Understanding Inflow into Veteran Homelessness and Adapting Interventions

NCHV 2019
Thank you...

- To the Home Depot Foundation for funding this project. Their generous support has been instrumental in making this work come to life. We're grateful for their commitment to a future without veteran homelessness.

- To our partners at the VA who have been supportive of this project

- To the communities that are participating

- To the veterans who generously gave their time to speak to us as a part of this work
Built for Zero Background
Who We Are

COMMUNITY SOLUTIONS deploys the best problem solving tools from multiple sectors to help communities end homelessness and the conditions that create it.
Community Solutions and the Built for Zero Team has helped 11 communities end homelessness for their chronic and/or veteran populations.
A Movement Built on Counting Up

We designed the 100,000 Homes Campaign to help communities reach a large, aggregate housing total together. Only one metric mattered: *monthly housing placements*
The Pivot to Counting Down

You can't measure an end to homelessness by counting up. Instead, focus on the outcome measure (ex: # of people experiencing homelessness) and count down.
Toolkit for Solving Complex Problems

DATA ANALYTICS
Zoom in on the heart of the problem

HUMAN-CENTERED DESIGN
Engage people experiencing the problem to surface ideas

QUALITY IMPROVEMENT
Test and evaluate each idea with objective data

Facilitation
Create the conditions for groups to innovate collaboratively
Measuring System Dynamics of Homelessness

**INFLOW**
- Newly Identified
- Returned from Housing
- Returned from Inactive

**ACTIVELY HOMELESS**

**OUTFLOW**
- Moved to Inactive
- No longer meets population criteria
- Housing placements
Types of Inflow Data

**Newly identified**: The total number of veterans experiencing homelessness who have *newly* entered coordinated entry system over the course of the reporting month.

**Returned from housing**: The total number of veterans who were previously housed and have become unhoused or have otherwise returned to homelessness over the course of the reporting month.

**Returned from inactive**: The total number of veterans who were previously designated as inactive, per documented inactive policy, but have since reappeared or otherwise returned to homelessness over the course of the reporting month.
Evolution of the Veteran Inflow Project
We know that communities cannot reliably reach and sustain an end to veteran homelessness if inflow into the system is consistently exceeding outflow out of the system.
The Pivot to Counting Down

You can't measure an end to homelessness by counting up. Instead, focus on the outcome measure (ex: # of people experiencing homelessness) and **count down.**

![Graph showing the estimated path to functional zero](image)
Calculating Actively Homeless Numbers
(and why inflow matters!)

Current Actively Homeless Number = Previously Known Actively Homeless Number + Inflow - Outflow
Reducing inflow is a critical strategy for communities to accelerate their trajectory towards ending homelessness.

And, we believe inflow into homelessness is a negative outcome measure of other upstream systems.
How Did We Approach This Challenge?

In Phase I of this project, the Built for Zero team engaged 5 communities around inflow in two related streams:

1. Qualitative interviews with veterans experiencing homelessness in selected communities
2. Quantitative analysis of de-identified HMIS/BNL datasets

The data collection and system assessment was designed to support Phase II of the project - using a Quality Improvement methodology to identify and test potential interventions to reduce inflow into veteran homelessness.
Data Collection and Analysis

1. Execution and analysis of interviews with veterans experiencing homelessness from 5 communities

2. Analysis of community-level and systems data from the same 5 communities participating in interviews
Data Collection and Analysis

HVH Precision Analytics conducted initiative level analysis of BFZ aggregate data points

- Relationships between
  - community-level data points in any one community
  - community-level data points in different CoCs
  - community-level data points and time
  - community-level data points and external datasets (evictions, unemployment, fair market rent)
Community Selection Criteria

1. Correlation between inflow and actively homeless numbers
2. Explicit interest in targeting inflow as a means to reduce
3. Whether inflow numbers were static, volatile, or a combination
4. Size
5. Ability to report quality data
- Designing the project
- Identifying potential barriers
- Identifying potential partners
- Drafting materials

- Staffing the project
- Securing partners
- Securing community participation
- Finalizing Materials
- Collecting/Analyzing Data

- Convening communities
- Testing in communities
- Measuring efficacy
- Drafting report
- Preparing to scale successful interventions

<table>
<thead>
<tr>
<th>Ideation &amp; Pre-Planning</th>
<th>Phase I</th>
<th>Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-2017</td>
<td>March 2018</td>
<td>March 2019</td>
</tr>
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<td></td>
<td>Late Fall 2019</td>
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High Level Insights from Phase I
Methodology: Qualitative Interviews

- Two Built for Zero staff traveled to each participating community to conduct qualitative interviews (100 total interviews across 5 communities)
- Veterans signed an informed consent form
- Staff recorded anonymous interviews
- Interviews were transcribed
- Qualitative interview analysis codebook was developed
- Interviews were coded and analyzed for themes within and across communities
Cross-Community Themes

1. Lack of knowledge about/connection to VA services and resources available to Veterans before experiencing homelessness

2. Stigma associated with accessing and receiving VA and non VA services

3. Breakdown of family and peer networks as a precursor of homelessness

4. Substance abuse, alcoholism and mental health scenarios as a precursor of homelessness

5. Loss of employment/income and financial hardship as a precursor of homelessness

6. Medical emergencies/interventions as precursor of homelessness
How prevalent is a code across all five communities?

The Built for Zero team interviewed 100 veterans with experiences of homelessness based in Ann Arbor; Detroit; Fresno; Riverside; and Washington, D.C. We coded for specific experiences.

<table>
<thead>
<tr>
<th>Code</th>
<th>Percentage of respondents whose interviews contain a specific code across all five communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received VA services</td>
<td>75%</td>
</tr>
<tr>
<td>NonVA Services</td>
<td>73%</td>
</tr>
<tr>
<td>Breakdown of Family Network</td>
<td>63%</td>
</tr>
<tr>
<td>Peer Network</td>
<td>58%</td>
</tr>
<tr>
<td>Financial hardship</td>
<td>56%</td>
</tr>
<tr>
<td>Family Network</td>
<td>55%</td>
</tr>
<tr>
<td>Mental health</td>
<td>51%</td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td>51%</td>
</tr>
<tr>
<td>Network Impoverishment</td>
<td>51%</td>
</tr>
<tr>
<td>Medical Interventions</td>
<td>49%</td>
</tr>
<tr>
<td>Loss of Income/Employment</td>
<td>46%</td>
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<tr>
<td>Criminal Justice System</td>
<td>45%</td>
</tr>
<tr>
<td>Faith</td>
<td>45%</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>43%</td>
</tr>
<tr>
<td>Self-sufficiency</td>
<td>41%</td>
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<tr>
<td>Lack of Stability Returning from Service</td>
<td>38%</td>
</tr>
<tr>
<td>Medical Emergency/Crisis</td>
<td>38%</td>
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<tr>
<td>Supported Others</td>
<td>35%</td>
</tr>
<tr>
<td>Gratitude</td>
<td>34%</td>
</tr>
<tr>
<td>Non-completion of school</td>
<td>32%</td>
</tr>
<tr>
<td>Incarceration</td>
<td>31%</td>
</tr>
<tr>
<td>Dangerous Upbringing</td>
<td>30%</td>
</tr>
<tr>
<td>Exceptionalism</td>
<td>30%</td>
</tr>
<tr>
<td>Escaping home environment</td>
<td>29%</td>
</tr>
<tr>
<td>Disability</td>
<td>28%</td>
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<tr>
<td>Medication</td>
<td>27%</td>
</tr>
<tr>
<td>Depression</td>
<td>27%</td>
</tr>
<tr>
<td>Homelessness prevention</td>
<td>24%</td>
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<tr>
<td>Racism</td>
<td>24%</td>
</tr>
<tr>
<td>Education</td>
<td>22%</td>
</tr>
<tr>
<td>Victim of Crime</td>
<td>22%</td>
</tr>
<tr>
<td>Suicide</td>
<td>20%</td>
</tr>
<tr>
<td>Eviction</td>
<td>17%</td>
</tr>
<tr>
<td>Sexism</td>
<td>14%</td>
</tr>
<tr>
<td>Domestic Violence Incidence</td>
<td>11%</td>
</tr>
<tr>
<td>Loss of program</td>
<td>9%</td>
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<tr>
<td>Foster care involvement</td>
<td>7%</td>
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</tbody>
</table>
Methodology: HMIS Records

- Agencies in each community signed a data sharing agreement with Built for Zero

- Communities shared de-identified client records from HMIS systems and their By-Name Lists (over 2,000 records across 5 communities)

- The Built for Zero team and HVH Analytics conducted community specific and cross-community analysis
Phase I Insights

- Aggregate community level measures (inflow, actively homeless numbers and outflow) provided information on where to focus our efforts.

- HMIS records provided basic information about people in the system and was most useful at a community level.

- Speaking to veterans themselves generated user centered ideas about how to address parts of the system, in this case, inflow.
Phase II and Measuring Progress
Planning Improvement Projects

- Convening of Community leads and VA representatives from:
  - Ann Arbor/Washtenaw County
  - Washington, D.C.
  - Detroit
  - Fresno

- Reviewed Quality Improvement principles and planning small tests of change (Plan, Do, Study, Act)

- Provided communities with reports, including:
  - Community specific quantitative and qualitative analysis
  - Community specific improvement project suggestions
## Improvement Project Suggestions

<table>
<thead>
<tr>
<th>Connecting veterans exiting incarceration to employment and income generating programs</th>
<th>Data matching between veteran BNL and VAMC / CWT / VESO programs</th>
<th>Data matching between veteran BNL and VAMC, VA substance use and alcohol treatment programs</th>
<th>Deepening earlier connections between veterans and VA services before they are experiencing or are at risk of experiencing homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnering with VAMC to reduce LoT to receive DD214 papers</td>
<td>Conducting ‘At risk’ assessments of veterans at VAMC / CWT / VESO</td>
<td>Early identification of veterans at risk of homelessness due to alcohol or substance use dependency</td>
<td>Connecting veterans to relationship/family mediation services</td>
</tr>
<tr>
<td>Connecting with local substance use disorder treatment programs for early ID’ing and connection to resources for unstable or marginally housed veterans</td>
<td>Reducing veterans ‘lost in the shuffle’ between VAMC / CWT / VESO and prevention or non homelessness specific VA programs</td>
<td>Creating mentorship program with TCM for veterans returning home from service</td>
<td>Diverting veterans from the criminal justice system before they experience homelessness</td>
</tr>
<tr>
<td>Connecting aging veteran population to mainstream resources and assistance for seniors</td>
<td>Conducting targeted PR/Advertising Campaign with VAMC/CRRC to raise awareness of resources available to veterans</td>
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</tbody>
</table>
Plan / Do / Study / Act

**Plan** a small test of change
- Who will do what by when?
- Where will we test this idea?
- What do we think the impact is going to be?
- How will we measure if this impact is being achieved?

**Do** the test
- Implement your plan
- Measure what happens - document without judgement!

**Study** the results
- Did we carry out the plan as intended?
- Did it achieve the intended result?

**Act** on the results
- If the test did not yield the predicted impact - should we tweak the test and try again? Abandon the test?
- If it did - should we test again on a slightly bigger scale?
Why do a PDSA?

- Limited time, limited capacity, limited resources
  - Let’s try something on a small scale first before we spend all 3 overhauling a process
- Testing can reduce resistance to change
- Testing = learning
  - How much did this cost?
  - Did it have the intended consequence?
  - Were there any unintended consequences?
Let's Plan Together

We, the team in Exampleville, USA, will reduce our inflow by three points below the median by July 31, 2019
But how?
## PLAN

<table>
<thead>
<tr>
<th>What will we try?</th>
<th>Data Matching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why will we try it?</td>
<td>To see if other VA programs see the same vets on our By-Name List</td>
</tr>
<tr>
<td>Who will lead this project?</td>
<td>Elaine</td>
</tr>
<tr>
<td>Where and when will we test it?</td>
<td>We will data match for 2 weeks between BNL and CWT program</td>
</tr>
<tr>
<td>How will we know if it worked?</td>
<td>If there is 10% overlap between vets at CWT and vets on the BNL</td>
</tr>
</tbody>
</table>
**STUDY**

<table>
<thead>
<tr>
<th>Did we carry out the plan as intended?</th>
<th>Yes, Elaine and Amber looked at HOMES IDs for veterans at CWT and on the BNL for 2 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>What happened?</td>
<td>15% of veterans that accessed CWT services at the VA were eventually added to the BNL</td>
</tr>
</tbody>
</table>
Now what?

- Continue to data match for 1 month between CWT and BNL
- Ask ‘at risk’ or prevention questions at CWT for early identification
- Identify other VA programs for data matching
Measuring Success

- **Our Learning Question for Phase II:** Which strategies/improvement projects lead to measurable reductions in a community’s inflow?

- **How Do We Measure This?**
  - Communities are using Quality Improvement to drive measurable change
  - Communities are working with new partners and overcoming barriers
  - Communities are on track for a shift in their inflow data
Using QI to Drive Change

- Each community participating in this project has a coach that conducts regular check-ins with local teams.

- We have devised a ‘QI Adoption Scale’ to be used on coaching calls:
  - Did a community plan an improvement project from these findings?
  - Did they collect some baseline data and establish a way to collect future data?
  - Did they test a change idea/intervention?
  - Did they collect data beyond the baseline?
  - Did they take action based on the result of the tested idea and data collected?
  - Did this project result in a stated goal?
Coaches also collect information about emerging partnerships:
- Did a community team form any new relationships (at the VA, with other organizations, etc) through working on their improvement project?
- Are those new entities actively involved in implementing the improvement project?
- Is the new entity acting any differently because of the results of the improvement project?

And addressing barriers:
- Has the community team identified any barriers to overcome as a result of planning an improvement project?
- Are steps being taken to overcome this barrier?
- Has it been successfully overcome?
Communities are ‘On Track for a Shift’ in Inflow Data

Inflow Total  Use drop-down at right to adjust metric displayed

3 or more inflow data points below the median
Phase II Insights (so far)

- Attribution can be challenging - did implementing 1 improvement project cause a reduction in inflow?

- Communities indicated that progress may be slower than originally anticipated, but that is because they are building new relationships to do this work

- Communities are trying new projects, and it's exciting!
Thank You!
Questions?