



The Transformation of VA Grant and Per Diem Programs: Considerations for Communities

Introduction

Homelessness among Veterans has been reduced by nearly 50% between 2010 and 2018, and more than 75 communities have effectively ended Veteran homelessness. The U.S. Department of Veterans Affairs (VA) Grant and Per Diem (GPD) programs are an important part of this work. A recent transformation in the GPD program positions it to have an even greater role in ensuring that homelessness among Veterans is a rare, brief, and one-time experience.

Through the release of the FY 2017 GPD Notice of Funding Availability, the VA initiated a transformation intended to update services, develop programs based on current community needs, evolve with the changing needs of Veterans, ensure that GPD resources are integrated with local Continuums of Care (CoCs), and better serve Veterans experiencing homelessness.

This document provides an overview of the housing models currently funded through GPD, describes the current mix of implementation of the various GPD models, and provides some considerations for CoCs and community stakeholders as this transformation is implemented and navigated locally.

Overview of GPD Models

Recent GPD NOFAs have provided funding for the following housing models: (1) Bridge Housing; (2) Low Demand GPD; (3) Hospital to Housing; (4) Clinical Treatment; (5) Service-Intensive Transitional Housing; (6) Transition in Place; and (7) Service Centers. Each model is described briefly below, including the intent of the housing model, the characteristics of a Veteran that might need and choose that model, the services that are available in the program, and the VA's benchmarks for permanent housing exits.

1. Bridge Housing

Intent: To provide a short-term stay (i.e., target less than 90 days) in transitional housing for a Veteran with a pre-identified permanent housing destination.

Target population: Bridge Housing is appropriate for a Veteran who has accepted a permanent housing intervention but is not able to immediately move into a permanent unit, and who chooses to stay in Bridge Housing in the interim. To be eligible for Bridge Housing, the Veteran must have been offered and accepted the intervention either prior to admission or within the first 14 days of admission. While the stay is expected to be less than 90 days, the length of stay will vary depending on local housing markets and unit availability.

Services: Services are primarily housing-focused, rather than treatment-focused.

Housing placement benchmark: Per VA grant agreements with GPD providers, exits from Bridge Housing into permanent housing should be at least 70%.

2. Low Demand GPD

Intent: To offer transitional housing that has low demands on Veterans and is operated with a harm reduction philosophy. In Low Demand GPD, the emphasis is on the engagement of the Veteran participant within a safe environment. For instance, sobriety is not required of Veterans, nor is compliance with mental health treatment, during the Veteran's stay in the Low Demand placement.

Target population: Low Demand GPD is appropriate for any Veteran who does not choose another alternative, such as a permanent housing program (e.g., rapid rehousing), Clinical Treatment or a Service Intensive program. The population might include those who have experienced long-term homelessness, those who do not need or have not committed to treatment, and others who simply prefer a low demand environment.

Services: Services should be actively and consistently offered to the Veteran, but participation in services may not be required. Offered services must include case management, as well as access to behavioral health services and referrals for benefits. To meet the permanent housing benchmark, services should be housing-focused, rather than treatment-focused.

Housing placement benchmark: Per VA grant agreements with GPD providers, exits from a Low Demand GPD program into permanent housing should be 50% or higher.

3. Hospital to Housing

Intent: To address both the housing and recuperative care needs of Veterans who have been hospitalized. This model is also referred to as respite care.

Target population: A Hospital to Housing placement is appropriate for a Veteran who has been evaluated in an emergency department or inpatient health care setting and determined suitable for direct transfer into the program and chooses that placement above other appropriate options. The Veteran must be able to perform activities of daily living independently and must have a post-discharge plan coordinating care with the medical center.

Services: The Veteran must have access to appropriate ongoing services as detailed in the discharge and care management plans, including ongoing clinical care and case management. A VA medical center care team (e.g., VA Homeless Patient Aligned Care Team, or HPACT) commits to providing follow-up care for Veterans residing in Hospital to Housing models. To provide adequate access, Hospital to Housing sites must be close to a medical center.

Housing placement benchmark: Per VA grant agreements with GPD providers, exits from this program into permanent housing should be at least 65%.

4. Clinical Treatment

Intent: To provide Clinical Treatment along with housing-focused and income-focused services.

Target population: Clinical Treatment is appropriate for a Veteran who chooses to enter a residential treatment setting to address a substance use disorder and/or mental health diagnosis and elects the GPD treatment program among other alternatives.

Services: While clinical treatment is a cornerstone of this program, providers are also required to offer services that improve the likelihood of a Veteran exiting to permanent housing and increasing household income. All services must be individualized; lengths of stay are expected to vary across Veterans.

Housing placement benchmark: Per VA grant agreements with GPD providers, exits from Clinical Treatment into permanent housing should be 65% or higher. In addition, at least 50% of exiting Veterans are expected to be employed.

5. Service-Intensive Transitional Housing

Intent: To provide time-limited housing along with a range of services to facilitate exit into permanent housing as rapidly as appropriate.

Target population: This model is appropriate for Veterans who choose a Service-Intensive Transitional Program over a permanent housing option or alternative program.

Services: Individualized services are provided to help the Veteran increase income and/or benefits, as well as obtain permanent housing. Services, as well as lengths of stay, are individualized, rather than program-driven.

Housing placement benchmark: Per VA grant agreements with GPD providers, exits from Service-Intensive Transitional Housing into permanent housing should be at least 65%. In addition, at least 50% of exiting Veterans are expected to be employed.

6. Transition in Place (TIP)

Intent: To provide a Veteran with services and a transitional housing unit, that, after an individualized period of time, becomes their permanent housing residence.

Target population: TIP is for a Veteran who chooses a transitional housing environment and expects to remain in permanent housing by leasing the same unit.

Services: Individualized services are provided to help the Veteran increase income and/or benefits, as well as remain stably housed. Types, intensity, and time frames of services are individualized, rather than program-driven.

Housing placement benchmark: Per VA grant agreements with GPD providers, exits from the TIP program into permanent housing should be at least 75%. In addition, at least 50% of exiting Veterans are expected to be employed.

7. Service Centers

Intent: To engage Veterans experiencing homelessness and offer them information and connections to housing and services.

Target population: Centers serve any Veteran experiencing homelessness who is seeking assistance to obtain housing, employment, health care, or benefits.

Services: The scope of services depends upon the Veteran, as well as the community inventory of resources, with the intent of engaging Veterans and connecting them to resources.

Housing placement benchmark: Service centers are not residential and there is no housing placement benchmark.

The Current Mix of GPD Models

GPD programs have been funded for all the models summarized above. While the exact number of beds available for each model varies somewhat on a monthly basis, we can examine current data to identify patterns in how GPD is being used nationally. This section is based on an analysis of GPD grants in effect in April 2019. A complete listing of all GPD programs is available through the [VA GPD website](#).

As of April 2019, there were about 12,850 GPD beds funded through the VA across the country, as well as 18 GPD-funded service centers. The approximate breakdown by model type is shown below.

Model	Approximate # of Beds as of April 2019	Approximate % of Total Beds as of April 2019
Bridge Housing	2,400	19%
Low Demand GPD	1,300	10%
Hospital to Housing	370	3%
Clinical Treatment	3,100	24%
Service-Intensive Transitional Housing	5,100	40%
Transition in Place	580	5%
National Total	12,850	100.0%

VA services are divided into 18 regional Veterans Integrated Service Networks (VISNs). Each VISN responds to the individualized needs of the Veterans and the communities it serves. To better understand the geographic dispersion of GPD program types by VISN, refer to the VISN map provided in Appendix I (or on the [VA website](#)) and the Mix of GPD Models by VISN presented in Appendix II.

As an example of the geographic variation of GPD models, the proportion of Service-Intensive Transitional Housing ranges from a high of 62% in VISN 15 (MO and KS) to 24% in VISN 2 (NY and NJ). Similarly, bridge beds constitute 27% of GPD beds in VISN 22 (NM, AZ, and southern CA) and only 5% in VISN 15 (MO and KS). The greatest proportion of GPD beds dedicated to clinical treatment is found in VISN 2 at 59% (NY and NJ) as compared to a low of 3% in VISN 20 (WA, OR, ID). There are no low demand GPD beds in VISN 15 (MO and KS), while in VISN 23 (ND, SD, NE, MN, IA), 23% of GPD beds are low demand.

Another way to examine the geographic dispersion of bed types is to compare the relatively service/treatment intensive models (Clinical Treatment (CT), Service-Intensive Transitional Housing (SITH), Transition in Place (TIP), and Hospital to Housing (H2H)) to the relatively less service-intensive models (Low Demand (LD) and Bridge). Below are the percentages of each by VISN and for the nation.

VISN	Approx. # of Beds as of April 2019	CT, SITH, TIP, H2H	Bridge and LD
1: New England (CT, ME, MA, NH, RI, VT)	990	82.6%	17.4%
2: NY, NJ	510	86.7%	13.3%
4: PA, DE, NJ, OH	735	80.4%	19.6%
5: Capitol (MD, VA, DC, WV)	480	67.2%	32.8%
6: Mid-Atlantic (NC, VA)	440	72.2%	27.8%
7: Southeast (AL, GA, SC)	375	77.0%	23.0%
8: Sunshine (FL, PR, VI)	1,125	76.2%	23.8%
9: Mid-South (KY, TN)	615	83.6%	16.4%
10: IN, KY, OH, MI, IL	1,110	62.9%	37.1%
12: Great Lakes (IL, IN, MI, WI)	575	70.2%	29.8%
15: Heartland (IL, KS, MO)	170	95.3%	4.7%
16: South Central (AK, LA, MS, OK, TX)	570	80.2%	19.8%
17: Heart of Texas (TX)	325	69.7%	30.3%
19: Rocky Mountain (OK, MT, CO, NV, UT, WY)	530	75.6%	24.4%
20: Northwest (AK, ID, MT, OR, WA)	645	69.4%	30.6%
21: Sierra Pacific (CA, NV, HI, AS, GU, MP, PI)	1,210	67.9%	32.1%
22: Desert Pacific (CA, AZ, NM)	2,125	54.4%	45.6%
23: Midwest (MN, IA, IL, ND, SD, NE, WI)	320	68.5%	31.5%
Total	12,850	71.1%	28.9%

There are no general conclusions that can be drawn regarding the variations in GPD use across VISNs or CoCs. The appropriate mix of GPD-funded models for a particular community will vary based on the needs and choices of Veterans experiencing homelessness and the extent to which their preferences can be met by non-GPD resources. For instance, GPD low demand beds may be needed in one community because Veterans prefer that model and there are not enough general population low demand beds

locally. In another community, there may be sufficient low demand beds already in place through the CoC, therefore GPD resources should be used for other models still needed.

Below we offer some considerations for CoCs and community stakeholders as they work with their local GPD providers. Stakeholders can find a list of GPD providers and the program models for which they have been funded on the [VA GPD webpage](#) and the [Grant and Per Diem Program FY 2019 Grants](#) list.

Considerations for Continuums of Care, VA Programs, and Community Stakeholders

Gaining a common understanding of GPD programs in the community

Because the VA GPD program has changed in recent years, one cannot assume that the way a local GPD program operated three years ago is still the case today. It is critical that CoC stakeholders, including VAMC HUD-VASH and SSVF providers, understand which model(s) are used by local GPD programs, how beds are allocated among the models, and how referrals are received into the programs.

Further, even if a GPD program has not changed from one model to another, the program may still have changed eligibility and entry requirements, as well as requirements for ongoing program participation. And finally, local GPD providers should have made changes aimed at individualizing services and shortening average and median lengths of stay in their programs.

Integrating GPD programs into HMIS and Coordinated Entry

GPD programs are encouraged to participate in their CoC's Homeless Management Information System (HMIS) and expected to participate in Coordinated Entry (CE) processes. In applications for funding, GPD providers are required to describe their involvement with their communities' CE systems and how their projects fit into that system. GPD providers should recognize that participation in HMIS and Coordinated Entry processes strengthens the community's coordinated crisis response system and, most importantly, better serves the Veteran experiencing homelessness.

If a local GPD program has not yet opted into HMIS and CE processes, the CoC should continue to work with that program to ensure that GPD program leaders understand the importance of integration into the system – particularly for the benefit of the Veterans themselves. It may be that a similar participating program (e.g., SSVF, faith-based provider) can be helpful in this regard by sharing its experience with CE processes and HMIS, dispelling any misconceptions that the GPD program operators might have, and encouraging the GPD program to participate as part of the broader effort of the local community as a whole.

Alternatively, the CoC may wish to focus on overcoming any barriers to participation. For instance, if GPD staff capacity and resources are issues, the CoC may be able to identify resources to help staff an HMIS/CE specialist for the GPD program. Finally, in some communities where GPD programs receive additional funding from local government or the local philanthropic sector, those funders have chosen to require the provider to participate in HMIS and CE processes to benefit the entire community and continuum.

Even if a local GPD program does not yet participate in HMIS and CE processes, it is important that any changes in model type, target subpopulation, and entry requirements be reflected within CE processes. If, for instance, a local GPD program operates both low demand and service-intensive beds, it is important that the Veteran be offered both options up front so they can make their own choice about which to enter. However, if CE processes combine all GPD models into one universal referral, the Veteran may lose some level of choice.

Determining the appropriate allocation of resources in a coordinated community system

The transformation of GPD into multiple models can be a game changer in some communities as they work to end homelessness among Veterans. While it is too early in the transformation process to have sufficient data to draw conclusions, it is expected that changes in GPD programs will reduce the lengths of stay in the programs and yield stronger housing outcomes not only for Veterans but for the system as a whole.

Ideally, the CoC, GPD and SSVF providers, VAMCs, and other key stakeholders should collaborate to determine the numbers and types of GPD beds available in the community, since GPD programs are an integral component of the service system for Veterans. By collaboratively determining and forecasting needs for specific types of beds and services, CoCs and GPD providers can ensure that the right mix of models are available to Veterans experiencing homelessness, with Veteran choice a primary consideration.

There is an interdependent relationship between the mix of GPD models and the mix of non-GPD beds and programs in the community. For instance, if there is a severe shortage of low demand emergency shelters for all those experiencing homelessness, adding low demand GPD beds for Veterans might be optimal. If the local SSVF program is encountering delays in move-ins due to the scarcity of housing that is affordable and available, it makes sense for the CoC and GPD programs to prioritize adding bridge beds. Similarly, if Veterans with behavioral health disorders can adequately meet their treatment needs and desires through outpatient VA health and SSVF services after moving into SSVF-supported permanent housing, then fewer clinical treatment and service-intensive beds are needed.

Creating a range of Veteran-driven pathways out of homelessness

Each Veteran experiencing homelessness has their own set of strengths, challenges, and preferences. Therefore, it is critical that there be a range of options offered to the Veteran, so they can choose their own preferred path to stable permanent housing. Communities should ensure that options are offered in proportion to the level of Veteran need and desire for various pathways. For all VA and CoC programs, the primacy of Veteran choice must be safeguarded.

For example, given a diverse set of options, many Veteran households may choose to move directly from a general population emergency shelter into permanent housing with the help of SSVF. Another Veteran with a large household may face delays in finding rental housing of an appropriate size through SSVF and choose to stay in GPD bridge housing until an appropriate unit is identified. A third Veteran

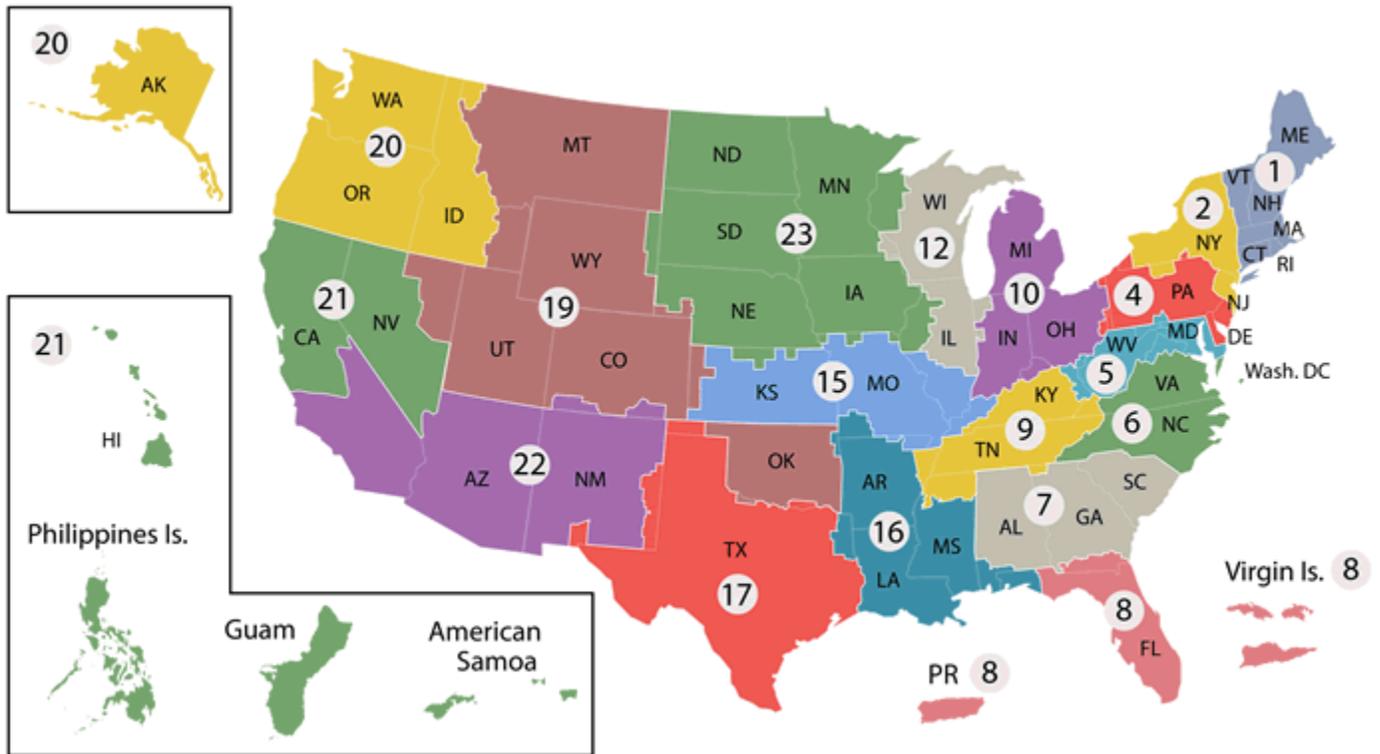
may wish to address a substance use disorder through GPD Clinical Treatment before moving into a HUD-VASH program.

In order to make the best choice for their household, Veterans must be provided a diverse range of options from which to choose based on their own strengths, preferences, and needs. The role of all the stakeholders – GPD, SSVF, HUD-VASH, VAMC, CoC, and many others – is to ensure that each Veteran can choose their own best pathway into stable permanent housing and improved quality of life.

Conclusion

Clearly, CoCs, GPD providers, and other VA programs have much to talk about and collaborate on to ensure that every Veteran experiencing homelessness has adequate choice to meet their needs, to move as quickly as possible into permanent housing, and to remain stably housed. In addition to the GPD program, the vast array of services offered by the VA, along with the interplay among the VA programs and with the CoC programs, provide a solid platform upon which to ensure that homelessness experienced by Veterans is rare, brief, and one-time.

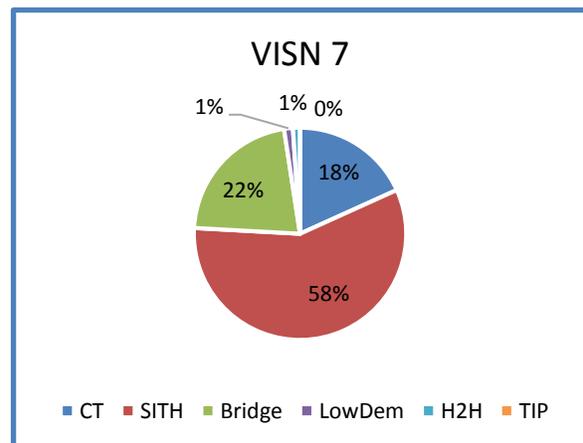
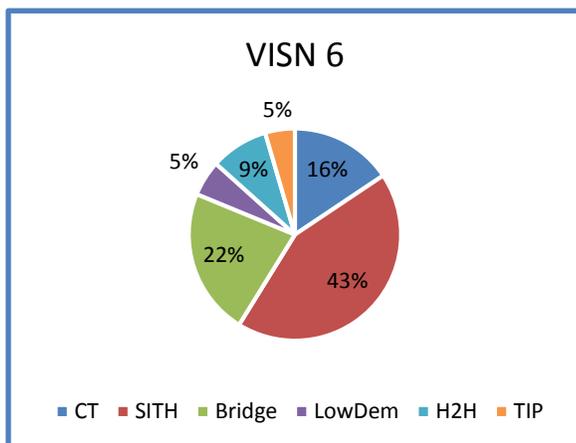
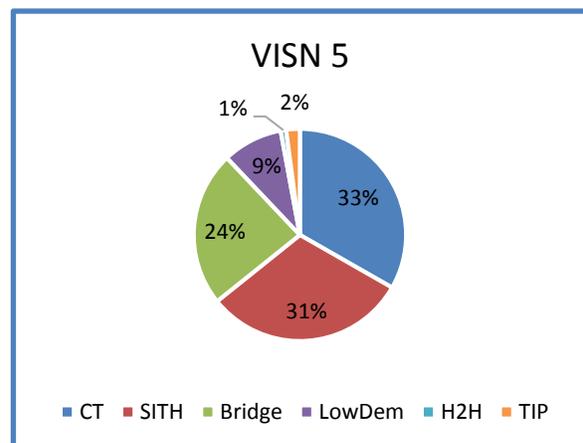
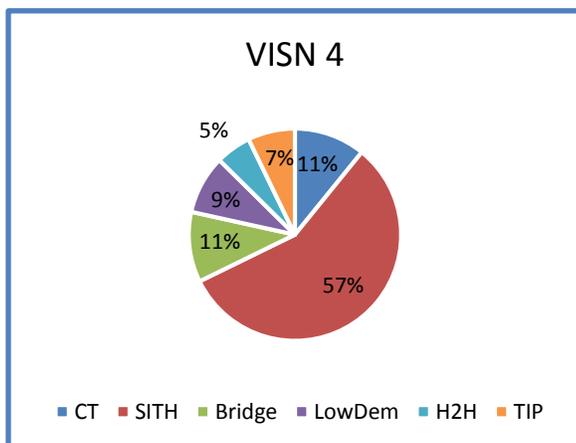
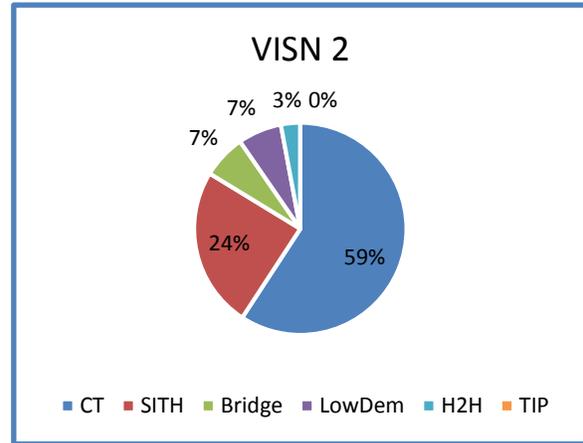
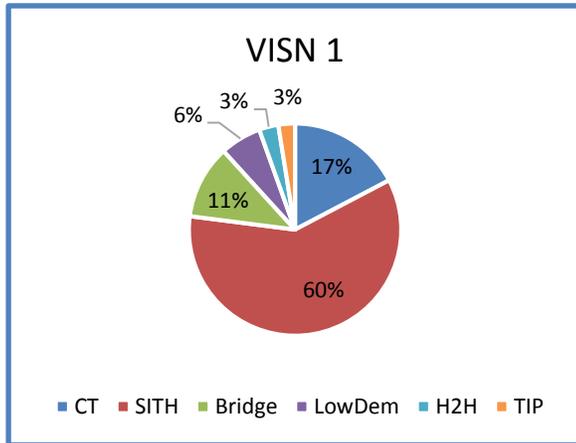
APPENDIX I: VISN Geographic Areas



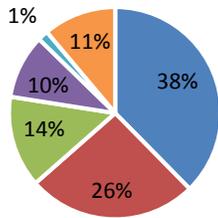
Source: [U.S. Department of Veteran Affairs VHA Locations](#)

APPENDIX II: Mix of GPD Models by VISN as of April 2019

Key	Clinical Treatment	CT
	Service-Intensive	SITH
	Transitional Housing	
	Bridge Housing	Bridge
	Low Demand GPD	LowDem
	Hospital to Housing	H2H
	Transition in Place	TIP

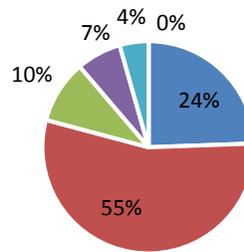


VISN 8



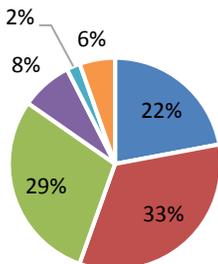
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VISN 9



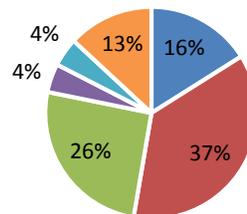
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VISN 10



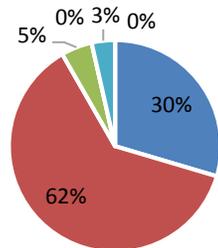
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VISN 12



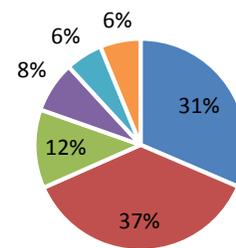
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VISN 15



■ CT ■ SITH ■ Bridge ■ LowDem ■ H2H ■ TIP

VISN 16



■ CT ■ SITH ■ Bridge ■ LowDem ■ H2H ■ TIP

