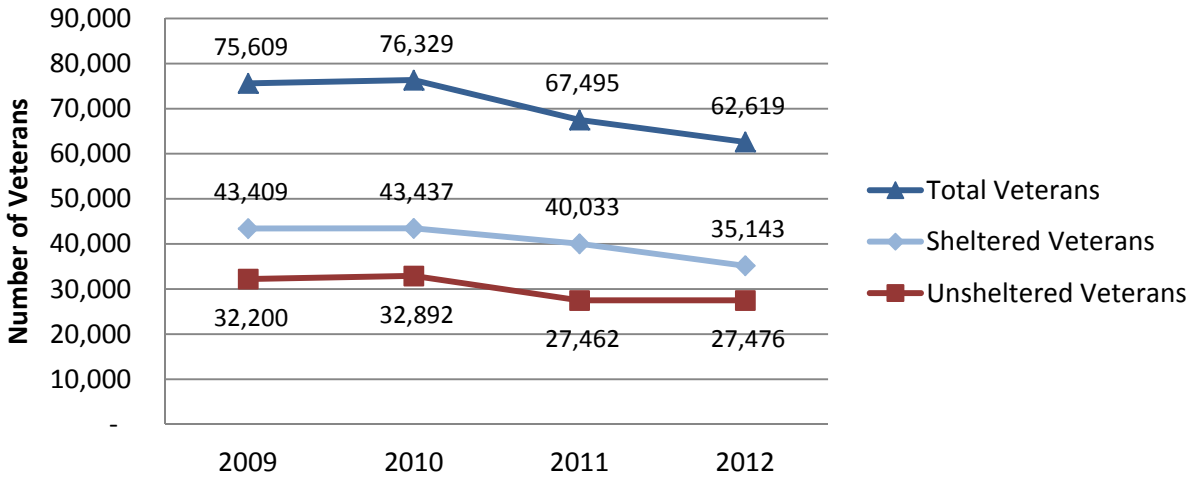
Positive Outliers: Communities on track to end homelessness among Veterans

Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness sets the goal of ending homelessness for all Veterans by the end of 2015. The 2012 Point in Time (PIT) count reported that, as a nation, there has been a 17 percent reduction in total number of homeless Veterans since 2009.

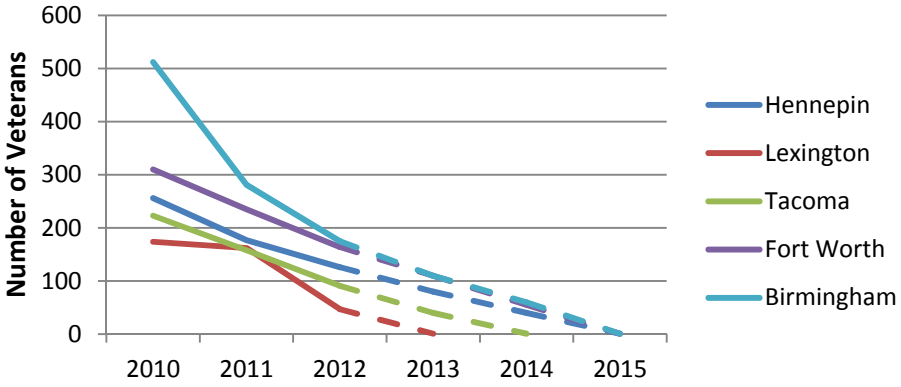
Figure 1. National Trends in Veterans Experiencing Homelessness, 2009-2012



Source: HUD Point-in-Time data, 2009-2012

While some communities have reported small reductions or even increases in the total number of Veterans experiencing homelessness, other communities have reported remarkable success. USICH has identified five communities (Lexington, KY, Hennepin County, MN, Tacoma, WA, Birmingham, AL and Fort Worth, TX) that not only have had dramatic reductions in the number of Veterans experiencing homelessness but are on-track to meet the Federal goal.

Figure 2. Point-in-Time Trends for 5 Communities On-Track to End Veteran Homelessness



Source: HUD Point-in-Time data 2009-2012 with projections to 2015 based on current trends

These five communities have been identified as "positive outliers" in that they are on-track to end Veteran homelessness by 2015 based on current trends. To better understand the characteristics that have led these communities to be on track to end Veteran homelessness, USICH interviewed homeless service leaders from these communities to find common themes that have provided a foundation for their success.

Themes among Positive Outlier Communities

1. **Communication and integration of services across the community**: This theme was consistent across all five of the positive outliers identified. Each community reported that there are three main components of the service delivery structure targeting homeless Veterans: local Continuum of Care providers (CoC), Department of Veterans Affairs programs (HUD/VA Supportive Housing, Supportive Services for Veteran Families, Grant and per Diem and VA Medical services) and the local Public Housing Authority (PHA). The community leaders identified all knew by first name the leaders in each of the three sectors and reported that they have, at a minimum, monthly standing meetings for problem solving and collaboration. In Tacoma, for example, most of the staff that provides case management targeting homeless Veterans were hired by the VA or from non-profit CoC providers, and both VA and CoC providers receive referrals directly from one central intake agency. This seamless collaboration across agencies created efficiencies that leveraged available resources to maximize effectiveness and reduce time between issuing of HUD-VASH vouchers. This collaboration also created a better way to overcome the different eligibility requirements of each sector so that all Veterans (whether they receive VA benefits or not) could access services to leave homelessness.

2. **Commitment to Housing First:** Three of the five communities reported a long history of embracing Housing First practices as the foundational philosophy across the community. The

other two communities reported inconsistent adoption of Housing First practices across their VA and CoC homeless programs. In some communities the VA Medical Centers were leaders in adopting Housing First practices, while in others they had only recently begun implementing Housing First across their programs. There was consensus across all communities that Housing First was the most effective way to provide permanent supportive housing for chronically homeless Veterans. Specifically, community leaders reported that housing was offered to homeless Veterans regardless of their commitment to sobriety.

3. **Targeting:** All communities reported an advanced understanding of the necessity to match the available programs to the specific individual needs of each Veteran. To achieve this, each community reported a process where every homeless Veteran was thoroughly assessed by skilled and committed providers so that their needs could be met with the most effective and least expensive program available. For example, individuals who were recently homeless and were in need of job training or a shallow rent subsidy were provided this resource from local CoC providers or from Supportive Services from Veteran Families (SSVF) programs. In addition, individuals who had an extensive homeless history and might have severe mental illness were shepherded towards HUD-VASH. Four of the five communities reported a central intake process for all Veterans where up-front investment in assessment could be practiced to get an accurate understanding of the unique needs of every Veteran. Following thorough assessment, each Veteran was linked up with the service that provided "the right treatment for the condition." The targeting of VASH vouchers to Veterans experiencing chronic homelessness varied by community as some medical centers were just beginning to adopt Housing First practices for the HUD-VASH program.

4. **Use of Data:** Three of the five communities reported the utilization of community-wide data to target available resources. Each of the five communities reported significant success in sharing important client-specific data across the three sectors of service provision described above. In Tacoma, following consent of the Veteran, the comprehensive, individualized assessment conducted at the centrally located intake center was sent electronically to the service delivery agency (be it the VA or the local CoC provider) so that it arrived prior to the Veteran. The service delivery agency would then have the information easily available when the Veteran did arrive so that they could quickly offer targeted services.

5. **Use of mainstream services:** While most of the long term services targeting homeless Veterans were provided by the PHA and the VA, each of the five positive outlier communities reported significant coordination with mainstream services such as Medicaid, Social Security and child welfare services. Hennepin County cited expediting the provision of general assistance for Veterans experiencing homelessness. Both Birmingham and Tacoma cited close partnerships between Veterans programs and SOAR case managers to connect eligible Veterans to the SSI/SSDI benefit. These mainstream services were able to bridge the gaps in services provided by the VA and PHA and unstick the system to allow the overall service delivery to move forward smoothly. Occasionally, one specific agency would not be a good fit for the needs of a specific

Veteran. If one agency was a poor fit for a Veteran, the diversity of agencies available made it possible for other resources to be brought to bear to keep each individual Veteran on the path out of homelessness.

Conclusion: Each of the five positive outlier communities had their own unique story on how collaborations were formed across the main service delivery sectors. Some communities reported single charismatic leaders who brought all the agencies together under a common philosophy. Other cities reported sentinel events such as a tragic death of a Veteran experiencing homelessness that brought people together, while others described a grassroots effort led by Veterans working together. The stories of how these five communities got started towards a unified goal of ending homelessness are diverse. However, the foundation of how services are delivered in each of these communities had remarkable similarities. By embracing and promoting the components of success among these five positive outlier communities it may be possible to expand the number of communities on track to achieve the goal, and bring late adopters and early responders together so that we can achieve the goal of ending homeless for all Veterans by 2015.

Positive Outliers Snapshot				
Community	Total Homeless	Homeless Veterans	Summary	Contact Info
Hennepin County	3285	26	Strong community support and commitment to Housing First. HUD-VASH team hired from community homeless service providers and has strong knowledge of shelter staff, homeless Veterans, and makes connections with non-VA benefits and services.	Mathew Ayres, Office to End Homelessness, Matthew.ayres@co.hennepin.mn.us
Tacoma, WA	1997	91	Centralized intake system with assessment tool to identify right program for Veterans including CoC programs for Veterans ineligible for VA programs. Community-wide embrace of Housing First has led to 79% decrease in unsheltered homelessness.	S. Troy Christensen, Homeless Programs Administrator, tchris2@co.pierce.wa.us
Lexington, KY	1370	47	Citywide commitment to Veterans issues. Close coordination between VA staff and Continuum of Care, local shelters, and Veterans Service Organizations (VSOs). Volunteers of America develops Individual Development Plan for each Veteran experiencing homelessness.	David Christiansen, Executive Director of the Central Kentucky Housing and Homeless Initiative, davidccky@gmail.com
Fort Worth, TX	2123	164	Data sharing between CoC and VA to identify chronically homeless Veterans for HUD-VASH. New GPD programs were the tipping point in reducing the number of unsheltered Veterans.	Otis Thornton, Homeless Programs Director, Otis.Thornton@fortworthgov.org
Birmingham, AL	1707	175	Used data from VA, PHA, and CoC to improve targeting and planning. Shelters are all Housing First, no sobriety/treatment requirements.	Michael German, Director, HUD Birmingham Field Office, michael.german@hud.gov

Data Source: 2012 Point in Time Count