



Supportive Services for Veteran Families (SSVF) Webinar Series

Overview of the System Assessment & Improvement Toolkit

May 11, 2017

https://attendee.gotowebinar.com/recording/7405140826945206531

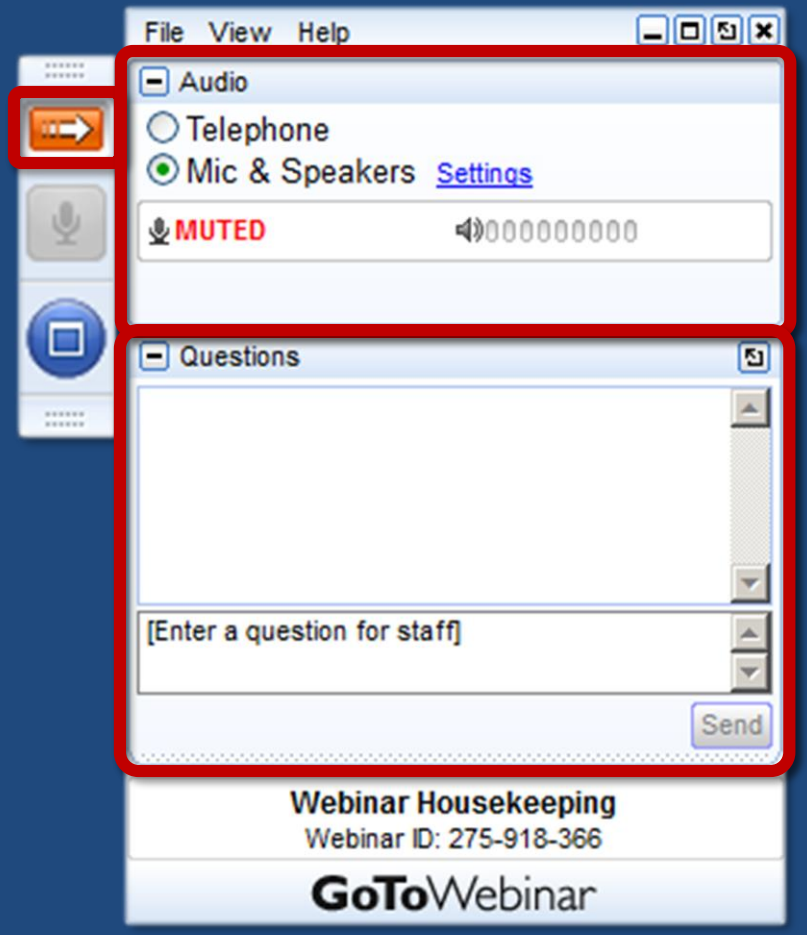
Presenters

- **Angie Fodor**, Project Manager, Comprehensive Health, Women's Health Services, Veterans Health Administration
- **Jill Albanese,** SSVF Regional Coordinator
- **Ashley Mann-McLellan,** SSVF Technical Assistance
- **Joyce Probst-McAlpine,** SSVF Technical Assistance

Webinar Format

- Webinar will last approximately 1.5 hours
- Participants' phone connections are "muted" due to the high number of callers
- Questions can also be submitted anytime to SSVF@va.gov

QUESTIONS…



Submit questions and comments via the Questions panel

U.S. Department of Veterans Affairs

Women Veteran's Health Care Overview

Women's Health Services (WHS)
Veterans Health Administration (VHA)
Department of Veterans Affairs (VA)

OVERVIEW

1. Who's Using VA Care
2. What's Offered
3. Cultural Transformation
4. Resources

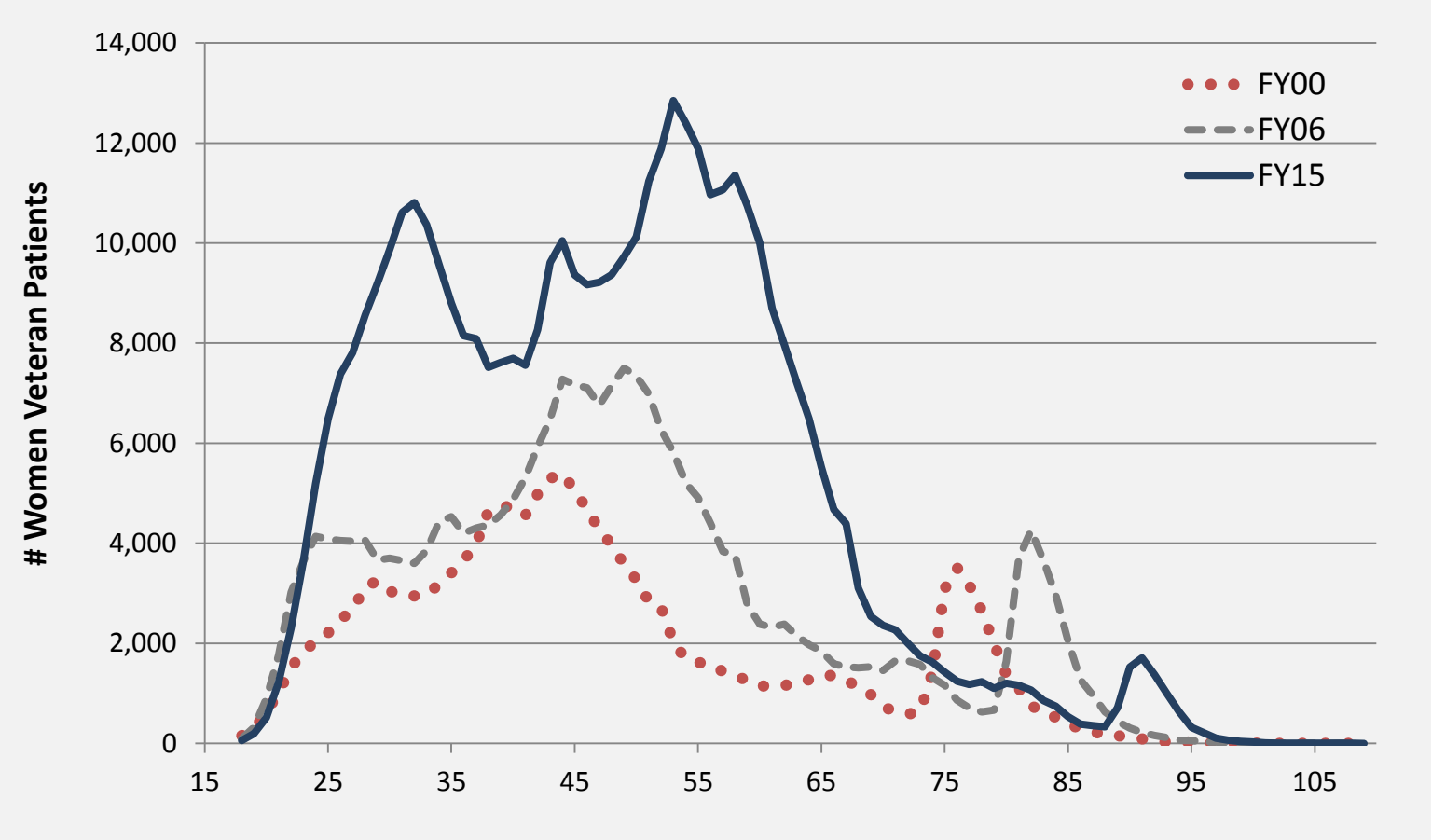
Who's Using VA Care

Women Veterans Using VA Care

- Women are the fastest growing subgroup of U.S. Veterans; there are more than 2.1 million women Veterans in the U.S. Women make up 15.5 percent of today's active duty military and 19 percent of National Guard and Reserve forces.
- Women Veterans who use VA are a young, racially diverse population with high rates of service connected disability, mental health conditions, sexual trauma, and musculoskeletal injuries and conditions. Those who enroll in VA are high utilizers of care, needing providers with expertise in managing Veterans with complex health conditions.
  - Nearly one in four women Veterans have experienced Military Sexual Trauma.
  - More women than men Veterans have a service connected (SC) disability (73 percent of women Veterans ages 18-44).
  - Over 30 percent of women Veterans use non-VA Care in the Community, coordinated and paid by VA.

FY15 Statistics	Women	Men
Average Age	47.9	62.5
> 12 Outpatient Encounters	51%	44%
Mental Health – Substance Use Condition	48%	31%
Musculoskeletal Injury	59%	48%

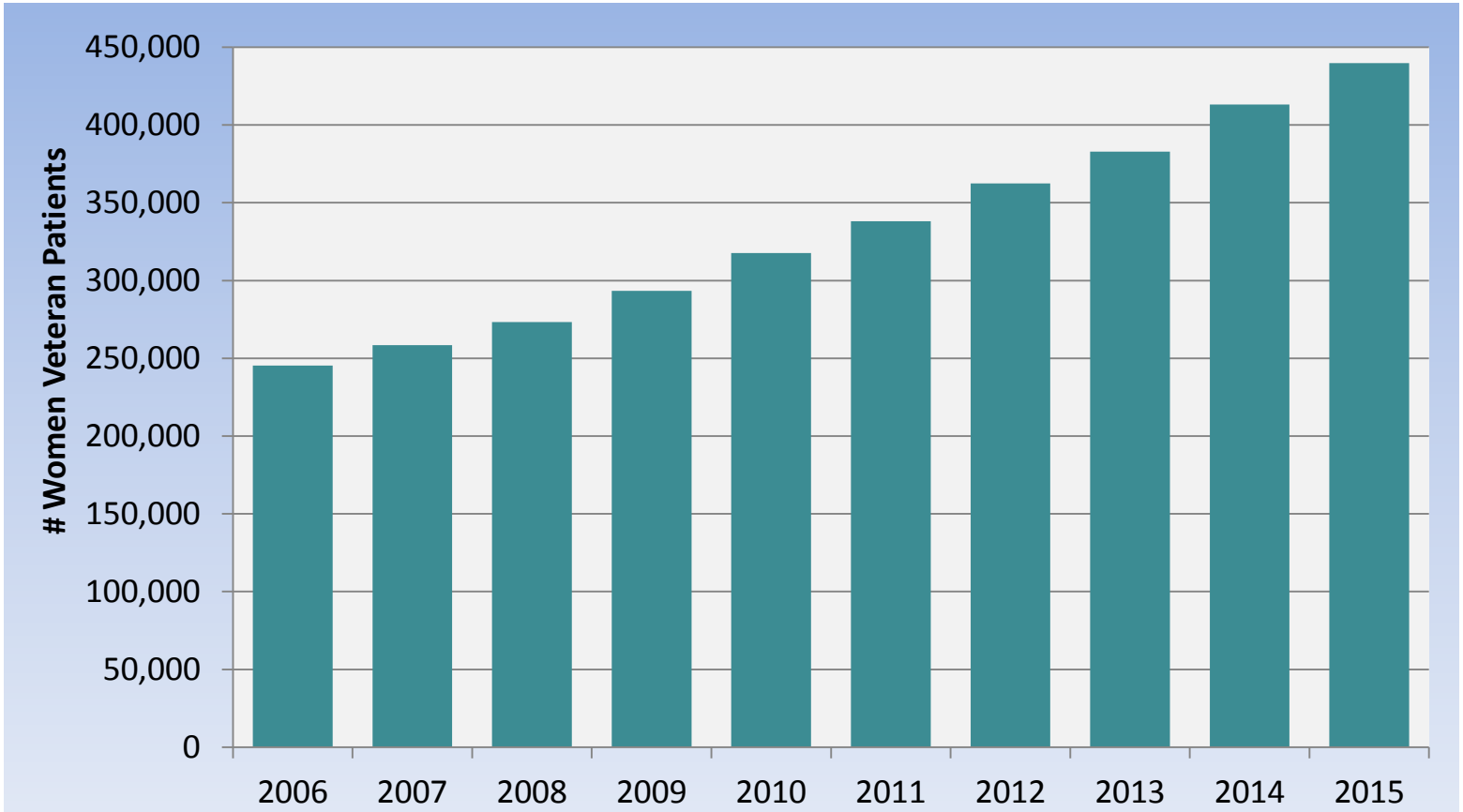
Age Distribution of Women Veteran Patients Fiscal Year (FY) 2000, FY2006, and FY2015



Cohort: Women Veteran patients with non-missing ages 18-110 years (inclusive). Women in F Y00: N=159,553; FY06: N=245,270; FY15: N=439,615.
Source: WHEI Master Database, FY15

Women Veteran Patients

Women using VHA services has nearly doubled in the past decade, growing from 245,301 in FY06 to 439,791 in FY15, a 79% increase over 10 years.



Cohort: Women Veteran patients in each year. Women in FY06: N=245,301; Women in FY15: N=439,791.
Source: WHEI Master Database, FY15

Ideal: Women Veterans Experience of VA

- High-quality, equitable care on par with that of men
- Care delivered in a safe and healing environment
- Seamless coordination of services
- Recognition as Veterans

What's Offered

Full Continuum of Health Care for Enrolled Women Veterans

- Comprehensive Primary Care
  (acute care, chronic illness and gender-specific care from a single provider)
- Gynecological care
- Mental Health
- Disease Management, Prevention and Screening
- Emergency Care
- Infertility Care
- Maternity Care (Newborn care up to 7 days)
- Specialty Care
- Long-Term Care Services and Supports
- Hospice/Palliative Care

Designated Women's Health Providers

- Complete primary care, including routine gynecologic care, from one designated women's health provider (DWHP) at all VA sites of care including Community Based Outpatient Clinics (CBOCs)
- DWHP's are primary care providers that are trained and/or experienced in women's health care.
- Research shows higher patient satisfaction with care, higher quality of gender specific care, and decreased attrition from VA health care when women are cared for by a DWHP

Women's Health Comprehensive Primary Care Clinic Models

- Model 1 - General Primary Care Clinics. Comprehensive primary care for the women Veteran is delivered by a DWHP. Women Veterans are seen within a general gender-neutral Primary Care Clinic. Mental health services for women should be co-located in the Clinic. Referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance.
- Model 2- Separate but Shared Space. Comprehensive primary care services for women Veterans are offered by DWHP in a separate but shared space that may be located within or adjacent to Primary Care Clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.
- Model 3- Women's Health Center (WHC). VHA facilities with larger women Veterans populations are encouraged to create Women's Health Centers (WHC) that provide the highest level of coordinated, high-quality comprehensive care to women Veterans.

Women's Health Education

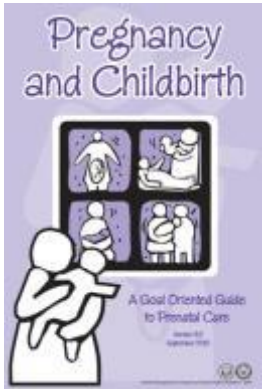
- Over 3,000 VA primary care providers trained through WH mini-residency program
- Monthly inter-professional webinars
- Grants sponsored to train providers
- Developed over 50 accredited on-demand online training sessions
- Breast and pelvic exam simulation equipment disseminated to all health care systems

Gynecology

- 196 gynecologists employed, on-site at 130 facilities
- When services are unavailable or not timely, Care in the Community (paid for by VA) is used
- Additionally, telehealth and tele-gynecology are options potentially available for underserved areas

Maternity Care

- National policies for Maternity Care Coordination
- Maternity Care Coordinators at each VA Medical Center
  - Facilitate communication between non-VA maternity care providers and VA-based health care providers
  - Provide support and education
  - Assist with lactation needs
  - Screen for post-partum needs
- Electronic record alerts providers to medications that may be hazardous during pregnancy



Newborn Care

- Care provided for up to but not more than seven days after birth
- Includes all post-delivery care services, including routine health care services that a newborn child requires
- The Veteran (mother) must be enrolled in VA care and receiving VA maternity benefits

Mammography

- Mammography can be provided in-house or through Care in the Community (paid for by VA)
- Over 60 VHA Health Care sites are now offering on-site digital mammography
- VA exceeds the private sector in mammography screening
- 84.6% of age-eligible Women Veterans received mammography screening in 2016

Cultural Transformation

Advocating Cultural Transformation

Women's Health Services is leading a VA-wide communication initiative to enhance the **language**, **practice,** and **culture** of VA to be **more inclusive of women Veterans.**

Women Veterans Self Identify Campaign

I'm One. I'm a Proud Veteran.

Resources

Women Veterans Call Center

Women Veteran Program Manager

- At each VA Medical Center nationwide, a Women Veteran Program Manager is designated to advise and advocate for women Veterans. She can help coordinate all the services that may be needed, from primary care to specialized care for chronic conditions or reproductive health.
- Woman Veterans who are interested in receiving care at VA should contact the nearest VA Medical Center and ask for the Women Veteran Program Manager.

Women Veterans and Homelessness

The VA National Center on Homelessness Among Veterans partnered with VA Women's Health Services to host a **virtual research symposium on women Veterans and homelessness**.

A report is also available that summarizes the research findings presented and panel discussion, and provides additional resources for further learning such as:

- **Suggested Readings**
  - Projecting the Need for VA Homeless Services Among Female Veterans
  - Characteristics and Needs of Women Veterans Experiencing Homelessness
  - Service Barriers Among Women Veterans Experiencing Homelessness
- **Archived Training Events and Presentations**

SUMMARY

1. Discussed Who's Using VA Care
2. Reviewed What's Offered
3. Shared Cultural Transformation Efforts
4. Provided Resources





SSVF Monitoring Toolkit

SSVF Monitoring Toolkit

- The SSVF Monitoring Toolkit
- All grantees subject to monitoring by VA to review grant management and provide technical assistance, if needed
- The SSVF Monitoring Toolkit, available on the SSVF website, is designed to assist grantees in preparing for on site visit
- Components of SSVF Monitoring Toolkit can be used throughout the grant year to ensure compliance and measure improvements in performance
- Webinar explaining monitoring and toolkit available: https://attendee.gotowebinar.com/recording/4159185687997307905

SSVF Monitoring Toolkit

- SSVF Monitoring Visit Checklist
  - Use the checklist to prepare for the visit before the monitoring visit
  - Ensure that appropriate staff are on site the day of the visit
  - Checklist for preparing response to VA after the visit
  - Monitor progress of any changes that have been implemented

SSVF Monitoring Toolkit

- SSVF Self Monitoring Tool
  - Ensure that the items can be checked off prior to monitoring visit
  - Items marked with (*) were most commonly missed UMP questions in FY16

Policies and Procedures (P&P)
☐ There are clearly written and detailed screening P&Ps specific to the program.
☐ There are clearly written and detailed P&Ps regarding how eligibility is determined specific to the program.
☐ There are clearly written P&Ps for prioritizing admissions and who is responsible for admission decisions.*
☐ There is a clearly written Critical Incident Policy which includes reporting and following up on incidents.
☐ There is a clearly written policy on ineligibility criteria and the practice of handling ineligible applicants.*
☐ There is a clearly written policy on protecting client information and requiring signed Releases of Information.

SSVF Monitoring Toolkit

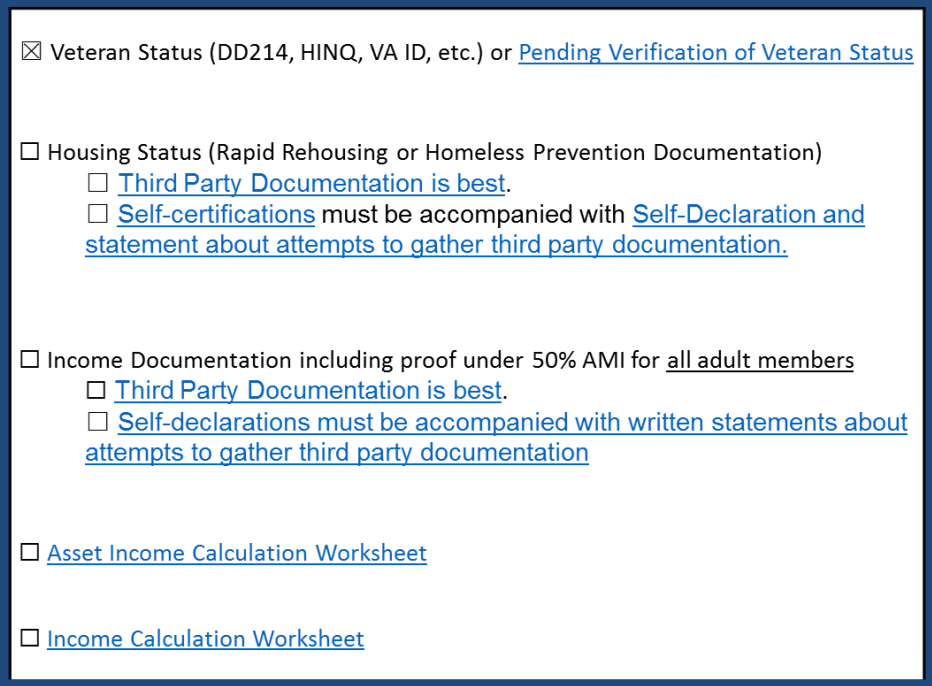
- SSVF Subcontractor Monitoring Guide
  - SSVF providers are required to have adequate controls in place
  - Ensure that subcontractors are delivering high level services
  - Tool can be used to monitor all subcontractors
  - Additional checklists are provided for type of subcontractor

SSVF Monitoring Toolkit

- SSVF Managers Tool
  - Conduct review of case files for completeness
  - Ensure consistent organization of client files
  - Use tool throughout grant year
  - Use with both paper and electronic files

SSVF Monitoring Toolkit

- SSVF Case File Tool
  - Organize files to prepare for monitoring visit
  - Ensure that required documentation is in all files
  - Tool is useful for internal quality assurance or peer review of files
  - Use with both paper and electronic files



☒ Veteran Status (DD214, HINQ, VA ID, etc.) or Pending Verification of Veteran Status

☐ Housing Status (Rapid Rehousing or Homeless Prevention Documentation)
- ☐ Third Party Documentation is best.
- ☐ Self-certifications must be accompanied with Self-Declaration and statement about attempts to gather third party documentation.

☐ Income Documentation including proof under 50% AMI for all adult members
- ☐ Third Party Documentation is best.
- ☐ Self-declarations must be accompanied with written statements about attempts to gather third party documentation

☐ Asset Income Calculation Worksheet

☐ Income Calculation Worksheet

SSVF Monitoring Toolkit

- SSVF UMP Crosswalk
- Grantees are assessed on meeting required standards from program regulations
  - SSVF Program Guide
  - Applicable NOFAs
  - Final Rule
  - OMB Circular
  - VA Data Guide

I1	Does the grantee maintain a Comprehensive Data Quality Plan to ensure completeness, timeliness, and accuracy of HMIS data?	DG: Data Quality Management
I2	Does the Data Quality Plan specifically detail staff responsibility including: timelines for data entry and HMIS Repository uploads, and ongoing quality assurance procedures?	DG: Data Quality Management
I3	Does the grantee successfully upload all client information to the SSVF HMIS Repository on a monthly basis? Is the grantee entering or exporting data to all CoCs served?	PG: Reporting Process
I4	Does the grantee entering or exporting data to all CoCs served?	DG: HMIS Participation Planning
I5	Is client file data accurately entered into the grantee's HMIS system?	DG: Accuracy



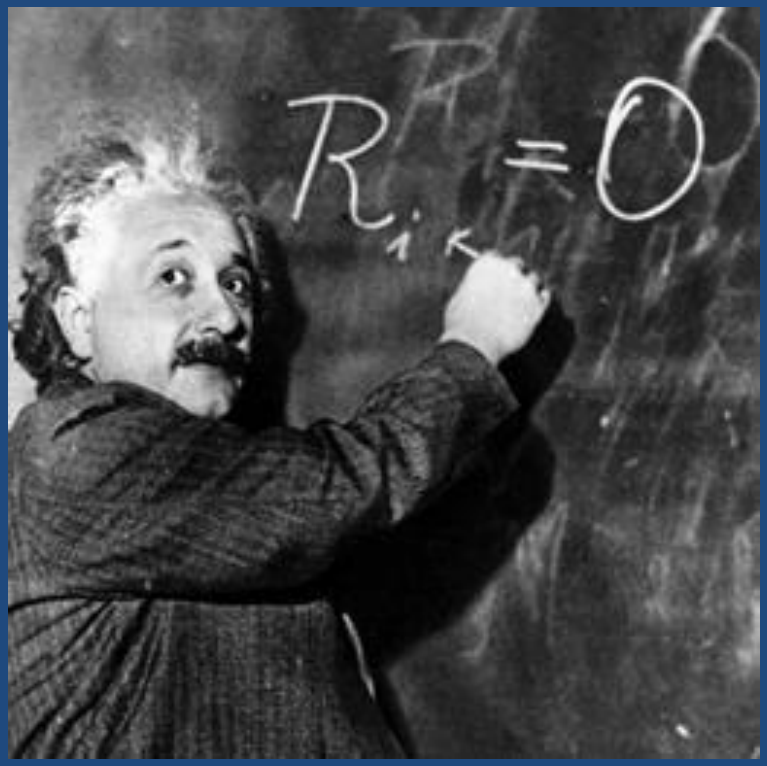


Using the System Assessment & Improvement Toolkit

VA SSVF Webinar
May 11, 2017
Presented by: Joyce MacAlpine, Abt Associates
Ashley Mann-McLellan, TAC

Discovering The Cure

- Coordinated entry (driven by Housing First)
- By-name list
- Community planning that matches resources to need
- Case conferencing



Introductions

Ashley Mann-McLellan

- Technical Assistance Collaborative (TAC)

Joyce Probst MacAlpine

- Abt Associates

Goals for Today's Webinar

- Background: System Assessment & Improvement Toolkit
- Toolkit Set Up
- How to Use the Toolkit
- Questions

Poll Question #1

Have you ever participated in a system assessment and improvement process? *(Examples may be system mapping, charrettes, community challenges, boot camps)*

- Yes
- No
- Unsure





The Background of the Toolkit

Defining an End to Homelessness

Federal Criteria & Benchmarks

An end to homelessness **does not mean that no one will ever experience a housing crisis again**….

An end to homelessness means that every community will have a **systematic response in place** that ensures homelessness is **prevented whenever possible or is otherwise a rare, brief, and non-recurring** experience.

Essential System Elements
Federal Criteria & Benchmarks

- **Quickly identify** & **engage** people experiencing homelessness
- **Prevent** homelessness and **divert** people from entering system
- Immediate access to **low-barrier shelter** & crisis services
- Quickly connect people to **housing**

Essential Element: Leadership & Goals

System assessment and improvement needs the key ingredients of…

1.) Local Leadership Group

- Drive work to end Veteran homelessness
- Define performance measures
- Evaluate and track progress

2.) Established Community Goals

- Common expectations of what your system is working to achieve

Poll Question #2

Has your community established formal goals to define an end to Veteran homelessness?

1. **Yes-** we are formally pursuing the Fed B/C, Functional Zero or our own locally set measures.
2. **Maybe-** It is unclear: Our goals may need a refresh or more stakeholders to buy in
3. **No-** we have not defined goals, or we do not have a leadership team to drive the work

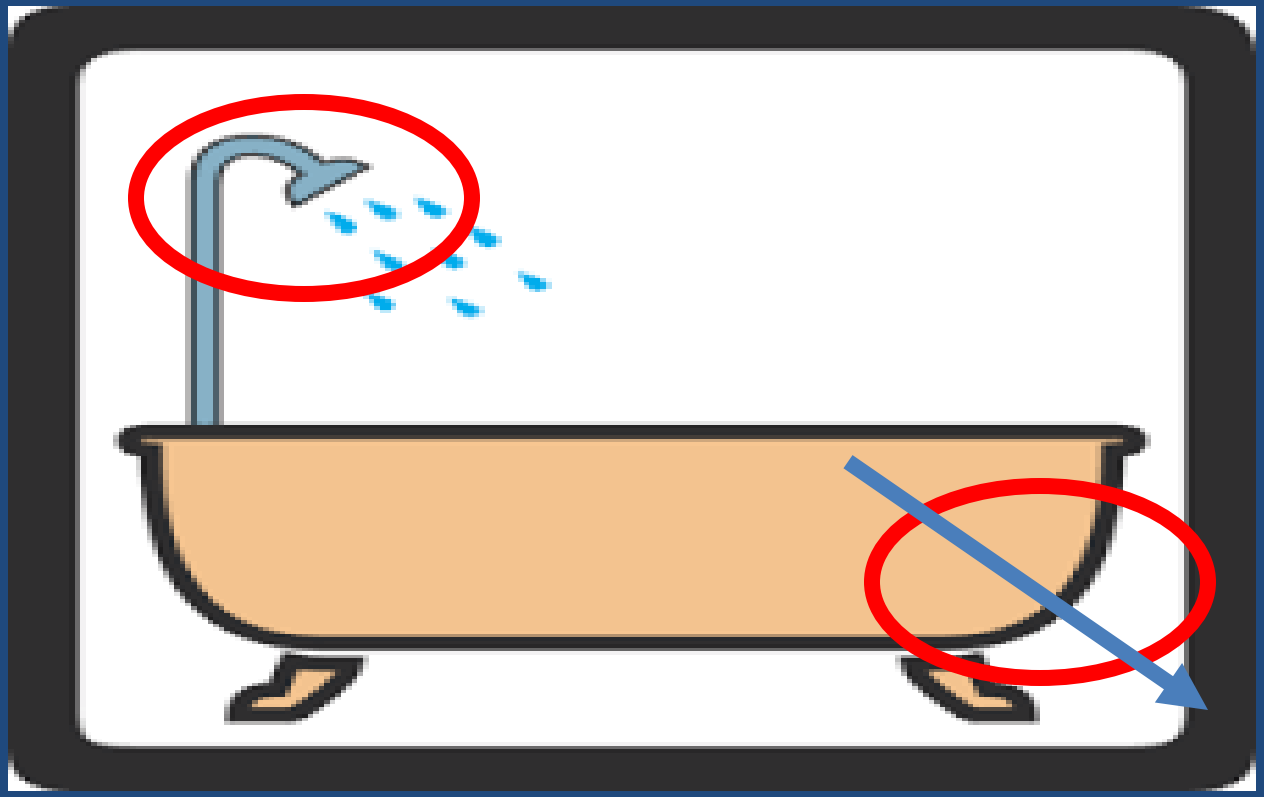
What is System Assessment & Improvement?

Organize homeless assistance and *optimize* system functions & performance

Optimization: an act, process, or methodology of making something (as a design, system, or decision) as fully perfect, functional, or effective as possible.

-Merriam-Webster Dictionary

What is System Assessment & Improvement?



Goals of System Assessment & Improvement

- Make systems perform effectively
- Achieve system, community and federal goals
- Create and implement a shared understanding of how the system should function
- Create sustainability with infrastructure
  - P/P's, MOU's, training, evaluation mechanism

A Focus on System Assessment & Improvement

Common Reasons from Communities

- Processes are missing, ineffective or inconsistently applied
- Veterans who are referred to permanent housing interventions are not connecting to them
- Veterans at different points in the system who should have received similar supports are treated differently

Poll Question #3

What is the most pressing reason for your community to use a system assessment and improvement process?

1. # of homeless Veterans continues to rise
2. We are stuck in meeting the goal of ending homelessness
3. Stakeholders have different views on how Veterans flow through our system
4. We do not have a sustainable system with formal policies or procedures/agreements/evaluation



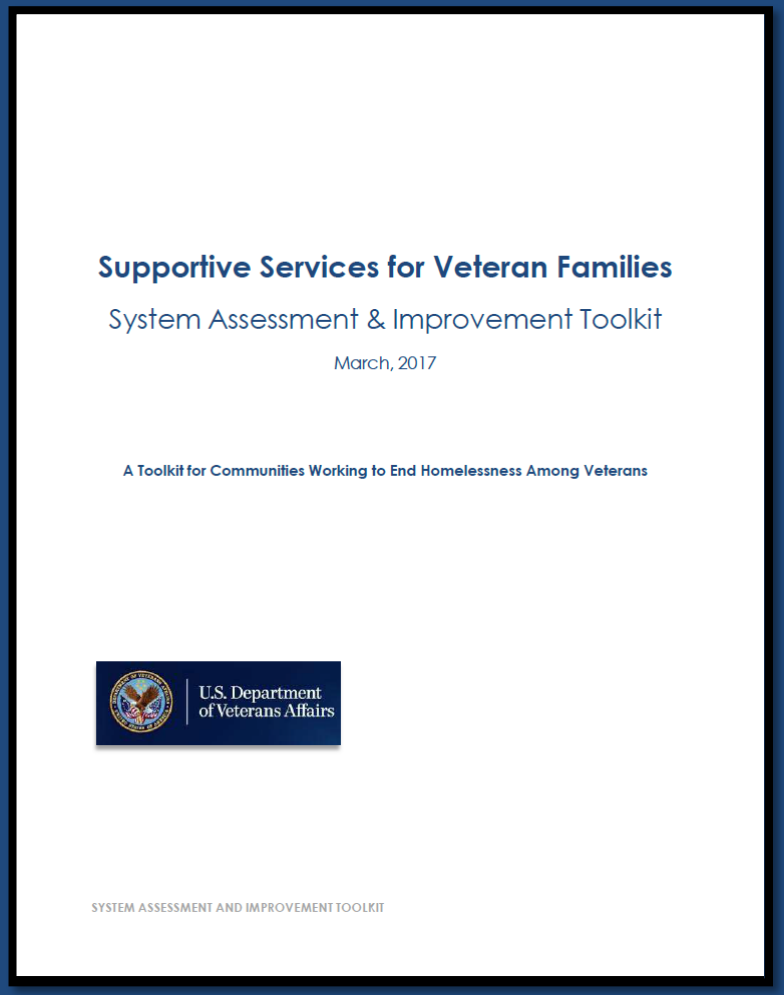


Toolkit Set Up

Toolkit Set Up

- Available on the home page of the SSVF University

- Toolkit includes:
  - –Toolkit guide
  - –Assessment questions
  - –Assessment report templates
  - –Action step tracking tool
  - –System diagram template
  - –Policies & procedures template



Toolkit Set Up

TABLE OF CONTENTS

1.) How to Use This Toolkit – page 4

2.) Identify – pages 5-9

The System Assessment & Improvement Guide: The Guide provides communities with a step by step process of identifying the key stakeholders, components and flow of the current system response. Key questions and considerations are provided to identify the current state of the system, as well as to assess, re-vision, create action, formalize and continuously improve the system response to homelessness.

3.) Assess – pages 10-19

Component Assessment Questions: Homelessness response systems typically have four components that work together to end Veteran homelessness: *1.) Entry points, 2.) Transitional Housing, 3.) Permanent Housing, and 4.) Homelessness Prevention*. The Component Assessment Questions can be used to assess how each of these components currently function in your system by reviewing these questions with the administering providers.

4.) Re-Vision – pages 20-23

Assessment Report and System Diagram Samples: The Assessment Report sample provides communities with a model of how to organize the findings about your system using the Federal Criteria and Benchmarks as a framework. The Assessment Report sample is populated with potential findings a community may encounter during the assessment. A system diagram accompanies the Re-Vision section to provide

- Audience: System leaders such as SSVF
- Table of Contents links to each section
- Color changes with each step
- Word version of customizable templates





How to Use the Toolkit

The Approach: System Assessment & Improvement

1. **IDENTIFY** Create a collective understanding of the system
2. **ASSESS** the current components & participant flow
3. **RE-VISION:** Use findings to envision desired system response
4. **ACTION PLAN** : Set concrete steps to achieve outcomes
5. **FORMALIZE AND CONTINUOUS IMPROVEMENT:** Create infrastructure with policies, procedures, and evaluation mechanisms

Identify: Current System Response

Identify Current System Components, Providers and Client Flow

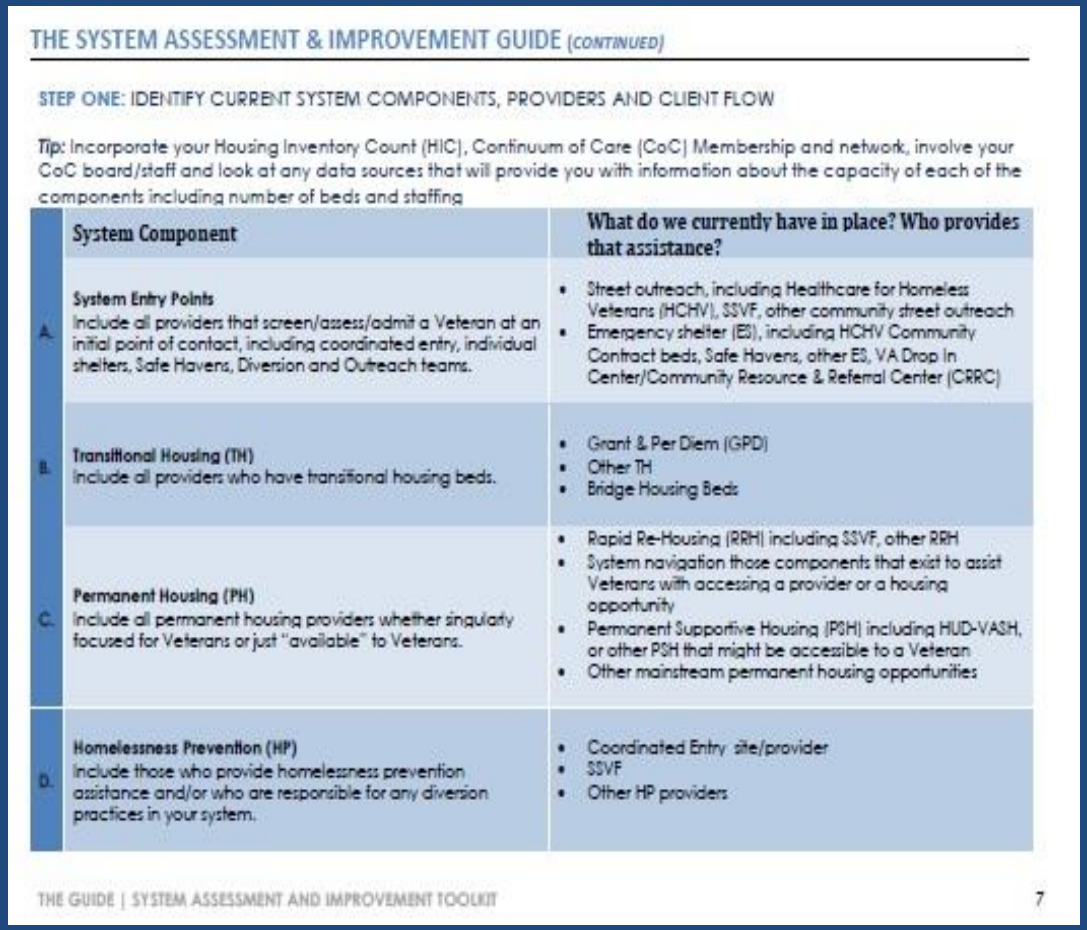
- System components and providers within each component
  1. System entry points (shelter, outreach)
  2. Transitional housing, including GPD
  3. Rapid re-housing (and system navigation)
  4. Permanent supportive housing
  5. Homelessness prevention

TIP:
Use most recent Housing Inventory Count (HIC) from CoC to ID

- General client flow between components

- Data collection processes

Identify: Current System Response



THE SYSTEM ASSESSMENT & IMPROVEMENT GUIDE *(CONTINUED)*

STEP ONE: IDENTIFY CURRENT SYSTEM COMPONENTS, PROVIDERS AND CLIENT FLOW

Tip: Incorporate your Housing Inventory Count (HIC), Continuum of Care (CoC) Membership and network, involve your CoC board/staff and look at any data sources that will provide you with information about the capacity of each of the components including number of beds and staffing

	System Component	What do we currently have in place? Who provides that assistance?
A.	**System Entry Points** Include all providers that screen/assess/admit a Veteran at an initial point of contact, including coordinated entry, individual shelters, Safe Havens, Diversion and Outreach teams.	• Street outreach, including Healthcare for Homeless Veterans (HCHV), SSVF, other community street outreach • Emergency shelter (ES), including HCHV Community Contract beds, Safe Havens, other ES, VA Drop In Center/Community Resource & Referral Center (CRRC)
B.	**Transitional Housing (TH)** Include all providers who have transitional housing beds.	• Grant & Per Diem (GPD) • Other TH • Bridge Housing Beds
C.	**Permanent Housing (PH)** Include all permanent housing providers whether singularly focused for Veterans or just "available" to Veterans.	• Rapid Re-Housing (RRH) including SSVF, other RRH • System navigation those components that exist to assist Veterans with accessing a provider or a housing opportunity • Permanent Supportive Housing (PSH) including HUD-VASH, or other PSH that might be accessible to a Veteran • Other mainstream permanent housing opportunities
D.	**Homelessness Prevention (HP)** Include those who provide homelessness prevention assistance and/or who are responsible for any diversion practices in your system.	• Coordinated Entry site/provider • SSVF • Other HP providers

THE GUIDE | SYSTEM ASSESSMENT AND IMPROVEMENT TOOLKIT 7

- Overview Guide reviews steps of assessment and improvement process
- Includes breakdown of questions to assist your community to create a common vision of the current system set up

Assess: How Each Component Functions

Example Component Assessment Questions *(page 11)*

- Emergency shelter

What is the protocol for immediately connecting potentially eligible Veterans to appropriate PH programs including SSVF, HUD-VASH and other RRH or PSH options?

- Transitional housing, including GPD

Are more intensive GPD/TH services targeted to Veterans who want or need it?

- Rapid re-housing (and system navigation)

Is there a protocol for using SSVF or other RRH or PH assistance as a bridge to quickly house a Veteran when they are awaiting a permanent housing subsidy (e.g., HUD-VASH not immediately available)?

Re-vision Your Desired System

Use Findings from Steps 1 and 2 to:

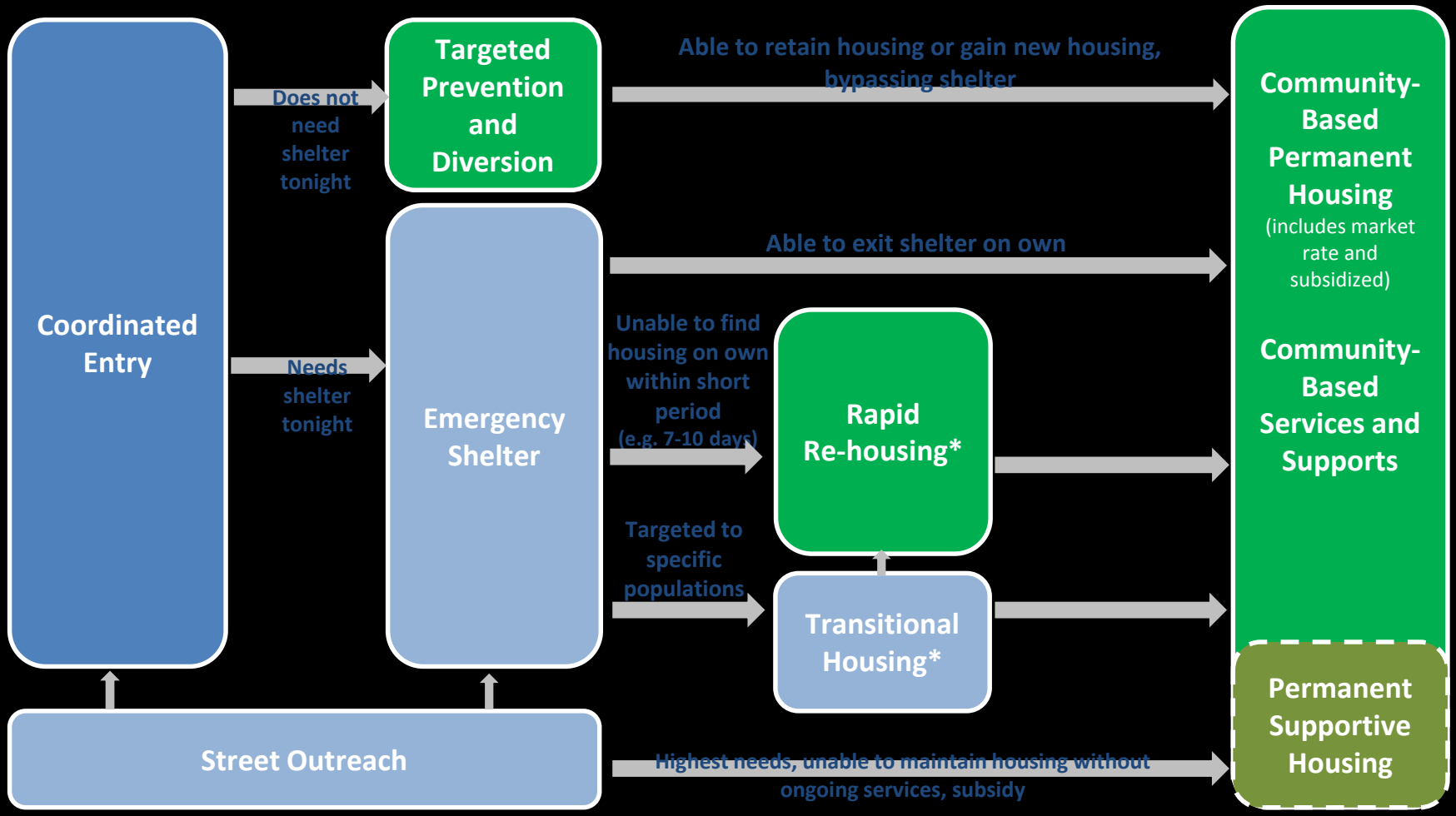
- Design Desired System
- Identify System Gaps and Changes Needed to Achieve Desired System
- Organize findings within larger system goals (i.e. Federal Criteria & Benchmarks)

TIP:
Identify and address system staffing needs

Re-vision Your Desired System

CRITERIA AND BENCHMARKS	ANYTOWN SYSTEM DESCRIBED DURING ASSESSMENT MEETINGS
Criteria 1: Has the community identified all Veterans experiencing homelessness? a) Does the community have a By Name/Master List? b) Is the list updated at least monthly? c) Does the community conduct comprehensive and coordinated outreach? d) Are Veterans in TH (GPD /TH on the list? e) Does the list include chronically homeless, long-term homeless and non-chronically homeless Veterans? f) Does the list include all Veterans who served in the armed forces regardless of how long they served/type of discharge?	A. Veterans are not always assessed when they are identified; Veterans may be referred to assessment provider but not transported. • No standard process to engage Veterans after a night in shelter • Chronic status determination not always correct B. Many outreach teams work to engage with unsheltered and sheltered Veterans, but no coordination across assessment teams to ensure that the whole city is covered. C. Veteran status, including eligibility for Veterans Health Administration (VHA) care, often not determined when Veteran is first identified. Veterans are referred to permanent housing interventions without determination of Veteran status. D. Outreach workers aren't trained in policies and procedures for Veteran system.

HOMELESS CRISIS RESPONSE SYSTEM
General Components & Client Flow



*May serve as "bridge" to PSH, when appropriate/needed

Action Plan

- Develop Action Plan by Component to Address Gaps/Changes
- Frame within larger system goals
- Document Plans and Agreements

Action Plan

ACTION: ACTION STEP TRACKING TOOL

The Action Step Tracking Tool can be used as a framework to define, assign, measure and track discrete tasks that contribute to the re-vision of your system. The tool is formatted to align with the Federal Criteria and Benchmarks to End Veteran Homelessness as a way to assist stakeholders to understand how their roles contribute to the larger goal. Each section is framed by one of the Criteria; within each section are the benchmarks that correspond to the Criteria goals.

For your convenience, we have provided a blank template of the Action Step Tracking Tool as a part of this toolkit.

Goal: Criteria #1 The community has identified all Veterans experiencing homelessness.

This includes the use of outreach, multiple data sources and the use of a By Name/Master List to identify and enumerate all homeless Veterans, including those who are chronic, and all who served in the armed forces, regardless of how long they served or the type of discharge they received.

Action Step	Start Date	End Date	Person(s) Responsible	Measure that Action is Complete	Notes & Status Updates
Street Outreach**[Example]** Develop brief, written street outreach strategy	12/10/16	1/10/17	Jill	Brief written strategy is finalized and adopted by all participating programs; identified key community points of contact (e.g., VAMC staff, law enforcement, library staff, 211, etc.); expected frequency of outreach and basic steps for what assistance (low-barrier shelter, low-barrier permanent housing assistance) should be offered and what data should be collected.	
System Front Door**[Example]** Establish data collection workflow and tools to populate by name list	11/30/16	1/30/17	John	Data collection workflow and tools are finalized and adopted by all participating agencies. Staff responsible for data collection are trained on the tools and workflow.	

Formalize & Continuous Improvement

- Document System Flow, Policies and Procedures
  - *Regularly review and update policies & procedures*
- Train System Providers on New Flow, P&Ps
- Establish Performance Measures and Targets
- Implement the Re-Designed System
- Monitor, Evaluate & Improve Performance

Formalize & Continuous Improvement

SAMPLE POLICIES & PROCEDURES TEMPLATE

ENDING VETERAN HOMELESSNESS IN [COC NAME]:
POLICIES AND PROCEDURES FOR A COMPREHENSIVE SYSTEM RESPONSE

Introduction and Background

In 2010, the U.S. Interagency Council on Homelessness (USICH) introduced the first comprehensive federal strategy to prevent and end homelessness. This plan, called Opening Doors, outlined a number of goals related to ending homelessness in the U.S. – the first of these committed to ending Veteran homelessness by 2016.

In 2015, the USICH, along with the Department of Housing and Urban Development (HUD) and the Department of Veteran Affairs (VA), adopted a vision of what it means to end homelessness and shared specific criteria and benchmarks for ending Veteran homelessness in order to help guide communities as they take action to achieve the goal, with a focus on long-term, lasting solutions.

In line with the federal goals outlined in Opening Doors, the [CoC name] Continuum of Care has committed to a goal of effectively ending Veteran homelessness in the CoC by 2017. To that end, the [CoC name] has focused recent efforts on…[additional local context/priorities]

The [CoC name] has determined that ending Veteran homelessness in our CoC means the following:

[SAMPLE LANGUAGE]

Where Veteran homelessness does occur, it is rare, brief, and non-recurring. More specifically, every identified homeless Veteran who is unsheltered is immediately offered access to low-barrier shelter, and every Veteran who is unsheltered or in emergency shelter, Safe Havens, or Transitional Housing in the [CoC name] is immediately offered access to low-barrier permanent housing placement and stabilization assistance. Veterans who accept assistance will be re-housed within an average of [90 days or other CoC goal]. To achieve this, the [CoC name] is committed to the principles of Housing First, which means our system is primarily focused on quick placement into permanent housing, respecting Veteran choice, and targeting our resources to those with greatest needs.

Questions

Supportive Services for Veteran Families

Thank you

Powerpoint Presentation will be posted on
http://www.va.gov/homeless/ssvfuniversity.asp

Questions?
Go To: http://www.va.gov/homeless/ssvf.asp
Email: SSVF@va.gov