Data As an Outreach Tool: Engaging Non-VA Eligible and Chronically Homeless Veterans

New England Center and Home for Veterans

Meagan Beatty, MSW

Sarah Johnson, MA

Objectives

1. How to utilize data for outreach and engagement purposes
2. How to successfully collaborate with providers and utilize community resources
3. Develop an understanding of the unique needs and barriers of non-VA eligible Veterans

New England Center and Home for Veterans

The Mission of the New England Center and Home for Veterans (NECHV) is to equip Veterans who are facing or at-risk of homelessness with the tools for economic self-sufficiency and to provide them a path to achieve successful and dignified independent living.

A service and care provider for former military service men and women, the NECHV offers a broad array of programs and services that enable success, reintegration, meaningful employment and independent living.

Veterans Welcome Home Program

- Funded by the City of Boston via HUD pass-through money
  - Closed referrals from the City of Boston Veteran List
- Targets Veterans who are chronically homeless and categorically in-eligible for HUD/VASH
- Case managers provide outreach, case management, and long-term stabilization services
  - Progressive Engagement used for outreach
- Extremely low-threshold (low barrier)

Veterans Working Group

- Developed in response to chronic Veterans homelessness
- Veterans By Name List
  - Cohort
  - Ranking
- Encourages collaboration among providers to problem solve and identify housing pathways

Boston Coordinated Care Hub

- Behavioral Health Community Partner through MassHealth, Massachusetts's Medicaid system.
- Consortium partnership between Boston Healthcare for the Homeless Program and local agencies that serve the homeless population.
- Targets high utilizers of healthcare services with highest behavioral health risks including ED visits, substance use, serious mental illness, and homelessness.
- The Hub offers Nurse Care Management and Care Coordination to these patients. Care Coordinators offer support for physical and mental health and coordination amongst providers.

Boston Coordinated Care Hub

Identify & Find Patient	Enroll	Assess	Plan	Support During Care Transitions	Ongoing Care & Outreach
- Massachusetts Medicaid data referral	- Explain how we can help - Gain consent to provide services & communicate with other providers	- Identify patient's needs and preferences, with a formalized assessment entered into record using specific tool	- Collaboratively develop care plan	- Discharge planning with hospitals - Follow-up within 3 days after discharge - Medication reconciliation	- Provide regular care through monthly touch points - Provide proactive outreach - Update care plan regularly

Data Sources

Boston City Homelessness Data	Massachusetts Medicaid Data
• ETO/HMIS* (Efforts to Outcome) data transfers to a database created by the city of Boston-the Warehouse (Veterans By Name List) • The Warehouse tracks length of homelessness and shelter locations	• High utilizer data • PreManage Notifications • Primary Care and Accountable Care Organization contacts

*All clients sign a release of information for this database

NECHV

NEW ENGLAND CENTER
AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

Data as a Tool for Outreach

- Veterans Working Group
- Locate hard to track clients
- Identify services being used
- Identify community contacts
- Connect with providers
- Progressive engagement

NECHV

NEW ENGLAND CENTER AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

Uniting Factors

VWH

- Categorically Ineligible for HUD/VASH
- Chronic Long-Term Stayers
- Can furnish DD-214

BCCH

- High-Utilizers of ED
- Serious Mental Illness/Complex Medical Condition
- Substance Use History

Mutual Clients

- Low Threshold for Care
- Ineligible for VA services
- Complex mental health/medical conditions
- History of Substance Use
- Unique Needs

NECHV

New England Center
And Home for Veterans
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

Unique Needs of Population

- **Difficulty trusting providers**
  - Identify as a Veteran, receive offer for VA funded services, furnish DD214, then become ineligible for services
- **Substance use disorders**
  - Internalized stigma around substance use
- **Untreated mental health**
  - Stigma and disengagement in services
- **Chronic homelessness**
  - Fears and concerns about housing, loss of community once housed

NECHV

NEW ENGLAND CENTER
AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

How We Meet These Needs

- **Difficulty trusting providers**
  - Providing low-threshold services, meeting the Veteran where they are at, Trauma Informed Care
- **Substance use disorders**
  - Harm Reduction Model, use of Motivational Interviewing
- **Untreated mental health**
  - Psychoeducation, referrals to low-threshold providers
- **Chronic homelessness**
  - Open conversations and normalizing the fear, use of Motivational Interviewing regarding ambivalence

NECHV

NEW ENGLAND CENTER
AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

Frequently Used Interventions

1. Motivational Interviewing

2. Harm Reduction

3. Trauma Informed Care

Motivational Interviewing

- Evidence based treatment
- Started with substance use treatment
- Now used with a variety of other behavior changes
- Used with chronically homeless Veterans
- Goal is to engage in change talk and work through the stages of change

Stages of Change

Stages of Change: PRIMARY TASKS

1. PRECONTEMPLATION
Definition: Not yet considering change or is unwilling or unable to change
Primary Task Raising awareness

2. CONTEMPLATION
Definition: Sees the possibility of change but is ambivalent and uncertain
Primary Task Resolving ambivalence, Helping to choose change

3. DETERMINATION
Definition: Committed to changing but still considering what to do
Primary Task Help identify appropriate change strategies

4. ACTION
Definition: Taking steps toward change but hasn't stabilized in the change process
Primary Task Help implement change strategies and learn to eliminate potential relapses

5. MAINTENANCE
Definition: Has achieved the goals and is working to maintain change
Primary Task Develop new skills for maintaining recovery

6. RECURRENCE
Definition: Experienced a recurrence of the problems
Primary Task Cope with consequences and determine what to do next

Harm Reduction

"Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."

- Harm Reduction Coalition

Harm Reduction

- Accept that substance use is part of the community and this population.
- Non-judgemental and directive interventions
  - Motivational Interviewing
- Strengths based approach, celebrates "Any Positive Change"
- Promote safer use rather than strictly sobriety.

Harm Reduction vs. Abstinence Only

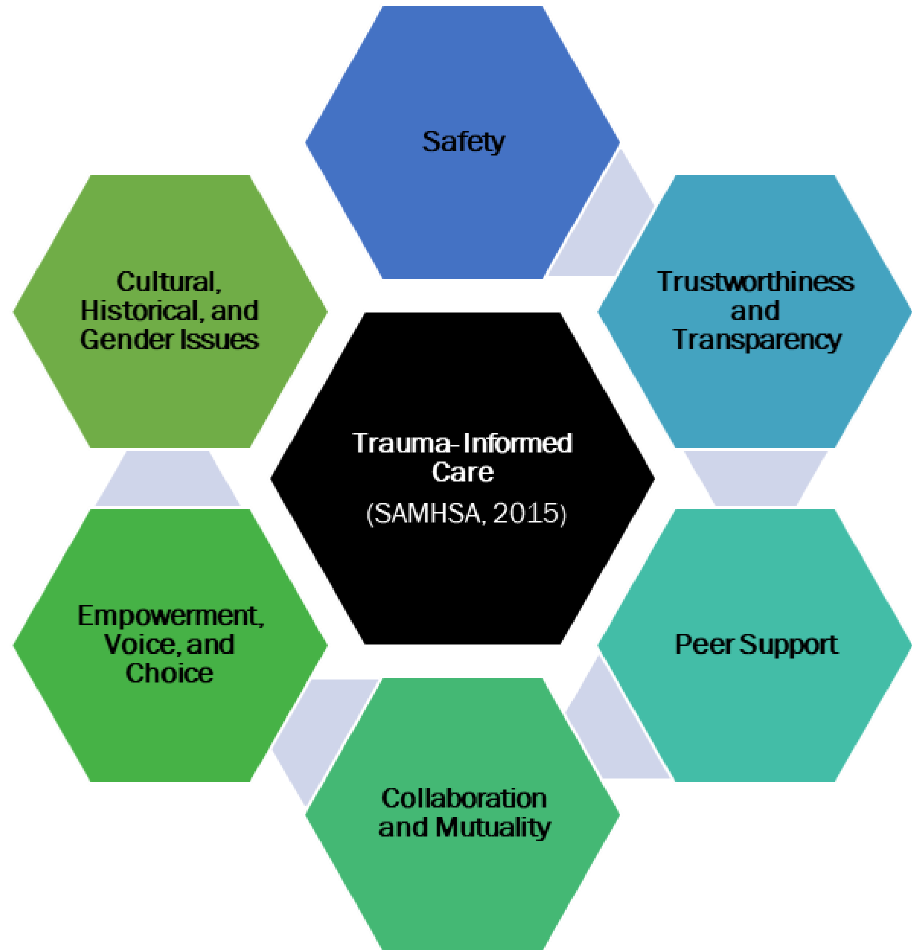
Harm Reduction	Abstinence Only
Decrease in risky behavior is viewed as a success	Any risky behavior is usually viewed as un-successful
Use of a less harmful substance is viewed as success	Length of sobriety measures success
Providers will meet with individuals while under the influence, within reason	Providers will not meet with individuals unless sober

Trauma Informed Care

- Trauma Informed Care is an evidence-based treatment that involves understanding, recognizing, and responding to the effects of all types of trauma.
- It assumes everyone has been through trauma.
- Trauma affects the individual, families, and communities in different ways.
- Trauma Informed Care is a comprehensive approach that involves both organizational and clinical aspects.

NEW ENGLAND CENTER AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

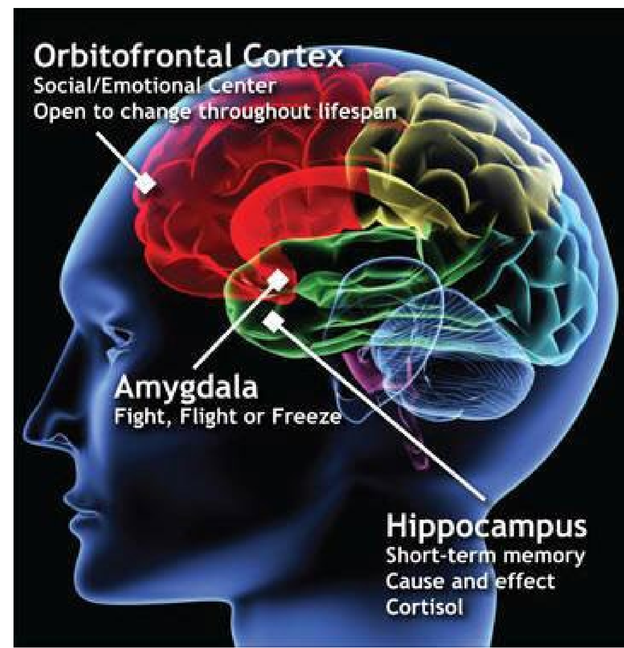
Six Key Principles of Trauma Informed Care



NEW ENGLAND CENTER AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

Trauma In The Brain

- Research supports the ways trauma affects the brain. An identified relationship between exposure to traumatic events, compromised development and immune systems, and increased health risks (behavioral and physical health).
- Fight or Flight: Resiliency in homelessness doesn't always translate to housing.
- Examples:
  - Coping Skills
  - Basic Life Skills
  - Substance Use/Self Medication



Case Study: Veteran A

Demographics: Veteran A is a 56-year-old, single, African-American, Army National Guard Veteran. Enlisted in March of 1980 and was released in June of 1980 due to physical disability (honorable discharge)

Living Situation: Homeless staying in shelters and on the street

Barriers: Untreated serious mental illness, complex medical conditions, significant legal history, polysubstance use disorder, history of incarceration, ambivalence

Community Providers: Pine Street Inn Veterans Outreach Team, Department of Mental Health Case Management, Veterans Welcome Home Case Management, Clinical Care Coordinator, Nurse Case Manager, Primary Care and Medical Providers

Outreach, Engagement, and Stabilization Efforts: Veteran A

Outreach: Located Veteran in shelter, connected with providers already engaging the Veteran, ongoing outreach

Engagement: Met Veteran in his preferred setting with a provider he was comfortable with.

Stabilization: Ongoing efforts through extensive provider collaboration and brainstorming about community resources (housing, medical, mental health)

NECHV

NEW ENGLAND CENTER
AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

Day in the Life of Veteran A

- Street homeless. Barred from 3 primary Boston shelters that Veteran frequented in the past, refusal to stay at other area shelters or utilize additional homeless services.
- When weather is bad presents at emergency department for medical concern, usually between 2:00-3:00 AM. Will leave AMA in the early morning, around 6:00 or 7:00 AM.
- Multiple phone calls to providers requesting supports, resources, and belongings throughout the day.
- Will possibly present unannounced at provider's offices in the early morning or late afternoon.
- Missed appointments and need for medication refills due to instability of situation and insecure resources for medication management.
- Spends time with members of the community at local train stations and panhandling local commuters.
- Walking from destination to destination looking for a place to sit and eat or sit and catch breath.

Case Study: Veteran B

Demographics: Veteran B is a 60-year-old, single, Caucasian, Navy Veteran. Served from March of 1978- October 1985 with a bad conduct discharge

Living Situation: Housed in April 2018 after years of homelessness in shelters

Barriers: Physical disability, substance use disorder, serious mental illness, significant trauma history, history of incarceration, ambivalence

Community Providers: Veterans Welcome Home Case Management, Clinical Care Coordinator, Nurse Case Manager, Boston Health Care for the Homeless Program, OBOT Clinic and Medical Providers

NECHV

Outreach, Engagement, and Stabilization Efforts: Veteran B

Outreach: Veteran was staying at the NECHV, collaboration with existing providers

Engagement: Met Veteran in his preferred setting

Stabilization: Ongoing efforts through provider collaboration

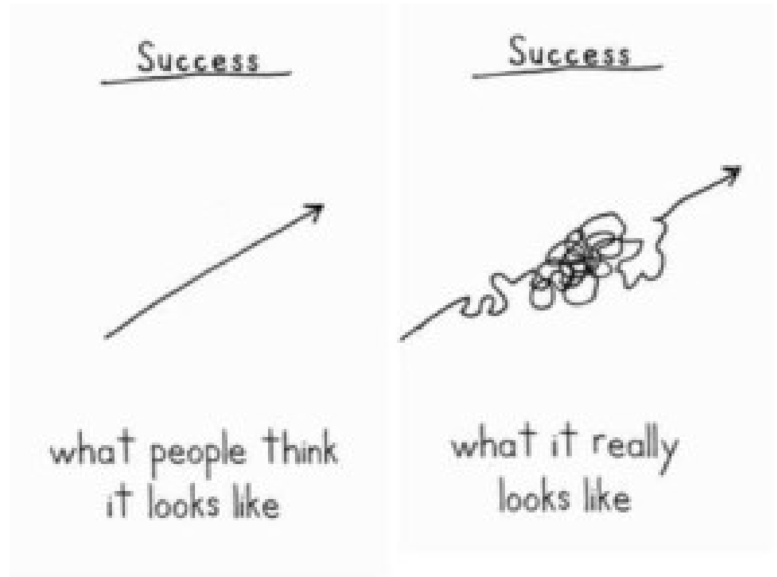
A Day in the Life of Veteran B

- Wakes up in apartment, possibly has an alcoholic beverage.
- Calls case manager to check in at 8:00 AM. Has appointment at BHCHP OBOT clinic later on in the day for his Suboxone refill. Tells case manager he will be in around 9:30 AM.
- Continues staying in apartment, isolated and drinking.
- Calls case manager around 11:00 AM. Sounds slightly intoxicated. Tells case manager he is on his way.
- Arrives to the NECHV around 1:00 PM. Veteran is intoxicated, but able to function. Case manager walks him to OBOT clinic for Suboxone script.
- Veteran and case manager meet for about 30 minutes. Veteran continues to demonstrate ambivalence and remains in pre-contemplative stage of change regarding recovery. Veteran discloses shame and embarrassment around alcohol use.

NEW ENGLAND CENTER AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

Keeping Veteran B (and others) Housed

- **Progress is NOT linear!**
- Intense collaboration with community providers (when applicable)
- Assistance in "basic", day-to-day tasks such as mailing rent, writing a money order
- Flexibility
- Consistency



NECHV

New England Center
And Home for Veterans
Education | Support | Employment | Housing

Gaps in the System

- Housing resources for complex CORI/SORI (housing vouchers)
- Lack of affordable housing stock
- Resources for adequate hospital discharge planning
- Fair housing
- Stabilization services and limitations (Housed vs. Homeless)
- Mental health companionship/support
- Medication instability within shelter system

Discussion and Questions

References

Addiction Counseling: Abstinence Versus Harm Reduction. (2014, July 24). Retrieved from https://www.new-hope-recovery.com/2014/07/addiction-counseling-abstinence-versus-harm-reduction/

Logan, D. E., & Marlatt, G. A. (2010). Harm reduction therapy: A practice-friendly review of research. *Journal of Clinical Psychology*. doi:10.1002/jclp.20669

Principles of Harm Reduction. (n.d.). Retrieved from https://harmreduction.org/about-us/principles-of-harm-reduction/

Schulman, M., & Menschner, C. (n.d.). *Laying the Groundwork for Trauma-Informed Care*[Pamphlet]. Center for Health Strategies.

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS PublicationNo. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.