains a call log of all incoming Veterans to the S.A.V.E. program and sends weekly report to Director.
- Collects and compiles all weekly reports from outreach staff and sends a composite report to the Director every Friday.
- Handles all scheduling for the team including events, presentations, and trainings.
- Handles team mailings (i.e. request for brochures and S.A.V.E. materials).
- Creates benefit folders for use by S.A.V.E. team members.
- Responsible for ordering and/or securing team supplies (i.e. pens, pencils, printer ink).
- Reports Directly to the Director
- Provides administrative support to the Director.

Note:

Outreach Coordinators, Operations Specialist, and team leaders will be responsible for completing any additional duties assigned to them by the Director. All assignments will be related to the overall mission of S.A.V.E. and the Department of Veteran Services.

On-call Coordinator/ On-Call Procedures

The S.A.V.E. team has set up a 24/7 phone line that Veterans and or family members can call after normal business hours for advice, guidance and support. The peer-line should and does not replace 911 or the national suicide prevention lifeline. The On-Call phone will be rotated between team members on a weekly basis. Each rotation will consist of two on call staff that will work together to handle any urgent situations that come up as well as an on call team leader to provide guidance, oversight of any incident, and will report to the Director on any critical incidents so they can be reported up the chain immediately.

On-call Procedures

- Always have the on-call phone readily available and have an ample charge
- Never forward the on call phone to your BB or any other device. If there is an emergency and coverage is needed the phone should be handed off and not forwarded to a BlackBerry. If you have to forward the on-call phone temporarily you may do so to the on call team

leaders BB and then unfoward it ASAP. Permission from the Director is required prior to transferring the phone.

- Try to not place the phone on silent.
- If a call is missed (i.e. due to sleep, other work) the missed phone call should be returned as soon as possible.
- Avoid situations where you are unable to answer the phone. If a situation is unavoidable, please see the above guidance on transferring the phone.
- When traveling in the state check the status of the phone's reception often. Try to minimize time spent in a cell phone "dead zone"
- Try to remain within MA while you are on call. If you need to travel outside of MA, let the Team Leader know, and the phone can then be transferred appropriately. It is your responsibility to know when you are on call and to plan your schedule the best you can around it.
- If you are unable to cover your on call rotation it is on you to find coverage, relay that to your team leader who will then make sure the on call team leader is aware. It is on you and the person covering to work out the details of the change. This change will not change the actual rotation but act as a substitute for that particular week.
- If you receive any additional calls while already engaged in handling a call, notify the on call Team Leader and they will delegate the calls as needed.
- Avoid entering into any situation that presents a danger to anyone including you, the Veteran, or family members of the Veteran without the proper authorities present. (Refer to the S.A.V.E. team crisis response plan)
- It is a good idea to take notes when speaking with a Veteran, family member, or provider on the peer-line. This can and or will help you if you need to fill out a Critical Incident Report (CIR).
- When taking over as the on-call coordinator the oncoming (OC) must make a test call immediately to the peer line to ensure that the phone is working properly.
- If you respond to a crisis situation, notify the on-call Team Leader as soon as the situation allows. Let the Team Leader know the address you are responding to, the time you arrive and the time you leave the address. You must also note in the (CIR) all steps taken. You should update the TL every 30 minutes on the status of the situation.
- When handing over the on-call phone to the next on-call coordinator, the relinquishing coordinator must ensure that the phone charger and carrying case are accounted for and given to the receiving on-call coordinator.
- When a coordinator relinquishes on-call duties, they are entitled to take 1 half day off work. The half day should be used within a week from the end of the on call rotation.
- The half-day comp time given off **WILL NOT** be deducted from current balances accrued by any member on the team.

Intake/Assessment

Veterans and family members who reach out to the SAVE Team for help can do so in one of two ways:

- The S.A.V.E. email address at save@massmail.state.ma.us
- The S.A.V.E. number at 617-210-5743. The Operations Specialist monitors both the email and the phone number. The (OS) will attempt to help the Veteran/family member by trying to answer their questions if possible however always offer's that the OC can come to their community and meet with them in person. The (OS) also tracks all Veterans/family members who reach out to the S.A.V.E. team via the SAVE database
- If the (OS) makes a referral to the OC s/he will email the appropriate OC, the name, contact information, and a brief description of what the Veteran/family member needs. If the case is transferred through the database, the OS should email the OC the assigned case number as a heads up letting the OC know a new case was referred. All emails with referrals should be sent to the OC with a Cc to the Team Leader.
- The (OS) will input the name, contact information of the Veteran/family member; reason they contacted the team and date of call or email to the S.A.V.E. team. All information will be annotated on the (OS) weekly call log. If the case was put into the database we can generate the weekly report through the system.
- The Excel spreadsheet phone log that the (OS) keeps will be done in chronological order by month. This list will be emailed to the Director weekly; Friday at 1600.
- If the OC/OS helps the Veteran with a link or referral over the phone or in person then the OC/OS will complete a Form 1. The OC then must call back within 72 hours to ensure that there was a successful link or referral and complete a form 4. Form 2 should be administered to every Veteran that will participate. This short intake form will provide screening's to identify possible, PTSD, TBI, Suicidal Ideation, and ultimately help us identify what are the issues the Veteran and family members are facing and help us better identify programs and services available to assist.
- All Veteran cases uploaded into the database will have a minimum of a Form 1 (First Contact) and a Form 4 (Follow Up).
- Avoid conducting a Form 2 (Initial Interview) over the phone, as it asks detailed potentially triggering questions. The need to use grounding techniques may arise and every effort should be made to administer this form in person. You will also get considerably different answers when you meet someone in their comfort zone in person vs. meeting them over the phone.

S.A.V.E. Team Crisis Response Plan

The OC on the SAVE Team will go wherever they need to in order to meet with a Veteran or family member. The SAVE Team **NEVER** asks the Veteran to meet the needs of the SAVE program, **WE** meet the needs of the Veteran. It is preferable to meet the Veteran/family member in a public place, but know it is not always possible. Conduct a thorough assessment of the Veteran's mental stability and check the meeting place to ensure the safety of the Veteran and the OC.

Before meeting with a Veteran, ensure that you obtain the number of the local police department and have it stored in your phone in the event you must call for police assistance.

- Always perform a wellness check if there is any suspicion of self-harm or harm to others. (Wellness check consists of calling the local police department. Explain who you are and what the team does and the nature of the situation and ask for them to perform a wellness check and call you back). If at all possible, keeping time and safety in mind, offer to meet the officers on scene or prior to going onto the scene. Your rapport with and knowledge of the Veteran may make the difference of a positive vs. negative outcome.
- If you ever find yourself in a crisis situation while performing a visit with a Veteran, try to avoid going into a house alone; while responding to a crisis situation. If possible have the local police department come with you or perform a wellness check prior to arrival. Do not have the police leave until you leave or the situation is deemed safe.
- Find out if the Veteran has any weapons in the house. If the Veteran does have weapons, ask the Veteran to secure them before entering. If there are weapons involved during a crisis response you must bring a law enforcement officer with you no matter where you will be meeting the Veteran.
- Ask the Veteran if there are any animals in the house. If so ask the Veteran to ensure that they are removed from the immediate area of your meeting.
- Anytime a crisis or potential crisis situation comes up you must do a clinical consult as soon as the situation is safe to do so. You should utilize your clinical support through RiverSide Community Care and especially after hours rely on their regional emergency services team. See the list of regional emergency services team attached. They will provide you with guidance and if needed emergency assessments of the Veterans well-being. Remember to take notes and keep track of who you spoke to, what time, and what recommendations were made. These will all be needed for the final CIR.
- If the on-call psychologist/psychiatrist performs a Section-12 (Pink Slip) on the Veteran, call the VA and speak with the on call psychologist/psychiatrist and update them on the current situation. Then try to ensure that the Veteran will be transported to the VA if they are eligible.

- Every effort should be made to notify the on call team leader the status of the Veteran you are working with as well as your status every 30minutes during a crisis response. The team leader will then relay all details to the Director who will keep the Deputy Secretary updated throughout the Critical Incident.
- The final CIR should be passed up the Deputy Secretary no more than 2 hours after the Crisis response is over.

Standards of Dress

While there is no actual enforceable dress code within (DVS) and the S.A.V.E. team, all S.A.V.E. team members are encouraged to wear clean, wrinkle-free professional attire. It is important to know your audience and dress accordingly. Your dress and personal appearance should always be neat and clean. Examples of what can be worn in various situations are outlined below.

Outreach Events

- Button down dress shirt or SAVE polo
- Dress slacks
- Skirts (female)
- Dress shoes
- S.A.V.E Pin
- Blazer
- Tie (male)

Community Outreach

- Button down shirt or S.A.V.E. Polo in summer months
- Jeans that are clean and free of holes
- Khaki pants
- Casual shoes (try to avoid sneakers)
- S.A.V.E. hats
- S.A.V.E. lapel pins
- Clean boots
- Long sleeve shirts

Business Meetings/Service Provider Meetings

- Dress pants or skirt, dress shirt and tie
- Suit
- Clean dress shoes
- Blazer
- Wearing jeans is not suggested unless it is appropriate to the service providers environment

NOTE:

Unless a team member is going to a business or service provider meeting, casual dress is allowed every Friday; Jeans, sneakers and collarless shirts may be worn. Clothing should be in good taste and contain no graphic pictures or language.

Outreach Kits

It is important to have all of the information on both Federal and Massachusetts state benefits readily available. The SAVE team has two outreach kits that are maintained by the (OC). At a minimum the outreach kits will contain the following materials in the parenthetical amounts.

- SAVE Peer Support Brochures (100)
- We Owe You Brochure (100)
- Welcome Home Book (50)
- Give-an-Hour (100)
- Mass Housing (100)
- Women's Veterans' Network Brochures (50)
- DYK WVN Cards (50)
- SHARP brochures
- SHARP Business cards
- All DVS programs promotional items
- Bonus Division Flier (100)
- Plastic Brochure Holder (15)
- SAVE Business Cards (100)
- Veteran Laws and Benefit Book (15)
- Newsletter signup sheet DVS/WVN
- SAVE tear offs with box to drop them in.
- Clipboard (2)
- Scotch Tape (1 roll)
- Pens (2)

Calling Out Sick

Being a part of the SA.V.E. Team is a highly demanding and stressful job. It is important that members of the team take care of themselves when they get sick. Below are the procedures for calling out sick.

- A member of the team calling out sick must notify the OS and their team leader AT LEAST 1 hour prior to start of shift (i.e. if you start at 9AM, the OS/TL is notified by 8AM)
- If the OS/TL cannot be reached via phone send an email to the OS/TL stating that the member wishes to take a sick day.
- Once the team member has been approved to take a sick day they must annotate it on their Outlook calendar and must ensure that their time card reflects sick time taking.

Comp-Time

The members of the S.A.V.E. time are allowed to accrue comp-time and use this time for sick, personal and vacation days. The standard work week for the S.A.V.E. team is 7.5 hours a day Monday thru Friday, totaling 37.5 hours. Payroll dictates the standard workweek runs from Sunday-Saturday. Once a team member works over 37.5 hours they begin to accrue comp-time.

- The first 2.5 hours of comp-time will be annotated in the *comp-time straight* column of the comp-time sheet. Everything over 2.5 hours for the remainder of the Sunday-Saturday week will be annotated in the *comp-time premium column on the comp-time sheet.*
- Team members are not allowed to carry more than 90 hours of comp-time at any given time.
- Team members, at their discretion, can use comp-time. The comp-time must be approved by the TL or Director depending on how long of time is being requested.
- Staff are expected to keep an updated version of their comp time sheet and all full time employee's (not contractors) should be submitting their hours through self-service time and attendance.

Reimbursements

Team members will be reimbursed for all mileage accrued for work purposes and unexpected expenses that are paid out of pocket for work items. Team members may also be reimbursed for money spent on meals provided to Veterans they are working with.

- Team members are reimbursed $0.45 for every mile traveled while attending a work related function.
- Travel from the team member's home of residence to their appointed place of work is not reimbursable.
- Team member must provide receipts for all expenses claimed on the reimbursement form with the exception of miles traveled.
- Reimbursement forms should be submitted to the Director bi-weekly on the Tuesday the week opposite of pay. This is done to allow for enough time to check and make corrections to the reimbursement prior to turning it in for payment.
- If the reimbursement form is not filled out correctly, signed and dated it WILL NOT be submitted and expenses will not be reimbursed until the corrections are made.
- Large items purchased for work (i.e. GPS units) become the property of (DVS) and the S.A.V.E. team once fully reimbursed.
- The Director must pre-approve all large purchases ahead of time.
- Staff can reimburse emergency hotel stays for Veterans and their families in emergency situations. They must be pre-approved by the Director prior to any hotel rooms being paid for.

Self-Service Time and Attendance

Every member of the S.A.V.E team is responsible for filling out and submitting their time sheet through the SSTA online system. The standard workday Monday-Friday is 7.5 hours a day.

- Hours must be submitted through SSTA by 1700hrs every Thursday.
- The time approver assigned to each staff member must approve all reporting staffs time by 1200hrs every Friday.
- Please see the attached SSTA sheet for further instructions on how to use the system.

Vacation Time/Time Off

Every S.A.V.E. team member has the ability to take time off for vacations, holidays, and other personal time. Taking time off is essential to unwinding and releasing workplace stress. In order to take extended time off the procedures below must be followed:

- A leave request must be filled out, dated and signed. It must be turned in to the TL or Director depending on the amount of time requested for approval.
- A leave request should be turned in at least 2 weeks prior to taking time off, or as soon as possible.
- The TL/Director PRIOR to taking the time off needs to approve the leave request.
- Team members may use any and all accrued comp-time, however, taking more than 2 weeks off at a time should be avoided due to team casework load. Any request over two weeks will require approval from the Deputy Secretary as well.
- Once the leave request is approved the staff member is required to let the OS know the dates s/he will be away. The TL should keep a copy of the leave request from in the employee's personnel file.
- A leave request form should be filled out if a team member is taking more than one day of leave.

Probationary Period/Training

New members to the S.A.V.E. team are required to fulfill a 90-day probationary period. During this time under the supervision of their assigned team leader the new team members will work out of the Chelsea or Holyoke office and will also work closely with senior team members working on various case and database issues. During time they will also shadow team members during outreach events, provider meetings, interventions, and other day-to-day activities that will take place.

This period has been put in place to ensure that every facet of case management and outreach work has been covered and understood by the new members. Once the probation period is over and the team leader decides the new members are ready to take on their new roles with minimal guidance and oversight they will take on full responsibility for their outreach area and

cases. Below is a list of trainings that new S.A.V.E. Team members who work directly with Veterans and family members must attend.

- Initial database training, to include submission of all intake forms
- OPR Certification
- Attends all offered MIRECC courses through Bedford VA (VA Peer Certificates)
- DVS Peer Support Training
- Community Outreach Work with an TL/OC
- In Depth overview of DVS 101 to be conducted by the directors of each program.
- Suicide Prevention Training- Veterans Administration
- Crisis intervention/community- services RiverSide Community Care
- Traumatic Brain Injury - SHIP
- PTSD/Mental health overview- Veterans Administration/RiverSide Community Care
- Self-Care - Tom Hannon
- The team receives regular trainings, continuing education courses, Professional Development courses, and has a monthly meeting with outside providers to continue to learn about the new benefits and services within their assigned communities to further assist the Veterans and Families with whom they are working.

Event Staffing/Procedures

The S.A.V.E. team is invited to many outreach events. It is important that the team staffs as many of these as the S.A.V.E. mission allows. The event protocol to be followed is below.

- Every effort should be made to schedule outreach events **AT LEAST 2 WEEKS FROM THE DATE OF THE EVENT**
- At least one OC should try to stay at the table at all times.
- It is the assigned staff's job to ensure they have a full outreach kit and have any available outreach items (e.g., table cloths, canopies, promotional items, etc.)
- If you need to leave the table for any reason, as a courtesy, let the other staff know where you are going and how long you will be away from the table.
- The S.A.V.E. table should be setup at least 30 minutes prior to the start time of the outreach event. **MAKE SURE TO FOLLOW THE INSTRUCTIONS OF THE POINT OF CONTACT (POC) AT THE EVENT VENUE**.

Media Inquiries/Interviews

While conducting community outreach or staffing a service provider event, you may be asked to participate in a media interview. News stories on the mission of S.A.V.E. about the way help Veterans are an excellent way to bring awareness to the S.A.V.E. team and

the benefits available the Veterans of the Commonwealth. Guidelines for interacting with the media are as follows:

- Try to refer all media questions or requests for interviews to Matt Mckenna at DVS. He can be reached at MMckenna@MassMail.State.MA.US or at 617-210-5761.
- If the interview is unavoidable make every effort to remember what questions you are asked and what answers you give. Make sure you record the name and organization of the reporter.
- After the interview is over call or email Matt McKenna as soon as possible and give the interview information.
- **Do not** answer questions you don't know the answer to.
- **Do Not** offer your personal opinion on Departmental, state and/or political affairs.

iii. S.A.V.E. Fiscal Year 2014 Annual Report

The fundamental principle of the S.A.V.E. program is to advocate for Veterans who are not able to obtain the benefits they have earned due to institutional or personal barriers. The program's primary mission is prevention of suicide and mental health distress through early identification of issues facing Veterans when they return from service and proactively providing them with access to benefits and services that may address these issues and result in positive transitions back to civilian life. In FY14, S.A.V.E. highlights include:

Direct outreach provided to over 6,680 Veterans;

- Over 200 Veterans received direct referral and linkage services;
- We now have 319 followers on our Facebook fan page
- Over 190 Veterans received active case management with 12 of those involving critical incidents
- Partnership with the Massachusetts National Guard and provided peer support on site to the National Guard armory's and Camp Edwards and began beginning stages of imbedding S.A.V.E. with the MP and engineer units in MA
- Partnering with the Country station to support concerts to reach out to Veterans.
- Received the state Personal Recognition Award
- Recipient of the Manuel Carballo Governor's Award for Excellence in Public Service
- Created a S.A.V.E. fan page and twitter page.
- Participation in a SAMHSA Policy Academy for Veterans and Military Families, resulting in increased collaboration with the VA, DMH, DPH BSAS and the National Guard Family Program.

The peer concept of S.A.V.E. has served as a powerful national model, resulting in recognition by other states studying the model for implementation within their own states. Most recently S.A.V.E. and the Massachusetts National Guard, have collaborated to imbed SAVE into particular National Guard units that have been struggling with recent suicide completions within their units. SAVE has been to weekend drills to address the soldiers and offer peer to peer support. S.A.V.E. has also recently received training from the National Guard to have better knowledge of Guard specific benefits for soldiers who have not had the minimum requirement for Veteran benefits.

DVS has experienced increased requests for support and awareness education to include educators, clinical staff, first responders, and correctional officers. Most recently, we have received requests from hiring managers and employers who are eager to know more about military culture as a means to improve their processes to hire Veterans and support them when they return from deployment. We partnered with several agencies as part of the Interagency Task Force to Improve Employment Opportunities for Veterans in the Commonwealth. S.A.V.E.

members have presented “BattleMind” presentation to this task force. One of the Task Forces’ accomplishments was a Veteran focused job fair. As employment is an important protective factor for mental health, this was a very positive outcome.

The DVS version of BattleMind is a personal perspective of the training by the United States Army that focuses on the skills used in military service for survival, and how those skills, while helpful during military service, may cause conflicts upon return home. This presentation was so well received by the participants who included Human Resource Managers and Diversity Officers that there are several more sessions scheduled in the future. The focus will be on educating hiring managers, Human Resources Staff and Managers about military culture and the needs of reintegrating Veterans and their families. S.A.V.E. delivered BattleMind presentations to varied audiences; First Responders, Clinicians, the UMASS Medical School Clerkship, Faculty, Service Providers, Corrections Staff, Probation Officers and DAs. This presentation has now been filmed by DMH for continued use in training clinicians, first responders, service providers, corrections staff and court personnel.

The Peer Model deployed so successfully by S.A.V.E. formed the basis for our program: Statewide Housing Advocacy for Reintegration and Prevention (SHARP) to combat homelessness. SHARP was launched in January of 2012, and over this year the teams have become fully integrated. Over the past year S.A.V.E. and SHARP have worked even more collaboratively, integrating many practices seamlessly. While SHARP peer specialists’ focus is homelessness prevention, we have learned that suicide prevention and mental health are very often elements of solving housing issues for Veterans as well. SHARP Peers are trained in suicide prevention as well which is a force multiplier in the suicide prevention mission.

S.A.V.E. received the Massachusetts Personal Recognition Award this last year as well the Manuel Carballo Award for their efforts in suicide prevention and community outreach. The Manuel Carballo award is presented to state employees or programs who selflessly personify a deep commitment to serving the people of the Commonwealth. We are grateful to have been nominated for and receive this great honor.

S.A.V.E. has revitalized its Facebook page as well added a Fan page to reach out via social media and to target Veterans that may have barriers to services. S.A.V.E. now has over 300 fans and continues to grow. S.A.V.E. last year was able to intervene on a Veteran that expressed possible suicide ideation through his Facebook feed and make sure he was safe. S.A.V.E. also utilizes Facebook to post upcoming Veteran based events as well information on Veterans’ benefits. We were informed that this project in collaboration with SHARP will be part of a poster exhibit at the State House on September.

S.A.V.E.'s staffing was relatively stable this year. The clinical support from our Riverside Community Care Clinicians, the team has maintained stability. We were able to convert one of the S.A.V.E. contractor staff to full time employees. This has resulted in better cohesion, employee confidence and longevity. We had two staff members attended the aspiring supervisor course to augment their leadership development skills in their team leader roles and plan to have two more staff trained this coming year. We have also worked more closely with both Soldiers' Homes which assists them in having more robust Veteran resource centers in their facilities.

Outreach

S.A.V.E. is a very active program in the Veterans' community that finds its Veterans through outreach in the community. We find our Veterans by utilizing the following outreach methods:

- Display tables at events throughout the Commonwealth at Veteran and local community events; i.e. Big E (Western MA), Run to Home Base, Motorcycle runs, Stand Downs and concerts.
- Presentations on all services provided by S.A.V.E, to include:
    - Suicide Prevention
    - Peer to Peer approach
    - Veterans Advocacy
    - Benefits Education
    - Referral services
    - First Responders Training
    - Mobile Services
    - Jail Diversion and Re-Entry Assistance
- Movie Theater Advertising
    - Facebook
    - Twitter
    - MassVetsAdvisor web portal
    - Marketing materials, T-shirts, caps, key chains, coasters, squeeze trucks etc.
    - Brochures and posters

Case management

Veterans that are served by the team are divided into two groups, 'link and referral only' and 'active'. Please see our intake process displayed below:

- First Contact – Outreach Coordinator determines if they need only a link and referral or active case management.
- If further services are needed the OC (Outreach Coordinator) helps the Veteran to prioritize their needs and educate them on their benefits and services.
- If further services are needed the OC opens an active case on the Veteran using the following process:

1. Develop an IAP (Individual Action Plan)
2. Identify Goals
3. Establish Objectives
4. Assign Activities for both Veteran and OC
5. Set expected completion date and follow up date
6. Graduate Veteran from program

Database

S.A.V.E utilizes an electronic intake process to capture all of the Veteran's necessary information and to ensure that all services provided by the program are consistent. The information is stored in a Structured Query Language (SQL) Database and monitored by the Director of the program. By analyzing the data we can identify:

- Number of Veterans in the program
- Problems and needs of Veterans at time of intake
- Solutions or proposed solutions to problems identified at intake
- Where Veterans are being referred and if these programs are effective or not
- Geographical trends
- Number of cases per OC
- Number of suicidal Veterans per OC
- Level of suicidal ideation

Veterans who were served by S.A.V.E. were found to have problems accessing benefits and/or services for the following issues:

- Suicide
- PTSD
- TBI
- Income
- Employment
- Housing
- Disability Compensation
- Medical equipment
- Legal assistance
- Healthcare
- Location of records (Service and Medical)
- Bonuses
- Training
- Education

<u>Population</u>

The population served varies from recently returned Veterans to Vietnam, Korean Era and World War II Veterans. While the majority of the Veterans served are recently returned Veterans, we have found that more Veterans of all eras have come forward due to the increased awareness statewide. Most of these Veterans exhibit symptoms of PTSD and TBI, but are still in the process of final diagnosis and claims. Our community-based approach has been very helpful in locating these Veterans and providing support.

Jail Diversion Efforts

The Department of Veterans' Services (DVS) formed the S.A.V.E. team in collaboration with the Department of Public Health. S.A.V.E. is a first in the nation suicide prevention, peer support and empowerment program designed to support returning service members that maybe experiencing difficulty transitioning to civilian life. We advocate on behalf of Veterans and their families to help secure access to their benefits that they have earned based upon their service and provide support for transition which can be difficult for some Veterans.

In support of Veterans involved with the criminal justice system we collaborated with the Veterans Administration and the Department of Probation and Department of Public Health to identify incarcerated Veterans with intent to provide supportive services to ease their re-entry into society. We were impressed by the expressions of hope from the Veterans we met there. We now receive referrals from probation departments to provide assistance to Veterans who have self-identified. S.A.V.E. members also lent support to Veterans involved with the Veterans' Treatment Court in Dedham as well as the newly formed Veterans' Treatment Court in Suffolk County. In the fourth quarter of Fiscal Year 2014, the Department of Mental Health entered into an Interagency Service Agreement with DVS for more peer support to Veterans involved in the courts. Through the VALOR Act II we anticipate this will expand even further. Although this is a separately funded program from S.A.V.E., this will allow for increased collaboration with S.A.V.E. and Jail Diversion efforts to prevent suicide and other destructive behaviors.

Conclusion

We have received requests from four other states on how to build S.A.V.E. programs in their states and building a national peer support toolkit. We have shared our structure, position descriptions and peer model concept and training topics to enable the program model to expand nationwide. Our efforts in FY 2015 include expanding social media coverage and introduction of the S.A.V.E. Twitter Page. We will assess how many new clients we are able to contact using social media and the impact it will have on our efforts and ability to provide direct support to Veterans needing vital services.

We are thankful to the Department of Public Health for their continued support in preventing suicide in the Veteran population.