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EVALUATING FEDERAL AND COMMUNITY EFFORTS TO ELIMINATE VETERAN HOMELESSNESS

HEARING

BEFORE THE

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EVALUATING FEDERAL AND COMMUNITY EFFORTS TO ELIMINATE VETERAN HOMELESSNESS

Thursday, December 11, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Denham, Benishek, Coffman, Wenstrup, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, Kuster, O'Rourke, and Walz.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. If I can take chairman's prerogative just a minute. I appreciate the members' indulgence. I have already apologized to the ranking member for not being able to be at the reception that was held in his honor that Ms. Brown hosted for him. I was, unfortunately, attending a funeral in The District.

But, you know, in the nature of this business, we see members come and we see members go. Sometimes some members are a little bit harder to say goodbye to because they have been an integral part of what has been going on in this process. So I would say that those of us who have been lucky enough to have worked with Mike Michaud, the ranking member, inside this committee and outside, will always remember him for his jovial nature and his constant willingness to bring both Democrats and Republicans together. This committee, I think, has been better because of Mike's leadership.

The work that he has done in this very room provides a perfect illustration of Mike's commonsense, bipartisan approach to getting things done. So, in an era that has been plagued by hyperpartisanship, Mike deserves great credit for his work to keep the House Committee on Veterans' Affairs one of the few places that is virtually immune from the way Washington has come to work. Our committee has lead the charge on uncovering the largest scandal in healthcare issues in VA history. During that time, Mike has been relentless in his pursuit of the truth in getting to the bottom of the all of the questions that our committee has answered.

This past summer, when it was time for the Senate and the House conference committee to get together to reach a deal on our

reform bill, Mike played an integral role to bringing both sides together to find common ground and that is why that piece of legislation was able to pass by such a wide margin in both the House and over in the Senate as well.

He is as serious as I was about seeing meaningful reform at the VA. His leadership was critical to helping all of us achieve our goals. I have served on this committee with Mike for over a decade now. I think you could probably count the number of committee hearings he has missed on one hand, and I think that is a testimony to his dedication to those that he serves and the passion that he has. Mike is a passionate, pragmatic member of this committee as anyone who has ever served on it has seen. America's veterans are losing a powerful voice in Washington, and this institution is saying goodbye to one of its finest Members.

So, Mike, thanks for your years of exemplary service to our committee, this Congress, to our Veterans, and to this country. I know I speak for everyone here saying you are going to be sorely missed.

Do have any comments?

Mr. MICHAUD. Thank you very much, Mr. Chairman, for that very kind and very generous remarks. I really appreciate it very much. As you know, this does mark my last hearing as member of this committee and this Congress. Although I am looking forward to the opportunity and the challenges that lie ahead of me, the years ahead, I definitely will miss this committee and the work that this committee has done over a number of years.

And to the incoming ranking member, Ms. Brown, I know you have spent 22 years on the committee. You have been a strong voice for our veterans, you know, here in this committee. I hope that you enjoy the ranking membership position as much as I have over the last, you know, several years.

And to my fellow Democrats, I want to thank you as well. I can't thank you enough for the work that you have done on this committee. You have made my job as a ranking member a very easy job, working together, particularly during these turbulent times over the last couple of years dealing with the VA. And I appreciate the energy and the excitement that you brought on the Democratic side. And I hope you will continue to with your efforts in the next Congress in the years ahead.

And to our Republican colleagues, I want to thank you very much. I have been on several CODELs with a lot of you over the years. I really appreciate the efforts that you have done to make this committee a bipartisan committee, and I cherish the friendship and the camaraderie that we have had over a number of years. And this committee definitely is a special committee. And although there are times that—when we differ on perspectives and how to best serve our veterans, we work together without regard to party. And that is what it is all about.

And I hope that the American people will look at this committee as a model and look at you, Mr. Chairman, as a leader and insist that their representatives do what we have done here over a number of years in this committee working together. And we can't do it alone. I want to thank Nancy and my staff on this side of the aisle for your tireless effort. I want to thank Jon Towers and the Republican majority staff as well. The committee staff has done a

phenomenal job over the last couple of years. And I really appreciate the work that you have done, especially the administrative staff. You keep everything on time and make sure that we have what we have to do, you know, as well. So I want to thank you very much.

And, in closing, Mr. Chairman, I really do appreciate our friendship over the years. And as you mentioned, you know, we meet a lot of individuals here in Congress. A lot we consider friends. There are some we consider friends in a more, you know, special way. And I consider you a very good friend. We have switched roles over the time as Members of Congress; so me being chair, you being ranking member and visa vera. And I really appreciate that, your openness, your willingness to listen to me as a minority member and as a ranking member and move forward in that regard. So I want to thank you very much.

And this time, in closing, I know you have talked on the House floor, you have talked in this committee about coming to the State of Maine, how you want to be able to shoot a moose. Unfortunately, I was not able to win the governorship. But, hopefully, you will not forget that—and I will not forget your efforts to try to shoot a moose in the State of Maine. So I do have something I would like to present to you, Mr. Chairman.

The CHAIRMAN. That is cool.

Mr. MICHAUD. Actually, in Maine, in the woods, moose, they do lose their antlers. And I have a constituent actually that goes through the woods to try to get moose antlers to carve out an eagle head in the moose antler. So this is the half of a moose antler.

Mr. Chairman, I would like to present it to you in your drive to actually get a full moose in the State of Maine. And I would like to present this to you as a parting gift for your friendship, your loyalty, but, more importantly, your work that you have done for veterans over a number of years, putting aside partisan politics to do what is right for our veterans. So here is a freedom antler with an eagle from the State of Maine. So——

The CHAIRMAN. Thank you, Mike, very much. If you ever go to Maine, you have to drink the state drink of Moxie when you come there. So it has been a great, great run. And I thank you.

I also want to say thank you to the departing members of our committee that won't be returning to this committee and we are going on to other assignments. We appreciate your diligence, especially over the last couple of years and understand that your work is just the beginning. We have a long way to go working with the Department, and I had a great conversation with the Secretary a couple of nights ago. We were on the same flight as I was leaving Washington. I do believe he is committed to making some changes, but he has got a lot of work to do. We are going to try to help him in every way we can.

So, with that, the committee will come to order. We are going to have a hearing this morning—it is actually the last hearing of the 113th Congress—evaluating Federal and community efforts to eliminate veteran homelessness. At this time of year, perhaps more than any other, the thought of anyone, particularly anyone who has served our Nation in uniform, without a home or a safe place to sleep is unconscionable and heartbraking. Unfortunately, homeless-

ness or the constant threat of it has become a way of life for far too many of our Nation's veterans.

In 2009, the Department of Veterans Affairs initiated a 5-year plan to eliminate veteran homelessness. As that deadline fast approaches, I am pleased to report that the VA has succeeded in reducing veteran homelessness by approximately 33 percent. Yet, as long as a single veteran struggles with housing instability or homelessness, our work remains.

Troublingly, a VA Inspector General report issued just last week found that VA's national call center for homeless veterans missed well over 40,000 opportunities to link homeless veteran callers to VA medical facilities and to ensure that they received their needed services. Some of these missed opportunities resulted from the unavailability of call center staff during peak business hours when veteran callers were transferred to answering machines, instead of call center employees. I think you will agree this is unacceptable for any government program, but particularly—particularly a population that is as vulnerable as this one is, a population that, for some, the ability to merely make a phone call is a logistical challenge. I look forward to hearing today how VA is correcting the serious deficiencies that the IG found and holding those at fault accountable for their management or mismanagement and oversight failures.

Unfortunately, the call center is just one concern that I have with VA's homeless programs. Based on the information from the VA, the Department has roughly 20 different programs designed to get homeless veterans off the streets and provide them with housing, healthcare, and employment assistance. The Departments of Housing and Urban Developments and Labor also have programs aimed at achieving the same goals. So I am encouraged to see the level of cooperation between these government agencies.

I understand that homeless veterans are a varied and complex group, and one program alone cannot effectively treat the unique needs of all of them. However, the plethora of different programs that are in place today beg the question of whether significant overlaps exist that both waste taxpayer money and limits the effectiveness of any single program's ability to effectively care for a veteran that may be in need.

I also have concerns about the increasingly insular focus the Department is placing on permanent housing. Except for the very few veterans for whom housing instability may be a lifelong concern due to underlying health conditions, the foremost goal of every program serving homeless veterans should be providing a bridge to an independent, a purpose-filled life, not a permanent, government-sponsored home.

Over the last several years, the American taxpayer has devoted record amounts of their tax Dollars to eliminating veteran homelessness, with funding for targeted homelessness programs increasing by almost 300 percent and funding for healthcare for homeless veterans increasing by more than 80 percent since fiscal year 2009. Despite this considerable investment, veteran homelessness will never be completely eliminated so long as veterans struggle with the underlying health conditions and are in an economic crisis.

Quickly and effectively diagnosing and treating those underlying health conditions and providing veterans who are able with job training and placement services is critical to empowering homeless veterans to successfully re-integrate into stable community environments. To truly honor and respect the service of a homeless veteran is to provide him or her with a pathway to a life of dignity and self-sufficiency, not just four walls and a roof.

With that, I now yield to the ranking member, Mr. Michaud, for an opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF RANKING MEMBER MICHAEL MICHAUD

Mr. MICHAUD. Thank you very much, Mr. Chairman.

The VA's goal of ending veterans homelessness by the year 2015 is an ambitious goal. A remarkable progress has been made by the VA to meet this challenge, but there is much more that still has to be done that we have to focus on.

As we all realize, VA cannot meet this goal alone. It will take the concerted effort and actions of the Federal Government and the assistance of organizations and individuals all across the country. And I look forward to the hearing today so that we can evaluate the effectiveness of this effort and applaud the real progress that has been made.

According to reports, homelessness among veterans has declined by 33 percent to roughly 50,000 since 2010. This is an accomplishment we all can be proud of, but we have still a lot of work to do in dealing with our homeless veterans. And it is simply unacceptable that any of our veterans do not have a roof over their head. I am also concerned that we are not taking adequate steps to address special populations, such as homeless woman veterans and those who need serious and sustainable assistance.

Today's hearing provides us with the opportunity to continue this discussion. It provides us the opportunity to discuss how we define the goals of ending veterans homelessness, the resources needed for that, and work that remains to be done in the years ahead.

And, with that, Mr. Chairman, I would ask for my full comments to be included in the record and look forward to hearing the panel's discussion this morning.

[THE PREPARED STATEMENT OF RANKING MEMBER MICHAEL MICHAUD APPEARS IN THE APPENDIX]

The CHAIRMAN. Without objection, your statement will be entered into the record. I would ask the first panel, if you could, come and take your seat. As you are taking your seats, I will introduce everyone.

Joining us on the first panel today is Baylee Crone, the executive director of the National Coalition for Homeless Veterans; Steven Berg, the vice president for programs and policy for the National Alliance to End Homelessness; John Downing, the chief executive officer of Soldier On; Phil Landis, president and chief executive officer of the Veterans Village of San Diego, of which several of us have had a chance to visit; Dr. Casey O'Donnell, the chief operating

officer of Impact Services Corporation; and Dr. Jon Sherin, the executive vice president for military communities and chief medical officer of Volunteers of America.

Thank you all for being here this morning to share your expertise.

Ms. Crone, you are first up. You are recognized with your opening statement.

STATEMENT OF BAYLEE CRONE

Ms. CRONE. Chairman Miller, Ranking Member Michaud, and distinguished members of the House Committee on Veterans Affairs, thank you for the opportunity to appear before this committee today. My name is Baylee Crone, and I am the executive director of the National Coalition for Homeless Veterans. On behalf of the more than 2100 community and faith-based organizations NCHV represents, I would like to thank all of you for your steadfast commitment to serving our Nation's most vulnerable heroes.

This testimony will focus on our understanding of the progress made to end veteran homelessness in this country, including efforts to match services to the needs of homeless and at-risk veterans through permanent housing, transitional housing, employment, and prevention initiatives.

National declines in veteran homelessness since 2009 are without precedent, as we have heard this morning. The successes we have seen to date and our future successes rely on the strength of VA's front lines, the community providers, and VA case managers who fight the daily battle to do more, better, and faster. The momentum is on the side of rapid change, and we are closer than ever to achieving our mission of effectively ending Veteran homelessness. However, any veteran homelessness is not a moment. It is a moving target.

Looking at one measure, the 2014 point-in-time count tells an important part of this story. On a single night in January, 49,933 veterans were homeless. This 33 percent decline since 2009 is more than a statistic. It represents a real measurable downward trend in homelessness among veterans. These significant drops happened as community organizations and VA medical centers have improved outreach and targeted their services to those with the most significant barriers. To make progress toward our mission, we must see drops in the point-in-time count, but that is not the only aspect of change we need to see.

Across the country, community organizations and VA partners are stepping in with the safety net and a hand up to self-sufficiency and independence. We are fostering empowerment. We are halting cycles of abuse. We are educating and protecting. These activities may not show up in any official point-in-time count, but they are and will continue to being the actions protecting against homelessness for many veterans.

The PIT count is a snapshot. Other data build out a more robust scene of the challenges we face in the road ahead. In 2014, 80 percent of unsheltered veterans moved out of unsheltered status in 3 days. In that same period, over 50,000 veterans achieved permanent housing through the supportive services for veteran families program, far outpacing the VA's goal of 40,000. These are some of

the data points that show us that fuller picture. Veterans are engaging when they need help. They are moving rapidly off the streets, and they are successfully moving into permanent housing.

The VA updated its homeless gaps analysis and launched the 25 cities campaign to promote community-based solutions to ending veteran homelessness in high-need areas. The picture gains more clarity. Results are being meticulously and consistently tracked to improve targeting to meet specific local and individual needs. The system has improved, and it is working. At NCHV, we demand that individual needs match specific services. We do not have a homeless veteran population. We have individual veterans who are homeless and have specific and unique needs profiles to be addressed through a coordinated system of care.

Wherever chronic, episodic, or at-risk homelessness exists, the VA and its community partners must be ready and armed. We can end chronic homelessness. We are already doing it through HUD–VASH and Housing First. We can functionally end episodic and recent homelessness. Rapid rehousing infrastructure, transitional housing, and income interventions are joining together to make this happen.

We can get ahead of homelessness through prevention. SSVF serves more veterans and their families more cost-effectively every single year.

The full picture is complicated, but it is lit up with hope. Ending veteran homelessness starts with the veteran, and people are complicated. Some individuals with complex needs profiles will be served by several programs. This does not mean that the services are being duplicated, but rather the organizations and programs are working together to address specific barriers to permanent housing. We believe in and will defend effective deployment of targeted resources to field research-based interventions when and where they are needed. As the number of veterans on the streets and in temporary shelter goes down, we will need to be more, not less, diligent in ensuring that we provide that hand up to those who remain on the streets.

We will end veteran homelessness, but reaching that benchmark happens when the systems in place are ready and able to immediately meet a veteran's needs should he fall into homelessness or be at high risk. As we make progress, resources will need to be redeployed, not withdrawn. We believe a surge is still needed now, not because we set a goal for 2015 and want to check a box, but because we have the momentum now to make it happen for veterans. This requires full funding HVRP, a surge in SSVF resources, and maintenance of current eligibility for veterans served through VHA homeless grant programs.

Thank you for the opportunity to present this testimony today. It is a privilege to work with this committee to ensure that every veteran in crisis has access to the support services they have earned through their service to this country. Thank you.

[THE PREPARED STATEMENT OF MS. BAYLEE CRONE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Crone.

Mr. Berg, thank you for being here. You are recognized for your opening statement.

STATEMENT OF STEVEN R. BERG

Mr. BERG. Thank you for having me. Thank you for all the members of the committee to come here. This is the end of this Congress today, it looks like, and I hope that this hearing will mark the beginning of a final push to achieve something very important in this country that is long overdue.

I have a lot of wonky things I can talk about about homelessness. At the National Alliance, we make a point of being experts on what it takes to end homelessness. But I sort of feel like, for 5 minutes, I really need to make this point: Once in a rare occasion, our country has a chance to do something that is really great, and that happens on the even more rare occasion when people in leadership positions recognize that that is what they are facing, that they are facing that kind of opportunity. And that the appropriate thing to do is to put aside business as usual and instead come together and focus on what we can be doing to make this result more likely to happen.

And if nothing else happens in this hearing, if no other message gets across, I hope people will leave with an understand that, when we are dealing with veterans homelessness, that is the situation we are facing. For way too long, veterans have been overrepresented among the homeless population. When modern homelessness first emerged in the economic crisis of the early 1980s, people would come back from Vietnam. A certain number of them were having a very hard time, and they became homeless in droves, and we let it happen. We didn't really understand what homelessness was all about then. We didn't know what the—what the right interventions were, but we didn't do anything to stop it. And since that time, veterans homelessness has been a bigger part of the problem than it should be. It shouldn't be any part of the problem.

So, right now, we have, I think, what we have seen going beyond the numbers, just—a 33 percent reduction is an important thing. But that didn't—it is important to understand that didn't happen by coincidence, it didn't happen by luck. It happened because a lot of people have been doing the right thing, including people in this committee, have been doing the right thing to make it happen. So I want to spend a couple of minutes talking about why this is working and a couple—and then a quick rundown of what we need to do next.

It is working for a couple of reasons. One, I think there has been leadership at the Federal level. I think the VA, after sort of skirting around the issue for a number of years, has embraced the idea that they are going to have to be the leaders on this. They can't look to anybody else. VA is going to have to be the leaders on this from the Federal Government's point of view.

They have understood, also, however, that they need to work with many others within the Federal Government, with HUD, with the Department of Labor, with other departments, with nonprofit communities all over the country to make these things happen.

The VA set up the National Center on Homelessness Among Veterans. This has been very important. A joint project with the University of Pennsylvania where there is some—at the University of Pennsylvania happens to be where some of the real experts on homelessness around the country teach there. Dr. Dennis Culhane,

if any of you have never met him, if you can sit and talk with him about homelessness for a little while, you will feel like you are a smarter person than before you started talking to him. I guarantee it.

The VA has put the right kind of program models in place with the help of Congress. Congress has authorized new programs, both more intensive programs that are more about long-term housing and supports like the HUD–VASH program. But then, as Mr. Miller started by saying, most homeless veterans don't need long-term intensive help. They need short-term help to deal with a short-term crisis, and that is what this rapid rehousing model and the SSVF program are all about. Tremendously effective.

And, finally, communities are seizing control of this issue and taking it upon themselves, through the leadership of mayors, through the leadership of veterans healthcare directors, to use the tools that Congress and the VA have made available and really put them to work and try to get results. VA is helping with that with various technical assistance initiatives. Other people need help as well. We are trying to do our part at the National Alliance to End Homelessness to spread that information.

There is some work that Congress needs to do. I have outlined that in my written testimony. There are some short-term fixes to a couple of the programs that would be very important. We are going to have a longer-term need, as veterans homelessness gets down close to zero, to redesign the homeless programs to be about preventing homelessness. That shift from intervention to prevention will be a very important work for this committee in the next Congress. And we are looking forward to working with you all at that time. Thank you very much.

[THE PREPARED STATEMENT OF MR. STEVEN BERG APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Berg.

Mr. Downing, it is good to see you and you are recognized.

STATEMENT OF JOHN F. DOWNING

Mr. DOWNING. Good morning, Mr. Miller. It is a privilege to be here with your committee.

Congressman Michaud, it is great to be with you, a fellow New Englander, and the fellow that really, if you lived in New England, has really revived the Togus Medical Center and made it a facility that is really much more interactive with all the other facilities in the area.

I am honored to be here today on behalf of Soldier On and the 3,800 veterans we have served last year. We have become the largest provider of supportive service grants of veterans of the United States of America. Soldier On operates eight SSVF grants throughout five Eastern States. This was accomplished with the assistance of Congressman Richie Neal and James McGovern from Massachusetts; Congressman Chris Smith from New Jersey; Congressman Chris Gibson from New York.

In addition to that, we serve 76 counties in Mississippi; 23 counties in Pennsylvania; and we now do the 4 western counties in Massachusetts. Next year, we are slated to increase the breadth and depth of our services and assist more than 5,300 veterans and

family members with special focus on the chronically homeless veterans whose lives are reduced by an average of 20 years when compared to their stably housed brothers and sisters.

The Department of Veterans Affairs' goal to end veteran homelessness by 2015 was not a goal that could take place without examining and combatting the underlying effects that cause poverty and which really is the cause of homelessness. The lack of safe affordable housing, with services on site, has allowed veterans in poverty and those suffering from untreated and undertreated mental health and addiction disorders to be left forgotten and alone in their prolonged states of homelessness.

Eliminating homelessness requires a society to look at these causes of poverty, which in a capitalistic society are rooted in income and cultural enrichment that we translate to mean education. As a result of that, the lack of those opportunities, the reality is that our goal has been to bring each homeless veteran back to the center of their life.

With great help from the national director of homelessness, Lisa Pape, Soldier On became a leading grant per diem shelter bed provided for the VA. And we house every night 265 men and women in western Massachusetts homeless veterans, every night; 13 of them are women. And for 13 years, the 13 women—every woman that has ever come into our care—and we need to hear this—70 percent of the homeless women that come into our care experienced sexual trauma before they enlisted in the military; 100 percent of the women in my care have suffered military sexual trauma. It is a dynamic that we can't deny, and it is one that we must face more effectively in the Department of Defense on how we treat this issue. And we must begin to put women in charge of this issue and allow them to review and establish the standards by which we are going to be held accountable. And until we do that, we will continue this tragedy.

I also want to make sure that we understand that safe, sustainable affordable housing is one of the keys to ending homelessness. But housing itself doesn't do it. We need to deliver services to the housing. How can we continue to expect men and women who are chronically mentally ill, addicted, don't have transportation, are underemployed, to keep three or four or five appointments a week? How can we expect them to find medical centers 30, 40, 50 miles from where they live? We must find them. We must go out and seek them.

And we have been motivated by the SSVF work we do and by, really, the push from Vince Kane, when he was the director at the Center for Excellence, to get out there and do it. Not to have excuses. And so we have really worked hard at SSVF, and we are looking to continue to develop beautiful, affordable housing that veterans own and live in and deliver services to them.

So, with the VAi2, we were awarded $6 million. And at the North Hampton VA in Massachusetts, we are now building 44 units of limited equity co-op for homeless veterans to own, live in, and have the services delivered to them there, and 16 units for women and children. And women and children, when we talk to them about moving to the community or moving to staying on the hospital

grounds, they chose to stay on the hospital grounds because they felt safe and secure there.

So we need to understand that this—that the Housing First model really works, but it only works when we deliver services where people live and we must be mobile. The VA has got to get mobile, and we have got to stop funding this incompetent—skilled incompetent bureaucracy and begin to make it accountable by going out and identifying the veterans delivering the services where they live. Thank you.

[THE PREPARED STATEMENT OF MR. JOHN DOWNING APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Downing.

Mr. Landis, thank you for being with us today. You are recognized.

STATEMENT OF PHIL LANDIS

Mr. LANDIS. Thank you, Mr. Chairman, members of the committee. My name is Phil Landis. So I am a president and a chief executive officers of Veterans Village of San Diego. And, sir, thank you for visiting us last year.

As a matter of disclosure, you should be aware that I am a member of the VA Advisory Committee on Homeless Veterans and I am neither speaking for the VA, nor for the advisory committee today.

Veterans Village of San Diego is a nationally recognized nonprofit that has served veterans since 1981. Using six pillars of prevention, intervention, treatment, aftercare, employment services, and housing, VVSD assists veterans who have substance abuse and mental health issues, including men and women recently returned from Iraq and Afghanistan.

Working with addiction case managers and mental health professionals, residents have an opportunity to rebuild lives, repair relationships, and return to society as productive citizens. Housing First is an admirable and reasonable idea for many homeless veterans. In fact, since October of 2013, we have placed over 550 Veterans into permanent housing. However, for veterans with co-occurring disorders, housing without treatment is a major risk factor and, if left untreated or unmanaged, becomes progressive and life threatening.

VA is putting a preponderance of their homeless Dollars into repaid rehousing and VASH. They have eliminated new funding for grant and per diem. Grant and per diem funding focuses on treatment and employment for transitional housing. And there is a need for both. To substantially reduce or eliminate grant and per diem beds would be short-sighted and, quite frankly, disastrous.

Since the inception of our Supportive Services for Veteran Families, SSVF, program in 2013, we have assisted 263 veteran households who are homeless or at risk of becoming homeless into stable housing. This program is a great tool in fighting homelessness amongst the veteran population. The program prevents homelessness amongst veteran families and works with those who are homeless to rapidly enter permanent housing and utilizing the Housing First model.

This model works very well for many of the post 9/11 generation who only need a hand up. One of the benefits of the Housing First

model is the singular focus on addressing the participants' housing crisis. However, we have seen that the SSVF participants and others who are not ready to address their primary cause of homelessness, whether it is substance abuse or mental health issues, are not ready to maintain long-term housing stability. Therefore, having the option to be in a formal treatment setting or transitional housing program benefits them in the long run and gives them the opportunity to work on their barriers prior to obtaining permanent housing.

Our experience indicates that when a homeless veteran is denied the opportunity for a rehabilitation program or prematurely departs from a rehabilitation program in the VASH housing, unless intensive services continue, the risk of relapse, ending up in prison, or death occurs far too often. And here are just a few recent examples from our program: A veteran is placed into VASH housing that experienced severe, unintended consequences. Danielle, age 30, combat vet, within 2 weeks in VASH apartment, relapsed on heroin. She is now in jail. Michael, age 57, relapsed a short time after moving into VASH housing, lost his home and is now in prison. Thomas, age 41, was very active in a recovery program and community. Transitioned into VASH housing. Relapsed on methamphetamine within 3 months. Vernon, age 63, transitioned into VASH housing, relapsed on drug, now in prison. Phillip, age 33, combat vet going to school on the GI bill, school funding fell through due to low grades, relapsed on alcohol. He is currently awaiting transfer to a State prison. Walter, age 51, worked in active recovery program, found dead in VASH apartment in August of 2014. The medical examiner reported cause of death was alcohol related. Scott relapsed and lost apartment within 2 months. James, age 56, relapsed 1 month later, now in jail.

You kind of get the idea.

Now, here is one that we really need to pay attention to because it seems to be under the radar: Joe Vaughn, age 27, combat vet, was in a long-term residential treatment program. Doing extremely well. When he received his VA 100 percent disability rating, the HUD income cap rule forced us to exit him from the program. We are seeing more and more of that. It might be something you would like to focus on.

Homeless veterans who have lost their way due to substance use and/or mental health issues have also lost their job. And they have lost their community, their identity, their support system, their sense of camaraderie, their mission in life, and their financial stability. Programs that would provide housing but fail to address these underlying unmet needs will set veterans up for failure.

For those who are situationally homeless due to a recent family crisis, job loss, or medical condition, the Housing First model is truly ideal.

For those who are chronically homeless due to mental health issues, substance use, long-term medical conditions and/or criminal justice involvement, it is imperative to implement an assessment protocol that could triage the neediest, most vulnerable, high-risk, and disenfranchised veterans for whom residential treatment is essential.

Our goals at VVSD is to break the cycle of homelessness among veterans and their families. In order for us to succeed in our efforts, we think it is crucial that we address the various reasons veterans become homeless in the first place. Not all veterans are ready to sustain themselves in housing. Not every veteran will have substance abuse or mental health challenges.

But having both an SSVF and a veteran treatment center in the same agency allows us to make a substantial difference in the veteran community. One size does not fit all. And Housing First, at the exclusion of everything else, is just plain nonsense.

In conclusion, at Veterans Village of San Diego, we believe intensive services leads to self-sustaining independence and a maximizing of human potential and a meaningful, fulfilling life. Our veterans are worthy of nothing less. Thank you, sir.

[THE PREPARED STATEMENT OF MR. PHIL LANDIS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Landis.

Dr. O'Donnell, you are recognized.

STATEMENT OF CASEY O'DONNELL, PSY.D.

Dr. O'DONNELL. Good morning, Chairman Miller, Ranking Member Michaud, and esteemed committee members. Thank you for the opportunity to offer this testimony.

My name is Casey O'Donnell. I am currently the chief operating officer of Impact Services Corporation in Philadelphia. For the last 20 years, Impact has been providing both housing and employment-focused programs to homeless veterans who suffer from both mental illness and substance abuse.

Impact's current continuum of housing includes 150 beds of both transitional and permanent housing. Impact's program was one of the first and was one of the few programs in the Nation exclusively serving dually diagnosed formerly homeless veterans.

Since 1994, Impact has also been providing employment services through the Department of Labor's Homeless Veteran Reintegration Program. In addition to these programs, Impact has recently received surge priority one funding.

Finally, Impact will break ground on 26 units of affordable permanent housing for low-income veterans and their families, focusing on females, on Monday, December 15th. You are all welcome to join us for the groundbreaking.

We are working in close collaboration with the VA National Center on Homelessness Among Veterans to provide all of these services from a trauma-informed care model. I was invited to participate in the National Center's work group to implement trauma-informed care across the nation, both within the VA and among community-based providers.

The national center has been an invaluable collaborative partner in the provision of care to homeless veterans, and the center's work related to training and implementation will be critical to success. Men and women who have proudly served our country through military service should not be allowed to suffer in addiction and mental illness on the streets of any city for one night longer. It is all of our jobs to find veterans safe places to live, recover from trauma and substance abuse, and improve the quality of their lives.

In fact, it is believed by those of who us who are providers that trauma informed care is necessary to eradicate homelessness among veterans.

Setting the deadline of December 31, 2015, to end homelessness among veterans has become a critically important milestone for our country. Impact has been extremely active in the 25 Cities Initiative to end veteran homelessness in Philadelphia. The deadline is producing hard work, determination, and teamwork.

Over the last 11 months, with our many collaborative partners, we have placed 556 homeless veterans in permanent housing in Philadelphia. We have approximately 540 veterans left to house before the deadline of December 31st, 2015. The goal of ending veteran homelessness in Philadelphia is within our sights. We are ending veteran homelessness in Philadelphia by developing a safety net system that catches veterans before they become homeless, provides intervention, when necessary, to keep them housed, and gets them housed again if they have slipped back into homelessness. This safety net is important as we look at veterans who served in Iraq and Afghanistan who are potentially vulnerable and may be headed toward homelessness.

Research provided by the National Center on Homelessness Among Veterans suggests that this rapid safety net approach is allowing approximately 80 percent of veterans to stay housed after 90 days of case management and temporary financial assistance through SSVF. Recent data provided by the City of Philadelphia's Office of Supportive Housing also shows that the number of actual homeless veterans on the streets and in many programs in Philadelphia have decreased by 15 percent in the last year. We expect that percentage to dramatically decrease in 2015 and come to functional zero by January of 2016.

The safety net system has only been possible within the context of real partnerships that are being forged between the community and the VA as part of the 25 Cities Initiative in response to the deadline. These partnerships have brought HUD, the VA, local municipalities, housing authorities, and community organizations like Impact to a common table where systems have been changed by bringing two continuums, the city and the VA, into alignment on outreach and assessment and eventually on placement and retention to ensure that veterans are being moved into housing.

Further, I would like to say that housing without jobs or increased benefits is only a short-term strategy. Supportive housing, integrated with programs to get vets into jobs and/or access to benefits or increased benefits, provides a long-term recipe for self-sufficiency. We would like to see the VA and the Department of Labor work closely to integrate community-based job training and job development into current housing activities funded for veterans. A good place to start would be a pilot with community-based veteran organizations like Impact to better integrate SSFV, grant and per diem, HUD–VASH, and housing with HVRP programs.

Finally, Impact currently operates four grant per diem programs that move homeless veterans through various stages of recovery to self-sufficiency according to their needs. Our program is currently full. It is full because there remains a critical need for grant and per diem to provide stable housing and services for veterans. Im-

pact is extremely interested in working with Congress and the VA to test out several additional models of housing, utilizing the VA's grant and per diem program as the foundation of funding. Specifically, we would like to see a percentage of grant and per diem vets converted to provide supportive services and permanent housing, as opposed to only transitional housing, for formerly homeless veterans with mental health and substance abuse issues that require a higher degree of support than independent living can provide.

In conclusion, on behalf of my colleagues at Impact, myself, and the veterans that we serve, I would like to thank the members of the committee for this opportunity to testify. Thank you for listening.

[THE PREPARED STATEMENT OF MR. CASEY O'DONNELL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Dr. Sherin, you are recognized.

STATEMENT OF JON SHERIN, M.D., PH.D.

Dr. SHERIN. Thank you, Chairman Miller, Ranking Member Michaud, and the committee for convening today's hearing. My name is Jon Sherin. I am a psychiatrist and neurobiologist by trade. Though not a veteran myself, I have spent my entire professional life serving veterans of the United States military.

It was just 5 months ago that I testified in this same forum on the issue of suicide in the veteran community, and it honors me deeply to be here again testifying on homelessness, another true emergency confronting too many former servicemembers.

As a reminder, I worked for over a decade in VA, last as chief of mental health at the Miami VA. Three years ago, I left that post to join Volunteers of America, a large nonprofit whose legacy in this arena dates back to serving Civil War veterans. Today, providing for veterans is Volunteers of America's top priority. Alongside VA, this past year alone, we housed and supported roughly 20,000 homeless veterans in communities across the Nation.

Let me begin my testimony by making clear that ending veteran homelessness will require more than finding shelter for all homeless veterans. It will also require making sure that they have timely access to both a full range of services, including family support, mental healthcare, addiction treatment, legal aid, benefits assistance, and financial coaching, as well as a full range of opportunities, including education, training, and meaningful jobs.

At present, there are a number of Federal programs that have been very effective at bringing homeless veteran numbers down, due in large part to congressional support. Further success will rely upon Congress continuing to provide unprecedented resource and oversight to these efforts within Federal agencies—within Federal agencies but also in relation to multisector partnerships. To this end, I applaud the committee for inviting input from the partners on this panel. In the remainder of my testimony, I will summarize recommendations for select Federal programs and suggest adding a peer-to-peer strategy that could bolster our efforts.

Regarding select Federal programs, the following recommendations are made based on my own personal experience and input from numerous colleagues in both the VA and in the community.

They are meant as guidelines to more effectively help homeless veterans. In markets where VA's grant and per diem transitional housing inventory is not fully utilized, it should be repurposed to better match local supply with local demand and funded accordingly. No inventory should be dismantled, shelved, or otherwise deactivated until we end veteran homelessness. The VA's safe haven transitional program is highly effective for chronic, recidivistic homeless veterans and has changed the life trajectory of many veterans for whom all other interventions have failed, some over the course of decades. These programs tend to be full and, as such, more safe haven inventory needs to be developed.

HUD and VA's HUD–VASH permanent housing program is highly effective but only when adequately enriched by services alongside housing, in accordance with the Housing First model. In markets where VA is not equipped to provide adequate services, it is recommended that community partners be leveraged to do so.

The Support Services for Veteran Families program, SSVF, created and administered by VA's National Center for Homelessness Amongst Veterans in Philadelphia, is a game changer that has successfully served a massive number of veterans in a short period of time through a streamlined partnership process. It makes sense to expand the scope and the reach of this program by including mental health as well as employment offerings and by loosening eligibility requirements.

In terms of a peer-to-peer strategy, it would make sense to activate a robust, community-based workforce of trained and certified peers who can drive outreach resource navigation and advocacy for homeless veterans. Peers could be deployed to suitable VA campuses, housing facilities, and service centers and charged to connect homeless veterans to both VA and community resources. They could also be leveraged for the same purpose through the homeless crisis line, 211 exchanges, and Web-based portals such POS REP. Resource to fuel this workforce could be generated by approving veteran and peer-support training for VA work study and/or by enrichment of the support services grant.

In conclusion, we must actively embrace a philosophy, create a culture and insist on policies that hold us accountable for addressing the vast array of challenges known to emerge for some veterans in the context of civilian life because it is these challenges that predictably precede the loss of a place to call home, something all of us need for life, liberty, and the pursuit of happiness. It is through your informed legislative stewardship that our country can promote conditions in which all sectors come together to form cohesive American communities that welcome veterans home, ensure they receive the services they need, and provide them ample opportunities to thrive. Thank you very much for hearing my testimony.

[THE PREPARED STATEMENT OF DR. JON SHERIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you all for your testimony today. We appreciate it, and any parts of your statement that were not read will be entered into the record as well.

I think we all believe that ending veteran homelessness is an important goal. It is a laudable goal, but getting to zero is very dif-

ficult. I think, Dr. O'Donnell, you had remarked about functional zero. Can you tell me what "functional zero" really means?

Mr. O'DONNELL. So there is actually an equation. I am sure someone in our audience can identify what that equation is. It is based on an average number of veterans housed for 3 months as compared to the number that are left. That is not the—the whole equation.

For us, it is ensuring—it is a more functional definition to ensure that there are enough slots of the appropriate kind of housing available for those that are left. Right. So as we decrease that number—so for Philadelphia, I believe it is 540 veterans, ensuring that each of those folks have the appropriate space to come to. So I personally don't ever believe that we will be at zero. Right. It is about the safety net. But functional zero is ensuring that each person has the appropriate level of care, hopefully, that that would indicate that they would stay there for longer with the appropriate level of services.

The CHAIRMAN. Those of you that provide group housing or housing in large numbers, how many or what percentage of your residents will never be able to get over that final hump, and will always be with us, with you?

Mr. Landis, then Mr. Downing, both.

Mr. DOWNING. Thank you. Go ahead.

Mr. LANDIS. Our population may be a subset of those that we treat at our rehabilitation center. Two-thirds of our residents have diagnosable chronic mental illness by the time they find us; 70 percent of the population have already been incarcerated; of the younger generation, the post-9/11 men and women, the statistic for incarceration is about 85 percent. We know that, for the vast majority of these men and women, many will be able to deal with their demons. They will be able to move forward, but they are not going to do it in isolation. It is only going to happen after intensive long-term residential treatment. It is not going to happen if that does not occur simultaneously, either with housing or with some form of a long-term treatment center. There is a subset of this population that will require our assistance for the rest of their lives, perhaps 25 percent.

But the rest, you know, if we do it right, what they should look forward to is a life that is balanced and a life where they have employment, because employment is a key factor in, I believe, happiness. They should be able to be self-sustaining. And they should be able to get on with the world as the way that we do in our own normal lives. But I would say, to answer your question, sir, a good 25 percent of this population is going to require our care for the rest of their lives.

The CHAIRMAN. Mr. Downing.

Mr. DOWNING. We look to shut down approximately 80 percent of our per diem beds over the next 5 years. We think about 80 percent of the men and women we serve can really function and grow living in their own dwelling with services delivered to them. And there are various levels of services people need.

On the average, in the community where we are working, what we are finding is veterans, essentially 50 and over, who have been homeless and chronically mentally ill for extended periods, can

work about 15 or 20 hours a week when they are really back to the center of their life. So if you look at those type of entry-level, limited-income jobs, with some supportive services and some small benefits, either from Social Security or the VA, somebody can have a comfortable life in supported housing with services delivered. So we think that that is a reasonable number.

We also believe that trauma-informed care, which has been mentioned here this morning, is an extremely important training that we all need to be continuously growing in because everyone that is in our care benefits from that. And what we have found, as we—we did some training with the National Alliance on Homelessness on trauma-informed care for the past year in our facilities—and all our staff has gone through it—and what we are finding is that where much people are much—feeling much safer discussing things that previously were kind of glossed over, pushed to the side. And I think that that is the type of thing that we need to get better at.

So, to me, I don't think we are ever going to end homelessness. I think about 20 percent of the people are either in the category of we don't have the skill or ability to figure out how to manage their needs better or we have some folks who somehow seem comfortable in that lifestyle. So, you know, we accept that. We would like to change that, but I don't think we can.

I don't know how you feel there, big guy.

The CHAIRMAN. I apologize. I need to move to Mr. Michaud.

Mr. LANDIS. I am sorry.

The CHAIRMAN [continuing]. We have other questions, but thank you.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

This is for each of the panelist. Do you see any overlap between the three major programs funded by the VA, VASH, GPD, SSVF? And we will start with Ms. Crone.

Ms. CRONE. Mr. Berg here will probably laugh at me because I always say that there are four critical programs when we are talking about programs essential for ending veteran homelessness, and I would include HVRP in that mix. I know it is funded through Department of Labor.

Like I mentioned in my statement, we don't look at the programs that exist and the people we are going to push into those programs. We look at each individual veteran and what their specific needs are. If you have—if you have a veteran who comes into a program and is in need of intensive services, multiple co-occurring disabilities, that person might be in transitional housing for a short period of time and move into HUD–VASH housing, using a HUD–VASH voucher. In that case, they are using both of those resources, but there are stepping stones to get that person into permanent housing.

On the other side, you may have someone who comes in who needs a short-term intervention and assistance with employment and services because they are unemployed, but they want to go back to work. They may be enrolled in SSVF to help them pay for their security deposit, and they may get employment services through HVRP. In that case, they are using two programs, but they

are using the best practices of what those programs are meant to provide in order to get themselves——

Mr. BERG. Yes. Thank you.

I would say one of the real advances that people who work on the issue of homelessness all over the country have made is understanding this idea that different homeless people need different levels of care and to set up a system with an array of interventions that are designed for that. And I think the three programs you mentioned, not to leave out HVRP, but those are the three big housing programs, and there are aligning themselves in many cities with that in mind. And SSFV deals with people for whom a short-term intervention is most appropriate. HUD–VASH is for the people with long-term permanent disabilities. GPD works well for people in sort of a middle group, really concentrating on recovery housing. There is always some overlap. You are never sure because people, once they get in a program like this, a lot of times, they improve tremendously. But I think that array of programs is the right one, and it is working well.

Mr. DOWNING. I would agree with that, Mr. Michaud. Also, just from my viewpoint, I think the HUD–VASH case manager should all be outsourced to community-based groups. I think they are much more geared to housing search. They are much better at working at it. There are professional agencies in the community that they should partner with to do that. I think trying to train people and bring them up to speed on that is just kind of insanity when there are so many groups—especially if you look at what has happened with CAP agencies in the Community Action Programs, have really done housing search extremely well in our communities. And we should be funding them with the VASH money to do it for our veterans, I believe.

The GPD program, I believe, has done a great job. And I think downsizing everybody can see coming. For SSVF, I really think this is what we have to get in our head: SSVF leverages tremendous amounts of community assets to work along with the VA Dollars. So what we have discovered is the average veteran who we serve in SSVF, we are spending somewhere between $2,400 to $4,400. Somebody in GPD for a year costs us $42,000. But when we do the 24 to 42 in the community, we are also bringing in community-based addiction services, we are bringing in finance management agencies, we are bringing in mental health agencies to work to help us stabilize, all at a different cost center and all available to other citizens. So that leveraging has really made, I think, that program much more effective. And I think it is why we are seeing the tremendous results with it.

Mr. LANDIS. If you develop a continuum of care within an agency, each one of these three programs complement the other and seem to work very well together.

Dr. SHERIN. There is definitely an overlap, but not redundancy, and I think that is the key element here.

Mr. O'DONNELL. I think that these are distinct programs. I would beg to differ with the concept of deactivating any grant per diem inventory, as I said in my testimony. I believe that that is critical inventory around the Nation that can be used to do things in addition to grant per diem housing, including bridge housing, rescue

housing. In addition, it could be used for permanent housing or permanent supportive housing. It could even be used for assisted living down the road, depending on the needs of the local community. I would also reiterate one of my co-panelists comments about HUD–VASH case management. Communities are very well-equipped to do this actually in a more efficient and cheaper, less expensive rather, manner.

The CHAIRMAN. Mr. Bilirakis, you are recognized for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. I want to thank Ranking Member Michaud for his advocacy on behalf of our veterans and being a great friend to our true American heroes over the year. It is been an honor to serve with you, sir.

The first question is for the entire panel. Last week, the Virginia Inspector General issued a report that found serious problems with VA's national call center for homeless veterans. The report found that the VA missed 40,500 opportunities to engage homeless veteran callers with needed services due to lapses in management and oversight, and I know the chairman mentioned this in his opening statement.

Furthermore, the IG's audit found that the majority of messages were left between 11 a.m. and 3 p.m. during the day. The report also stated that counselors spent significant amounts of time unavailable to answer calls during peak calls. This is during peak time periods. This is unacceptable. For the panel, were you surprised by the IG's findings regarding the call center? What are your personal experiences? I would like to hear from you. How would you suggest VA improve the call center's performance, and who do you think should be responsible for operating and overseeing the call center, and I guess we will start with Ms. Crone.

Ms. CRONE. NCHV has said publicly when this came out that we take this report very seriously, and it is completely unacceptable that any veteran in crisis, any veteran in need reaching out to something that should be operating 24/7 should go to voice mail. We are going to be following the progress on addressing these steps very closely because it is meaningful to us on a national level and to our members. We believe that the steps that are laid out to address the various issues with the call centers seem reasonable. We are going to be watching those very closely to make sure that they happen and that the timelines are stuck to. But what is important to remember with the call center is that it is a small piece, or it is a piece of the overall outreach effort that we have to homeless veterans within communities. The providers on this panel and the organizations that we work with, those are the people who are going out on the streets, that are under bridges, that are in shelters, that are looking for veterans in need of services.

So it is important to keep this in that bigger context, that these veterans are likely receiving services, and it is thanks to the community providers that are doing that through funding resources like SSVF. But, again, we will be watching it really closely.

Mr. BERG. I think the steps the VA appears to be taking to address the findings in here seem like the right thing to do. I think the IG is doing the IG's job, which is good. That is why they are there. We need to have things like this work. We need to also not get distracted from the major goal of what is going on. When some-

thing like this comes up, this is important, get it fixed; or if it is just not going to work, then get rid of it, and keep moving forward with stuff that works. That is our view.

Mr. Bilirakis. Mr. Downing.

Mr. DOWNING. Well, this was run by VHA, and it kind of boggles your mind that we have the 800 number for homeless and people in need going to VHA and not running it through the homeless program that has a lot of community partners and is used to contracting with community partners to provide service. Because I would suggest to you, again, that agencies like myself and others that operate 800 numbers are very good at responding to people 24 hours a day, are very good at getting the information to where it has to go so people get the critical intervention that we need to prevent a tragedy.

So I think that what we really have to do is challenge the VA again to look within itself and look at where is the competency in this group, and let that group of competent individuals operate it. And I think it is shameful that we just put it out there and say because we have done it and we have all this information flying around, it is going to work. I operate an 800 number for SSVF. I operate it with homeless veterans answering the phone 24 hours a day, and when you call and you are in one of our areas, we have a veteran, a case manager, in your home within 48 hours, any of the five states you are in that we work in. But we have learned that we have to get the information, respond to it, and have backups, and you need to have community partners that respond where you are weak; and that is what we are not doing with the VA. And I know, and I just can't believe with the history of the homeless program and its ability to contract, that that is not the perfect thing that should have been moved through them to do the outreach to veterans.

Mr. BILIRAKIS. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much, and now to the incoming ranking member, Ms. Brown, you are recognized.

Ms. BROWN. Thank you. Thank you, Mr. Chairman. First of all, I think this is a great day to talk about the fact that we have cut out one-third of the homelessness and we are moving in the right direction, and I have been on this committee for 22 years, and we have been working and discussing it for 22 years, and I do think there is a lot more we need to do, and certainly working with those stakeholders is extremely important. Our partners, like you said, the mayors, the different groups and organizations, we are moving forward, and I am very pleased with that.

I guess what is still very disturbing to me is the number of homeless veterans' families, when I see the children of just the veterans and the children and when I run into a mother and she can't have the children because there is not adequate housing. Can you address that for me, please? Either one of you.

Mr. O'DONNELL. If I may, this is exactly the reason we are opening these 26 units, and they will be available in September 2015. It took us 5 years to get where we needed to be to have the support to do this, but you are right. One of the problems is, especially in Philadelphia, there is very few places—I know of one—for a woman to find shelter with her children. There are single fathers also with

children, and we welcome them into the program, so many of those women have a fractured family for no other reason than their being homeless. So programs like ours will offer the opportunity to partner with, in Philadelphia it is DHS, Department of Human Services, to reunite moms and their kids. And there is a growing need. Twenty-six units isn't nearly enough.

Dr. SHERIN. Just a comment on that. At Volunteers of America, we have a great deal of a commitment to homeless families. We have facilities around the country that are focusing on this. We just are in the process of opening up a 78-unit facility in San Pedro called the Blue Butterfly Village specifically for homeless female veterans and their families.

We also just opened one in Chicago called Hope Manor II. This is a critical issue, and when you think about the stressors on family of serving, it is no surprise that we have this challenge. And I think when we look to funding through the Federal Government, we need to create the flexibility to create these programs. I can tell you that the Blue Butterfly Village in San Pedro took almost 15 years to get developed, and one of the reasons for that is that we couldn't get easements due to interference from the DoD.

Ms. BROWN. The key is there is a multiplicity of things. We cannot sit here and think that just getting a person a house is the answer. The homeless person had a house, but they need the counseling. They need the support services. They need the employment. So it is really us working with the stakeholders. It is not just getting a person temporary housing. They have really fallen through the safety net.

Mr. DOWNING. You are absolutely right, Ms. Brown, and I think that the issue again, and I want to go back to what Doc said. We need to be able to build affordable housing more rapidly, and we need to create priorities. And one of the issues is we are forced, because veterans are not a protected class under the Fair Housing Act, we have to compete with every other community of need for affordable housing money. There have been some special, the areas done on tax credits where there have been set-asides for stuff built in a medical zone, and we can get veterans housing lined up. I am doing that in Mississippi. And we are looking at models and we are working on models where we can utilize tax credits and integrate them with the affordable housing money to make it happen more rapidly.

I have four projects under construction right now, and the fastest one is 3½ years from the day we started. So it has been a long run. In the 5 years that I have been at it, I have got 39 units completed with people living in them for 3 years. It operates beautifully, but it is going to take a long time, and so there is a whole structure on the housing issue that we need to work on.

Ms. BROWN. Mr. Downing, I think you said something very important. Many of these programs are already in the community. It is just how do we partner with them, with these stakeholders. They are very good at finding housing and that supportive services that is needed.

Mr. DOWNING. Yes, ma'am. One of the things that has made me a great fan of Jeff Miller is that he absolutely attacks bureaucracy for the sake of the consumer. We need to be doing that on these

issues because the tragedy is this, and this is the hard part. What motivates me to do the work is simply this: 8 or 9 percent of the American people are veterans. Every one of them that put on that uniform for a day said to all of us, I will die for you. We need to clearly hear that that sets that community apart for services and opportunity ahead of every other group in America; and we need to make that sacred, and this committee has done more, I think for that, than any other group in America in bringing it to light and in getting the government agencies focused on that, and I really thank you all for that. I think it allows us to do our work with more dignity, and also with a sense of hope that we might not have had 10 years ago.

Ms. BROWN. Thank you very much. I yield back the balance of my time.

The CHAIRMAN. Thank you. Dr. Roe, you are recognized.

Dr. ROE. Thank you, Chairman. I also associate my remarks with what you said about Mr. Michaud. It has been a pleasure.

I think probably part of the VA and the bureaucracy, Mr. Downing, you share, Dr. O'Donnell, and I share with all of you. Setting up an 800 number doesn't fix anything if nobody answers the phone. So I think the people that solve the problem, I am sitting here looking at right here. Let me share with you a little bit of my frustration. At the Blue Butterfly Village, it may actually be about as long as that VA hospital in Florida that Ms. Brown has talked about since I have been here to get done. We had a flood in our area three years ago, tremendous flood. It took out about 100 homes. We weren't big enough for FEMA to help us. We took the local mayors, private-public partnerships, and we built 35 homes for these people in a year, had them in the homes, ready to go.

We are beginning to do that for veterans now, and we are using the Appalachian Service Project in East Tennessee. We are using private funds. We are using public funds. We can build a home for cheaper than the VA can rehab a house where we are. The biggest problem we are having, and I was going to ask Dr. O'Donnell this, the biggest problem we have with the HUD–VASH program and others is there is not enough housing stock. That is the biggest problem we have got. If we had more housing stock, we have got the vouchers; we just don't have a place to put the veterans. We just broke ground on several—it will make a little dent like you. In 8 or 9 months we will have seven apartments where we are for veterans. But that's the biggest challenge we have.

And the other challenge Mr. Downing brought up is this case management. It takes the VA forever to get a case manager. Those assets are already in the private community if they would just unleash them. And everything you have heard, I have heard in my own community. The VA needs to be a little less paternalistic and work with people like you all that are able to go out and do these services rapidly. Because somebody living under a bridge tonight is freezing. It is cold, and we need to get them off the street now and get them in this not just 6 months from now, but it is an emergency. I will start with in Philadelphia, how are those 500-plus folks going to get, what are you going to do with that? That would be the biggest challenge I see is where do you find 500 safe places that are approved for them to live in?

Mr. O'DONNELL. So collaboration with landlords, not my doing. It is a collaborative effort and there are landlords that, you know, want to do well and do good. So they are private owners that get approved to provide HUD–VASH housing, so having direct contact with landlords, but again, the 25 cities initiative—in Philadelphia it is called a boot camp. I don't know if it is called that elsewhere, but people get together in a room regularly. There is Mr. Steve Culbertson who else in the audience there helps lead this effort. They get together and they identify every name on the list. So in truth, there are more than 540 homeless veterans left in Philadelphia. Those are the names on that list that get reviewed regularly with benchmarks that we need to hit constantly. And that group holds themselves accountable and it is about partnership, and clarity, and communication, and also about transparency, which is at the heart of some of this.

Dr. ROE. Let me ask this, a little more global question. Are all the VA programs that we have, are they interconnected enough or do we need to have a review and say okay, let's make it simple and easier for organizations like you that are on the outside looking in? Is there a way to do that?

Dr. SHERIN. What I would say is that in the past several years that the National Center For Homelessness Amongst Veterans has created a new paradigm for partnership with community, which is one of the reasons why the SSVF program is so effective. When we talk about issues like the call center, communities are set up to do this type of work. We are set up to do intensive case management for HUD–VASH. I would strongly recommend that the VA consider leveraging the National Center For Homelessness Amongst Veterans to establish a larger continuum of services with communities around the Nation because it can do it in a much more streamlined fashion than through the VISNs and the medical centers.

Dr. ROE. There are local housing authorities that already has that case management set up. All you have to do is let them do it. I mean, they are already doing it right now. It would be really simple. But now you go and find a case manager. They got to be trained. They got to do all this—I don't know whether you all have run into that or not. I certainly have.

Mr. DOWNING. We would find the same thing. Look it, the bottom line is, the VA is going to continue to do these things unless it is demanded otherwise, you know. And we deal with all types of issues. But the reality for me is this: If I look at veterans and where they live, and as I go into rural areas, I am shocked at Vietnam veterans that we are identifying, 30 percent of the Vietnam veterans we identify in the five States we are in in rural America are at 30 percent of median income or less; 60 percent are at 50 percent of median income or less. So, you know, we have to see that individuals left unserved, unhoused, and not being cared for continuously have diminished power to help themselves.

Dr. ROE. Yes.

Mr. DOWNING. So we need to rethink that, and I have become more and more convinced, at some point, we have to give every veteran his card with his benefits loaded up in it and let him choose to go to the VA or choose to go to a community provider or a community hospital, because until we do that, I don't think we are

going to utilize the resources that are available that we all continuously refer to.

Do you know what I am saying? I just think we need to somehow manage that out, and I don't know how else to manage it out without leveraging the Dollars. And it is frustrating because we watch the same thing you watch, sir, that there is services here, and we are sitting with people being trained over here while people dwindle out of their housing voucher based on the fact that they can't get services.

I mean, it is difficult, so I would like to see that change.

Dr. ROE. I yield back.

The CHAIRMAN. Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman. This is for any of the panelists. I have heard from providers in my district that most funding available for creating new housing options for homeless veterans and homeless people in general is for capital costs, in other words, for startup and construction costs, rather than operations and maintenance. And while funding for capital costs is obviously very important, the providers in my district say they have trouble funding operations and maintenance.

Do you believe this is a problem, and do you think that funding for this type of housing should be more flexible? For any of you, Mr. Landis, Mr. Downing.

Mr. LANDIS. In my experience, planning the capital cost to build a project, although it is difficult and complex, pales in comparison to your point in that the funding for services is just not there, or there isn't much of it. And the two go hand in hand. You can't just have a place to live, and without being able to provide extensive services to the veterans that are in place, as I mentioned earlier, you are going to have veterans that fail in their housing and they lose their stable housing.

So the operational funding is critical to maintaining the stability of the vast majority of these men and women whom we are placing into housing.

Mr. Takano. Mr. Downing.

Mr. DOWNING. We found that operations were an issue until we got involved with SSVF and learned to build partnerships better with other community-based agencies, and it also gave us personnel in the area where we were doing housing. So you have staff with that. So what we have developed in our SSVF grants is we employ in all of our SSVF grants approximately five to seven veterans who work as peers, who do nothing but provide transportation for you to your appointments, or bring your appointments to you, depending on what the need is.

And what we have found, again, is that is really where it works. What causes the cost to go up in services is when you have to rely on a source, and I would assume all of us have learned that the more we can partner this out, we can do it. The second thing is, in building, I build nothing but limited equity cooperatives for the veterans to own and manage. The reason I do it is twofold. Number one, they pay taxes to the community we build them in, so I don't have that pushback that it is more non-taxable property. The second thing is, our cost of operations of maintenance is at 40 percent of the national average because people who own where they live,

when we say to our vets, you can go out and help us shovel the sidewalk, or we can pay guys 15 bucks an hour to do it, and they say, oh, no, if you are paying them 15, that is less income for us and our cooperative. Our costs go up. They get that. So we are finding that model works. There is ways to do these things. We just have to do the partnerships. I think if we can get the housing up, we will maintain it. Okay, I believe that.

Mr. Berg.

Mr. BERG. I think an analogy is to look at the private sector. In the private sector landlords don't get grants for operating costs. They collect rent. And from the rent, they pay the operating costs. Congress has put a lot of money on the table for rent subsidies for homeless veterans through the HUD–VASH program and through the SSVF program. I think what is starting to happen is, people who do veterans' housing, do site-based housing, are starting to change the way they do business a little bit in order to figure out how to use the rent subsidies as ways to finance that. I think it is realistic and it seems to be working.

Mr. TAKANO. Well, Mr. Berg, can you explain to me more in detail your suggestion to put in place a system that will find vulnerable veterans before they ever become homeless and prevent their homelessness entirely. Do you think the VA is heading in that direction already?

Mr. BERG. I think they are starting to head in that direction. And this is the long term vision. We need to end veterans' homelessness. And we are on track to do that. But then once we do that, we need to make sure it never comes back, and really transform into a prevention system. I think VA is already starting to do things like veterans who come into the health services facilities get asked certain questions to try to assess what their housing stability is, and then that information gets, at least the way it is supposed to work, and it does work this way in the places where it works well, that information gets transferred to people who can do something about it.

Mr. TAKANO. I mean, there seems to be certain higher-risk folks who are servicemembers, people who have been trained to disarm IEDs and who we know have been in more intense battles. It seems to me DoD should be able to provide data on these individuals and we can track these individuals as they move into—it ought to be that we are identifying more high-risk individuals.

Mr. BERG. Exactly. This is a future challenge. DoD knows a lot about people who are in the military, and it would be very helpful if they would share key information like that with VA as part of a sort of a——

Mr. TAKANO. They don't currently share that information?

Mr. BERG. There is some efforts underway to do that. I think there needs to be more.

Mr. TAKANO. Thank you, sir. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you. Dr. Benishek.

Dr. BENISHEK. Thank you, Mr. Chairman. I thank you all for being here today. I have got some great information from it. Mr. Downing, in particular, I really appreciate your passion——

Mr. DOWNING. Thank you.

Mr. BENISHEK [continuing]. And your frustration with the bureaucracy of the VA as I share that very much as well. And I guess one of the first things I think of when I hear about the difficulty in coordinating the VA with the community-based services that are available and that, it seems to me that each community has a different set of community-based services, and I am not sure if there is enough flexibility within the VA to be able to deal with that. I mean, how does the coordination occur? Do you know at what level the VA makes these decisions to get into partnership with the VA?

Mr. DOWNING. Speaking for SSVF and the grant per diem program that I work with, they absolutely encourage community partnership. They work with us in working it out. We regularly would call Lisa Pape and her staff and talk about, hey, how do we pass money through here? Can we make that work? Does that pass the sniff test?

Dr. BENISHEK. Is that happening just in your—my concern is——

Mr. DOWNING. I am doing that in all the States I am in. I have no trouble all. I find the veterans' services in communities very willing to interface and work. With SSVF, we can sometimes pay first month, last month, and do some things to assist so we can work the veteran's service officer and extend out benefits, and stabilize better, so all of that works——

Dr. BENISHEK. What I am saying is, there is obviously a failure somewhere because of the fact that this—for example, this phone-in service was not working.

Mr. DOWNING. But that was VHA, not the VA per diem. So it is done out of that big bureaucracy of healthcare and not under the little unit that just dealt with homelessness, the grant and per diem office and the homeless program.

Dr. BENISHEK. So do you feel as if that—why is the VHA taking care of this when it should be the homeless people?

Mr. DOWNING. You know what, Doc, or Mr. Congressman, I really can't answer that. I am befuddled by how they think. I have come to describe the VA as a bureaucracy that excels at skilled incompetency.

Dr. BENISHEK. I agree with you.

Mr. DOWNING. I don't know how they do it. I know this, that when I work with my community partners, when I deal with the grant and per diem folks or the people at the Center For Excellence in Philadelphia, I get answers. I get responses. I get frustrated sometimes, but I generally get, you know, I generally get supported in trying to move forward.

Dr. BENISHEK. Well, hopefully, the VA will——

Mr. DOWNING. The VA healthcare, they are the enemy to me. Even at the hospital that I house 225 homeless vets every night. Okay. They don't cooperate with me.

Dr. BENISHEK. All right, thank you for your answer, Mr. Downing.

I would just like to ask Mr. Berg a question sort of following up on Mr. Takano's question, and that is, how we can best, you know, and we didn't really breach about how to prevent this in the beginning when the person transitions from the DoD. I think there should be a better way of not waiting for somebody to reach out to the VA, but to make sure everybody on their discharge gets

some follow-up. And can you maybe comment on that a little bit more, Mr. Berg?

Mr. BERG. Sure. And just to go back to the previous question, I would just say, I work with several different Federal agencies and what I found with all of them, HUD, HHS, and VA, whatever you think about the agency in general, and people have different ideas, one of the good things about working on homelessness is in all those agencies the part of the agency that deals with homelessness seems to attract people who are very capable, very smart and very committed to getting things done. So I think that supports what Mr. Downing is saying.

On the prevention issue, what we see as an important long-term piece of the homelessness prevention system is exactly, as I said before, the DoD knows a lot about people who are in the military, and we know more and more about what the risk factors for homelessness are, both for people in general, and particularly for people who have been on active duty, depending on the kind of duty they had, the kind of injuries they have, what sort of medical conditions they have, what experiences they had while they were in the military, what characteristics they had before they ever joined the military. These are risk factors for homelessness in all of that. DoD knows a lot about that. VA doesn't have really any ready access to that kind of information, but that wouldn't have to be the case.

I could foresee a system where the homeless services part of the local VA Medical Center had a list of veterans who were, who had been identified as having these risk factors, that they could check on once in a while, not in any sort of intrusive way, but just as part of the normal course of business. We are a long way from having such a system, but I don't see—I think we have got the know-how to make a system like that work.

Dr. BENISHEK. Thank you. My time is expired.

The CHAIRMAN. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman. Mr. Downing, I wanted to follow-up with you on your comments on military sexual trauma. And I am just interested to know if there are, you know, sort of model programs for that and if it is consistent across the country. Do you have any idea of what the success rate is? Do any of our men and women who experience military sexual trauma, do they fall into the category? I think there were two of you who talked about 20 to 25 percent of veterans will need services for a lifetime and sort of not have the recovery that we all would hope for. Can you comment on that?

Mr. DOWNING. Well, first of all, I can comment on the women that we serve. It is hard for me to project it out nationally. Think about this: In 13 years, every night we are at 100 percent capacity for 12 beds for our women, every night. I have never had a woman with custody of children present. It kind of runs counter to all the thoughts I would expect to have take place.

So the first thing we found out is that women will live in horrific situations where they are absolutely horribly violated and everything rather than show up in a shelter with children because they don't want the children identified and then going into special care units in most States.

The second thing that we found is that we had to change how we operated our women's program. There is no male authority in our women's program. It is run all by women. No man has any power, has anything there. We pay all the bills. That is what we do. Soldier On pays the bills. We found out that was another issue was male authority, trust of men, that type of thing.

Finally, we found out the approaches we were taking really changed when we went to trauma-informed care into wellness. We got a grant for $150,000 from Newman's Own Foundation and we started a wellness program in our women's program. And we started to deal with the spirit, the mind and the body, and we started to see some real change. Now, I can only express the change in how people appear and then how women started to—our women never participated in any program that involved our men.

We now have former homeless women who are employees working on the call center, working as outreach workers, working as peers. We have women going to school. But the issue is, they want women-specific services, and it is very difficult because the VA does not accommodate that at all. At the rural VA center that I am at, there is no OB-GYN services at all. If a woman has a mental health break and needs to go to a unit, she goes on a unit with male patients; completely unacceptable to her.

So we have to, in our facility, we dual register all our women in Mass Health so they can choose to go community-base where they can see doctors that they are comfortable with and they can go to units for treatment where they feel safe. Doesn't make sense to me that we have—so that is that.

Finally, in the piece about recovery, I think the women generally recover because there is much more support in their community for one another than there is with the men. They tend to care for one another very much and they tend to look out for one another, so that even as they have moved into the community and established their lives, they come back and visit. They come back and help the women decorate their new apartment, just a number of those things. So I think there is more hope for us there. But the shocking part to me is that we continuously read about this in DoD. And you know, it is not run by women—do you know what I am saying?

Ms. BROWNLEY. Yes.

Mr. DOWNING. And it is like somehow we are going to get there. Well, I want to tell you something. When I first ran the women's program, I ran it like we ran the men's program. And in fact, they shared some space in the building where the men were. And I was very frustrated with it and women were coming and going, and it really wasn't working. And I went home one night and I am sitting with my wife and I have a daughter who is a special-needs teacher who happened to stop at the house, and I am talking about the women's program.

My daughter looks at me and she says, what the hell are you doing running a women's program. You stunk as a father. If it wasn't for mom, we all would have left you. And I am really? And I had to really—she wasn't joking. She was dead serious. Okay, and that is when I realized, my God, yeah, what do I know? And how do I—I didn't understand. Do you know what I am saying?

Mr. BROWNLEY. Yes.

Mr. DOWNING. So that is what we need to do, and we need to really say that across the board. I am sure Dr. Sherin has some other insights on women like that because I would assume in your practice, there has been a lot that you face.

Ms. BROWNLEY. Yes, sir, I think my time is up, but I would like to hear from other members maybe, you know, off time here about——

The CHAIRMAN. If we could do it off line because they are about to call votes, and I would like to go ahead and continue the questions. But thank you very much, and thank you for your spontaneity, Mr. Downing.

Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman. Dr. Sherin, I have got a question for you. You were talking about how we calculate homelessness, and I think you had, if I can quote you, you said certain homeless veterans populations, and then you went on to say, elude current methods of calculation. What populations are you referring to, and what do you think the true number of homelessness is?

Dr. SHERIN. I think you actually got the wrong doctor. I will hand it over to him, but let me just say real quick, I think we have to recognize that our estimates of homelessness are rough. You know, when we do the point time count, we get a sense on a given night how many veterans we are finding basically in the streets. First off, there is a whole year that we are looking to kind of estimate. Secondly, there are veterans that elude these techniques and these radars, for example, post-9/11 veterans I would say in large part, and female veterans.

Mr. COFFMAN. Okay, Mr. Landis.

Mr. LANDIS. No. I think that was yours.

Mr. O'DONNELL. So you asked for the actual number, and I don't know. But you asked about the population, and as you might imagine, as the number of homeless veterans that are known, I will speak to Philadelphia, to be in Philadelphia, those that are more elusive, might actually be choosing to live on the street for a whole host of reasons.

But as we find appropriate housing, some of those folks are the most difficult people to find appropriate housing and care for, significant mental illness, chronic and prolonged substance abuse and dependency. They are at a stage in their recovery where they—it is called precontemplative. You are not even considering the idea of abstinence from substance use. So those are the folks that I think no one really has figured out what long-term appropriate housing and care looks like, and I don't know the number.

Mr. COFFMAN. If we talk about the majority of the causes for veterans homelessness, I mean, when I left for my first overseas assignment with the United States Army in 1972, came back from my last overseas assignment with the United States Marine Corps in 2006, and so, but I never went to Vietnam. And that population, a conscript military, very intense war, a lot of drug and alcohol issues, doesn't the majority of homelessness right now come from that generation of veterans?

Mr. O'DONNELL. The generation that we are serving predominantly is from the Vietnam era.

Mr. COFFMAN. Vietnam era.

Mr. O'DONNELL. But within the last year, we went from 5 percent OEF/OIF veterans to 10 percent OEF/OIF veterans, so that is steadily and significantly increasing. And those guys haven't hit bottom yet. They are couch surfing. They are being incarcerated, often related to substance use. But your comments, and actually the comments about military sexual trauma, if you can expand the idea of trauma just from combat to complex trauma that occurs on the street, there is something implicit about being homeless that there is a threat of violence, interpersonal violence on a regular basis. We know there is a dose-duration relationship between trauma and all of the problems, including homelessness that come along with that.

Mr. COFFMAN. Well, doesn't it—any effective program for homeless veterans, doesn't it have to include a mental health component, particularly in substance abuse?

Mr. O'DONNELL. You would imagine so. If I had another choice today, I would say allow the VA to outstation mental heal providers. We are not allowed to provide psychotherapy. So there are evidence-based treatments for posttraumatic stress disorder and a hole host of other disorders related to trauma. We can't provide that service directly. We drive guys every day to the VA if they can get an appointment, but if mental healthcare providers could be outstationed to our facility, I will even pick up the occupancy cost. Right? We can try to find money, but if you can provide that level of care, yes, it is necessary, and then a longer discussion is about trauma-informed care, which is a culture change.

Mr. COFFMAN. It is about—I don't want to use the term outsourcing—well, I guess I would—about reimbursing private providers for providing the care or nonprofit providers for providing the care.

Mr. O'DONNELL. That would be an option, although I got to tell you, the VA has a whole branch that focuses on implementation and evaluation. So if mental healthcare providers are given the training to provide evidence-based therapy for specific disorders with some flexibility about context because that is relevant in implementation, I would suggest that before giving me money to go hire a therapist. The VA is able to monitor what therapies are being delivered and in what way.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

The Chairman. Ms. Kirkpatrick.

Ms. KIRKPATRICK. Thank you, panel, for being here. I represent a very large rural district in Arizona, and my staff and I talk with thousands of veterans, and it is very evident that housing is an acute need for veterans in rural Arizona and maybe throughout the country in rural areas. And so my question is, what is being done about that and especially in light of the VA reform bill that we recently passed allowing veterans to get care in their local communities where they live, under HUD–VASH, are they going to be able to get that in their communities? Are they going to be able to stay in their communities, or are they going to have to relocate just to get housing?

That is my general concern. I don't know who on the panel can best answer that. I will let you sort that out, but that is what I would like to hear about.

Dr. SHERIN. I have a few comments about that. At Volunteers of America in Northern Louisiana, we actually just received a pilot grant from the VA specifically to connect veterans in rural areas in the Tri-State area around Northern Louisiana to the services that they need around the horn, you know, healthcare services and human services.

In addition, we are looking to obviously provide housing through the HUD–VASH program when we can. I think that the challenge in rural areas is obviously significant. Leveraging technology is one part of the solution, and I think that the VA's willingness to outsource services to non-VA providers is going to be very, very important in rural areas going forward. And I would say this new generation, particularly those suffering from post-traumatic stress are retreating to more rural areas, and we need to be aware of that and get out ahead of that movement.

Ms. KIRKPATRICK. And let me just mention, I am hearing from veterans on housing, not necessarily who are living on streets or in the woods, but they are living with their children, or grandchildren, or friends. And in my mind, they still count as homeless because they don't have their own place. Mr. Downing, do you have anything to add?

Mr. DOWNING. We work in 76 counties in Mississippi. Most of them are rural. We have the same issues. What we found is the SSVF grants allow us to go out there. Now, we partner with Voice of Calvary out of Jackson to provide services there because they have a whole history down there and we have found that that really works. So what we have done, again, is we have, in Mississippi, we have seven peers and 11 outreach workers who do nothing but go to those areas, deliver services, and then try to get local agencies to work with us and partner with us to sustain some service for individuals because a 3- or 6-month process can get you to a little bit more stability and opportunity, but it is the long-term, how do we keep this going and keep you going in the right direction.

So at this point we have 2 years of experience there, and we are finding that is what works there. But what we need to do is increase SSVF funding, especially in the rural areas because we need to do much more transportation, and we need to get professionals to move out there with us.

I think what, again, what Dr.—is it Sherin?

Dr. SHERIN. Yes, sir.

Mr. DOWNING. What he said was, that if we can get the VA to contract for those services and we can make them mobile and they go with us, it is just so much more effective.

Dr. SHERIN. If I may, I have mentioned earlier the concept of leveraging the National Center For Homelessness Amongst Veterans to create a larger grant opportunity. That grant could be named reintegration services for veteran families, as one example, which would have a number of different resources available to use through that very responsive mechanism.

Ms. KIRKPATRICK. Thank you, panel. Yes, yes, Mr. Berg.

Mr. BERG. Just to say on this issue of housing, I think this is a longer-term problem that people on this committee are going to have to deal with. The long-term trend in the cost of rental housing

is up compared to the rest of costs of living. We went through a period in the mid-to late zeros where we had sort of a temporary lull in that, but housing costs are going to continue to be more and more of a burden. If the VA benefits system doesn't find some way to take account of that, they are going to leave more and more veterans pushed into homelessness and pushed into poverty.

Ms. KIRKPATRICK. Right, I completely agree. I think this is an absolutely top priority that we have got to address. And we don't even get to providing healthcare or mental healthcare without providing that housing stability. My time is up, but I thank the panel very much and I think we need to focus on this going forward. Thank you. I yield back.

The CHAIRMAN. Thank you, Ms. Kirkpatrick. To the first and second panel, please accept our apologies. We are going to have to step out. We have a series of votes right now. We should be able to return in about 30 minutes so we will stand in recess until that time.

[Recess.]

Mr. LAMBORN [presiding]. The committee will come back to order. We will resume the questioning of the first panelists. I want to thank you for staying here. We were interrupted. The chairman has so much going on and—all of us do. Important votes taking place, and then we leave for the rest of December to go back to our districts. So thank you for your indulgence in staying here and being willing to continue answering questions.

And, at this point, we are to Representative Walorski.

Ms. WALORSKI. Thank you, Mr. Chair.

Mr. LAMBORN. The floor is yours.

Ms. WALORSKI. Thank you, Mr. Chairman. Thank you to the panel, also, for being here. I am grateful for the work that you all do and—and for the heart that you have and your diligence in continuing to make a difference.

And I think one take-home—take-away that we can take home today from today's testimony is that there is measured success when local programs are tailored to meet the needs of veterans and take charge of the homeless veteran population. And in my district, although it does not receive any grant money from the VA, but we have the Robert L. Miller Sr. Veteran's Center in downtown South Bend, Indiana. It has 24 beds. They are always full. And the facility has an incredible proven track record. But, obviously, there is—you know, it is a small—it is a small step forward. We have other homeless shelters as well. But for us, in the middle of getting into winter now, everybody will be full and there is still going to be a need.

But their story does go to show that local community organizations doing the work on the ground achieve results. And—and that is why I am glad you are here, to hear about other stories, winning stories, things that work. But, I guess, I share the same passion you do that, for every success story, there are so many folks that are standing in the shadows that are counted as just nameless, homeless veterans.

The question I have is: In the research that you have all done in some of your—some of you maybe have alluded to a little bit of this. But in the research that you have done for the folks that come to your facility or that you end up involved somehow with an out-

reach as a net, what are the backgrounds that lead a lot of these veterans to homeless? And the one thing I want to know—I know some of you are going to say it is economic, it is mental health issues. And we get the same thing on our end in just handling our district phone calls.

But I just want to draw your attention to one really quick story. We have a—one of the first times I dealt with this really up close and personal was the homelessness veterans was the shelter in our area. But, secondly, when I was elected, we got a call last year from a homeless veteran. And he said, "I am living in my car and I have lost everything." And his issue, though, to me, was, you know, just another frustrating point about the efficiency of services delivered by the VA to the veteran community. This guy wasn't homeless. He became homeless. He lost his house and he lost everything but a car. And he called us because he had filed claims with the VA, and this went on for years. And we got involved and started to run the traps on that claim. And part of the claim was that he was unemployable with 100 percent service connected PTSD.

And after—years after he has been homeless, living in car, lost his family, lost everybody, we chased the bunny trail and he began to get the money—the back money that the VA owed him from some 4 or 5 years ago.

Today, our happily-ever after story is today, he is back on his feet. He has a home. His family is reunited. And the story ends happily. But there is still even hundreds in my own district where, you know, that is never going to happen. But when you look at the breakdown of a pie chart and say, if today the VA could run no backlogs, completely efficiently and all services rendered, delivered, and all that kind of thing, if the veteran was number one and we could solve this today with just that scenario, which I know, you know, is kind of hypothetical, how many veterans are coming into your services that perhaps could be—put back on the right path, if they had the claims resolved and really were not fighting with the bureaucracy of the VA itself? And I am just going to open up to whoever wants to answer that.

Dr. SHERIN. Well, you know, it is—I mean, it is a tough question. Obviously, if we could get perfect service out of all the different agencies, fewer veterans would fall out. What I have said for a long time—and I continue to say—is that the biggest problem is actually accessing resources, which is why I continue to push at Volunteers of America an effort to create what we like to think of as community concierge, which is veterans helping veterans, as battle buddies, navigate the systems. Okay. A veteran can engage another veteran better than anybody.

Ms. WALORSKI. Right. Exactly.

Dr. SHERIN. Family relationship.

Ms. WALORSKI. Yes.

Dr. SHERIN. Then, if they are supported by an organization like Volunteers of America or others who are on the panel, they have the ability, they can develop the process and content expertise that they need to navigate the systems. And then, when they show up at a nonprofit, at the VA——

Ms. WALORSKI. Right.

Dr. SHERIN [continuing]. Anywhere——

Ms. WALORSKI. Yes.

Dr. SHERIN [continuing]. Together, they are stronger.

Ms. WALORSKI. Yes.

Dr. SHERIN [continuing]. At kicking down the door and getting access to that resource.

Ms. WALORSKI. I agree. And that is why my hand and my heart goes out to you because what you are doing—and in my own community with the Miller Homeless Vet Center, privately run, privately funded, you know, no Federal money coming in, but they have certainly led the way. And my hope would be, for communities like ours, that we would be able to leverage more grant money that comes into communities to say, lets drive the money—I would rather see the finances driven to the frontline than held up in a bureaucracy. That is just the kind of—that is just how—in my world, it is so much more efficient and—but I applaud your efforts.

And if you just—if you could indulge me, Mr. Chairman, one second. If there was one thing the VA could—could do today, would it be the access of resources for all of you, as for Dr. Sharin?

Mr. DOWNING. It would for me.

Ms. WALORSKI. Yes.

Dr. SHERIN. Yes.

Ms. WALORSKI. Okay. Thank you, Mr. Chairman.

Mr. LAMBORN. Thank you.

Representative O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chair.

I wanted to begin by joining my colleagues in thanking Mr. Michaud for his service. This is the last day, I hope, of my first term in Congress. And serving on this committee with you, I have learned a lot and your style of leadership and your commitment to veterans has really been inspiring. And I—that inspiration will continue long after you leave. So I just want to thank you for your work for everyone that we serve on this committee.

And then for—Dr. Sherin, I really enjoyed your comments about, in reading some of the backup in your written comments and testimony about peer-to-peer services. And you cite a New York Times article, and it says this is a way to treat depression in the general population that might go viral. And you suggest how that might work for veterans, and you suggest something like an SSVF-type grant to fund that.

Can you talk a little bit about how that might work? What that might cost? How that grant might be structured? That seems like something that this committee could pick up and run with.

Dr. SHERIN. Well, I mean, to start, we want to try to, I think, use the SSVF program as a prototype because it is so flexible and responsive. And in the hands of community providers and, also, veterans who are being served, there is a clear recognition that this program works. So, once we have a mechanism like this, it is something that we should leverage because what it allows for the VA to do is to engage community providers in a direct way and to maintain fidelity with the needs of the community and the individuals.

There are a lot of funds—there are a lot of funds that are floating around doing different things. If we were able to, for one example, take HVRP money or money for employment and funnel it through SSVF, that would be an effective way, I think, to get services to homeless veterans so that, once they were actually housed, we could work on getting them employed.

Same thing around, you know, kind of around this circle of the human services: Leveraging peers is a critical part of the solution because—because many homeless veterans become disenfranchised, they become isolated. When you are in the military, the community, the family that is built is a critical part. And when you return to the country and things start to fracture around you, you become isolated. And, you know, we call it the other LOL, which—you know, which is the lethality of loneliness. Because veterans become isolated.

And, you know, the homeless lifestyle does not lend itself to, you know, any type of thriving behavior. So if you incorporate resources for a—for a program that is operated like SSVF. What that will do is it will give the homeless veterans that family piece so that they can belong, and also, the ability to access resources.

And I—sorry to be carrying on. But the other thing here is that this is an opportunity for a massive employment initiative. We could employ a huge number of veterans to do this work. And the veterans that do this work—and I say this from my own experience. I met with 15 of them yesterday in Los Angeles, that work gives them purpose, because that purpose is lost as well when they return.

Mr. O'ROURKE. Great. Great idea.

For, Ms. Crone, I spend a good deal of time when I am back in El Paso with the veterans in our community. We have a veterans town hall every quarter and a monthly town hall. And we have actually held some of them in a homeless shelter that primarily serves veterans. And so anecdotally, I have gotten a lot of good feedback.

We have the point-in-time count, you know, 56 veterans in El Paso. We know how many HUD–VASH vouchers there are outstanding. We know how many Dollars SSVF have come into the community, who holds the grant. How can I assess, what is a good measure? I know no measure will be perfect. But how do I know how El Paso is doing? How do any of us know how the communities are doing using the resources that are coming through and holding those who have those resources accountable for their use?

Ms. CRONE. That is a great question. So I appreciate it. Thank you very much.

Mr. O'ROURKE. You have 20 seconds to answer that question.

Ms. CRONE. Okay. But—oh, okay. Great.

Mr. O'ROURKE. No. I am kidding. I am kidding. Hopefully the chair will give me some time.

Ms. CRONE. The point-in-time count is a useful number, but you also want to be looking at factors like the lease-up rate, how quickly is someone being referred for a HUD–VASH voucher and how long from that referral point does it take until they are leased up. You want to be looking at their continuation in that permanent housing, once they are leased up with HUD–VASH.

For those individuals that don't need that extensive intervention—so maybe people who are going through SSVF—you want to be looking at how quickly, again, they are being placed into permanent housing, what the cost replacement is from year to year and its increase—or its decrease every year. It is improved every year with SSVF nationally. You also want to be looking at, for those individuals who are seeking out employment services, which ones are getting employed, what their wages are, and how long they are retaining that employment.

Mr. O'ROURKE. Is this something that is measured? And I can ask the VA. I know they are the next panel. Is this something that is measured by the VA for each community which they serve, the different metrics you just gave us?

Ms. CRONE. I think your best way to get some of that information is to directly ask the providers. They do pretty extensive tracking of their programs. And some of those programs, including the employment services, might be through Department of Labor.

Mr. O'ROURKE. Thank you.

Ms. CRONE. But, yes, you can ask me.

Mr. O'ROURKE. Very, very helpful. Thank you, Mr. Chairman.

Mr. LAMBORN. Representative Walz.

Mr. WALZ. Thank you, Mr. Chairman. Before I start, I think it maybe has all been said, but I wanted to thank the ranking member, Mr. Michaud, as everyone said here, just an absolute pillar of this committee and of Congress, a close friend. When I think now people from Maine, I think of Mr. Michaud, no nonsense, practical, hearty, dependable, consistent, all those things.

So I was thinking of my district, something to give you that I thought fit those attributes. And in my district, every single can of Spam in the world is produced there. So I think of you. I am going to—so we will pass it down.

Well, to each of you, thank you. You are doing the good work. I appreciate this, and many of you have been here. I want to say a couple of things.

First of all, Mr. Landis, thank you. I have been out to be with you. And in full disclosure, my wife and I support what you are doing out there and I appreciate the email updates and all the things you are doing. It is a model that many of you have here. It is not the same model, but it is a model based on efficiency, delivery, and that holistic approach. And for that, I am very, very grateful.

Dr. Sherin, in following up on my colleague's insightful questions on this peer-to-peer piece, as we sit here today, we are waiting. And at any point, that Veterans Suicide Bill and the ones you helped on are going to get there. A key component of that was the peer counseling piece. So I thank you for that. It looks like—and we just got word from the White House, they are waiting for it to sign it. So thank you for that. And I think we are moving forward.

A couple things I want to ask each of you. This issue of rural delivery—and I know I hear many of you talk about that. Mr. Downing, you talk about it. One of the realities we are going to have to understand, about 15 percent of the population is rural, like southern Minnesota, northern Maine, places like that, El Paso and others that you get out in the countryside. But about 45 percent of our

warriors come from there. I think that is cultural, far more than it is economic. But it is a reality.

One of the issues we have to grapple with is the shortage of providers is both in the private sector as well as in this. So one of the things, as we look for these solutions, and we look for them, it is not as simple as just putting the people into the private sector because, in many cases, those providers aren't there anyway. And so I say that because I think—and many of you are thinking about this, this holistic approach, and I have seen this in my community. We have MACV, which an integrated housing unit. Minnesota Valley Action—and they do it right. And we integrated and started early on after folks in Buffalo showed us to do this veterans courts, where we understand, instead of the criminal justice system, it is entrance into the community. That is private sector, working with the county, working with the city, working with the State, working with the VA.

So I think there are models out there. I caution us, though, from saying one way or another. If I go to charity navigator, not all the private charities are doing a wonderful job as many of you are. And I think it is our responsibility here and it is VA's responsibility to be that clearinghouse and to put those things into place. And I hear you on this. And I am saying, well, maybe one of those major responsibilities should be moving the resources in an accountable manner. I think I agree with you on this. I have two questions, though, I want to ask on this.

I—and many of them are here, and I know the Secretary and others will be here. And I—this isn't the PIC, the turf battle fight or whatever, but it seemed like to me as a veteran, one of the things is the disjointed nature of where many services are. There are 40,000 charities for veterans in this country, whatever.

Does it make sense to have DoL, Department of Labor, and VA have pieces of this? My goal was to bring it all into one. And that it was not to disparage either agency on that, but as a simple alignment. I ask each of you who deal with this on a regular basis.

Mr. DOWNING. I stopped all my DoL programs just because I had a difficult time with all the different reporting things, and it was easier for me to meet the various State funder sources in the VA and move on. And through SSVF, I was able to train people to be—to do job search, and we have built that component in. And we, also, in most of the States we are in, are partnering now with their employment divisions, okay, and their training divisions, and we are finding that it works extremely well.

Mr. WALZ. Do you think there is expertise in VA to clear some of that to get to those——

Mr. DOWNING. I do. I think, again, in the homeless program—and I want to go back here because VHA, I have real fears about. But the homeless program, the Center for Excellence, are very good at contracting. And we just need to fund them and encourage them to.

I think the second thing is, in rural areas, technology—I manage 76 counties in Mississippi from western Massachusetts.

Mr. WALZ. Okay.

Mr. DOWNING. You know, I pick up—or my staff pick up a phone and they can tell you where every car is, who is on time for their

appointments, who isn't, how many people are served there. That is all doable. But we need to have the resources, and we need to have the creative minds that say, hey, that is acceptable. Do you know what I am saying? It is hard to get the big system to buy that. So I think we are very capable of it.

Mr. WALZ. Well, I will let some of you—I am going to save this one for VA. But I want you to think about it. I have been in, you know, I am sure I have spoken about it till everybody is sick of hearing about this. But this idea of the strategic vision, the quadrennial veterans review type of thing. How does homelessness fit into their broader strategy? Do you feel like it is taken into that, or do we end up having programs that get attached on the side all the time? I am just wondering where homelessness fits into that veterans strategy? If any of you—do you think it is there? My time is up and just—why don't we hold it. I will let them answer, but just give you some——

Mr. LAMBORN. Yes. Representative Walz, I just—I hate to keep moving, but——

Mr. WALZ. No, no. If we are on the right track and all that—I yield back.

Mr. LAMBORN [continuing]. We have votes in about 45 minutes, so—and we have another panel of three people yet to go.

Representative Kuster.

Ms. KUSTER. Thank you very much, Mr. Chair. And I, too, want to commend Mr. Michaud for his wonderful leadership on this committee and thank you for mentorship to the new members of the committee.

I just wanted to ask a couple of questions. Mr. Downing, nice to meet you. You have a project that we are trying to get off the ground in my district of Plymouth, New Hampshire.

Mr. DOWNING. Yes, ma'am.

Ms. KUSTER. And I understand we have had some zoning board issues with a couple of the sites, and I am very hopeful that we will be successful with this site that you are looking at now.

Mr. DOWNING. I think we are. We had an offer that was accepted on the property. We are trying to work out the terms of that right now.

Ms. KUSTER. Terrific. Terrific.

Mr. DOWNING. So—and we have talked to Taylor Caswell. And we are moving ahead and doing applications on the financing.

Ms. KUSTER. Terrific. And so what I wanted to ask about is: Can you help me understand, you or any other members of the panel, how we go about the funding? What is the Federal rule in the actual capital funding? We have talked about that, sort of, the initial expense. I am very confident in the model that you are choosing of relying upon our community providers. We have a great deal of interest in this community. It is rural, but we have strong support, and I am very much looking forward to you coming to New Hampshire. Because, as they have told me, you are the gold standard and we have a great——

Mr. DOWNING. Thank you.

Ms. KUSTER [continuing]. Deal of need in that region. But can you just educate me on what the sources of capital funding are for these projects?

Mr. DOWNING. First of all, we get in line with every other affordable housing group on the home, if and however that money gets passed through in your State, we applied for that. Tax credits, both Federal and State, then, become issues. And we applied for those where they are applicable. And then we normally have approximately a 20 percent shortfall on anything we are going to build. And we usually go out and borrow some of that money and see what we can fund develop for the balance. And then that is how we put our model together.

There are two other models now that are really—we are looking at, one that I am doing in partnership with a major tax credit provider. And they are—they feel that we could more rapidly get to building using that model. And I have just met with a major defense contractor, and we are going to be meeting with them about buying the credits at a "Dollar″on a "Dollar ″ for veterans' housing. And if we could pull that off, it would then really rapidly increase the time.

So that—give an example, in Plymouth, New Hampshire, now that we finally found the piece of land and we are in agreement on the price and fair and we are all moving forward, it would be—with a more streamlined model, we should be able to start building in 18 months. It is probably going to take us, in the model we are in right now, because of the lack of tax credits in the State and the size of the State limits that, I believe we are going to be 2½ years to 3 years to finance. Okay.

Ms. KUSTER. I would love to help you out and maybe make some introductions to some of our businesses in the community that could be helpful.

Mr. DOWNING. Thank you. I would appreciate it, ma'am.

Ms. KUSTER. And we welcome you in my district.

Mr. DOWNING. Thank you.

Ms. KUSTER. Thank you.

I would like to ask—and this is for anyone in the panel. I am interested—we have talked about VA products and programs that are available and we have talked about private sector. Do you envision an impact, as in New Hampshire we have just expanded Medicaid under the Affordable Care Act. It is a big change for us. We are going to have 50,000 people with health insurance for the first time, many of them ever. And given our high population of veterans, do you envision this being helpful? And I think one of you had mentioned that Massachusetts—that you encourage them to take the healthcare coverage under the Massachusetts plan. Will this help provide alternatives so that our veterans can get the services they need in the community? And any comment from anyone on that?

Mr. BERG. Well, I would start by saying just the expansion of Medicaid really, by making sort of mental health treatment available to a lot more very low income people, helps on the issue of homelessness generally.

Now, for veterans, in the past, we have thought, okay, VA offers mental healthcare where that—that, at least, is more than people who aren't veterans get. I think there is a lot more talk about how these federally-funded systems should interact, the one for veterans and the one for nonveterans.

The other thing I would say is that there is a certain number of veterans, people who served on active duty in the military who are not eligible for VA healthcare. Based on a series of complicated rules. The Medicaid expansion is going to be what they need to rely on to get mental health agreement.

Ms. KUSTER. Excellent.

My time is up. But I appreciate it, and I certainly am hopeful in New Hampshire that that will happen and across the country. Thank you, Mr. Chair.

Mr. LAMBORN. That concludes our questions. Thank you all for being here on this important issue. We appreciate your testimony.

I would now welcome our second panel to the witness table. Joining us from the Department of Veterans Affairs is Lisa Pape, the executive director of Homeless Programs. Ms. Pape is accompanied by Thomas O'Toole, the Acting Director of the National Center for Homelessness Among Veterans.

We are also joined on our second panel by Jennifer Ho, the senior advisor to the Secretary on Housing and Services from the Department of Housing and Urban Development; and the Honorable Keith Kelly, the Assistant Secretary of Labor for the Veterans Employment and Training Service for the Department of Labor.

Thank you all for being here. We will begin with Ms. Pape. And if you are ready, you, may begin with your testimony.

STATEMENTS OF LISA PAPE, EXECUTIVE DIRECTOR, HOMELESS PROGRAMS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY THOMAS O'TOOLE, ACTING DIRECTOR, NATIONAL CENTER FOR HOMELESSNESS AMONG VETERANS, U.S. DEPARTMENT OF VETERANS AFFAIRS; JENNIFER HO, SENIOR ADVISOR ON HOUSING AND SERVICES TO THE SECRETARY, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT; HON. KEITH KELLY, ASSISTANT SECRETARY OF LABOR, VETERANS EMPLOYMENT AND TRAINING SERVICE, U.S. DEPARTMENT OF LABOR

STATEMENT OF LISA PAPE

Ms. PAPE. Good morning, chairman, and Ranking Member Michaud, and members of the committee. On behalf of Secretary McDonald, let me thank you and the committee for the opportunity to review our progress to prevent and end homelessness among our Nation's veterans. As you have indicated, I am here and pleased to be accompanied by Dr. Thomas O'Toole, the acting director of our National Center on Homelessness Among Veterans. And I have to just say thanks to the panel before us for all their good work and great partnerships.

This is the time to prevent and end homelessness among veterans. We owe every man and woman who has worn our Nation's military uniform no less. With the help of Congress, our Federal partners, and community providers, we have been making unprecedented strides, as you have heard today, to engage, support, treat, and house homeless and at-risk veterans. While the numbers are going down from almost 56,000 in 2013 to 49,900 on any given night in 2014, we know we have to accelerate the pace, use data

to drive our results, leverage mainstream systems, target resources in greatest need, and work better, faster and together.

Our goal: A systemic end to homelessness, no veteran sleeping on our streets, and every veteran having access to permanent housing. We have will have the capacity to quickly connect homeless or at-risk for homeless veterans with the help they need to achieve the housing stability they deserve. The ultimate goal is that all veterans have permanent sustainable housing with access to high quality healthcare.

VA knows we can't prevent and end homelessness alone, and we are committed to continued collaboration and fostering of strong partnerships. We have close working relationships with Federal partners, like the U.S. Interagency Council on Homelessness, HUD, Department of Labor, and others. Partnerships are key.

I would like to take a moment to thank our local partners from around the country. Your interest in being part of a collaborative solution to ending veterans' homelessness is extremely valuable and greatly appreciated. Lastly, I want to acknowledge the homeless and formerly homeless vets who are watching or here with us today. I thank you for our service, and we look forward to providing you with the continued care and support you deserve.

Our strong interagency collaborations have resulted in successful policies and programs. With the help of our partners and, as you have heard today, an unprecedented 33 percent decrease in the number of homeless—number of veterans without permanent housing who have stayed in shelters, missions, SROs, or in any other unstable or nonpermanent situation, and a 42 percent decrease in those who were literally sleeping on the streets in boxes or in abandoned buildings.

Our premiere collaboration is with HUD, in the Housing and Urban Development Veterans Affairs Supported Housing Program, HUD–VASH. Highly vulnerable veterans who have experienced homelessness for extended periods of time are best served through HUD–VASH. This collaborative provides housing choice rental assistance from HUD, with intense case management assistance from VA. Last year, nearly 56,000 veterans were assisted. We know permanent supported housing is the most effective tool for serving these chronically homeless veterans.

The SSVF, Supportive Service for Veterans Families program, rapidly rehouses homeless veterans and their families and prevents homelessness for those who are at risk. In fiscal years 2014 and 2015, the SSVF program awarded $507 million in grants that expanded SSVF from 319 community agencies to 383. Last year, our grantees served nearly 130,000 veterans and their family members, of which 27,500 were children. Additionally, 81 percent had a successful housing outcome.

The homeless providers grant per diem is our largest transitional housing program. It is for veterans who have need of extended rehab, focused help with employment, and housing searches, and are served in this program. In 2014, over 23,000 veterans were admitted and 14,600 exited into permanent housing.

For veterans entering the justice system who are already dealing with mental health or substance abuse issues, we have established Veterans Justice Outreach; 248 full-time specialists working di-

rectly with justice officials. VA works with treatment courts to ensure veterans get the treatment they need as opposed to using incarceration as the alternative.

In conclusion, VA, with our partners, are now closer to its goal than any other point in history. We know that targeting resources, utilizing evidence-based practices like Housing First, and strengthening collaborations are key. Through Congress's continued support, our vast partnerships and the commitment of our Federal partners we have made significant progress in our effort. We recognize that ending homelessness is not an endpoint, but a way point. We can never become complacent about our achievements or the same conditions that gave rise to homelessness will spawn this once more. VA will not rest.

Mr. Chairman, this concludes my testimony. My colleague and I are prepared to answer questions.

[THE PREPARED STATEMENT OF MS. LISA PAPE APPEARS IN THE APPENDIX]

Mr. LAMBORN. Thank you. Ms. Ho, you are now recognized for 5 minutes.

STATEMENT OF JENNIFER HO

Ms. HO. Chairman Lamborn, Ranking Member Michaud, and members of the committee, I am Jennifer Ho, senior advisor to HUD Secretary Castro. Thank you for the opportunity to discuss our collaborative work to eliminate veteran homelessness in America.

Since launching Opening Doors in June of 2014, the number of veterans experiencing homelessness on a single night has dropped by 33 percent to just under 50,000 veterans. This progress would not have been possible without funding from Congress. Thank you.

While much more needs to be done, we know that collaboration and new resources strategically deployed are key to our progress. HUD VA and the U.S. Interagency Council on Homelessness work together to combat a problem that cannot be solved by one agency alone. We work together every day to align our programs and to use limited resources as efficiently as possible.

Our most collaborative effort is HUD–VASH, supportive housing that combines housing vouchers from HUD with case management and clinical care provided by VA to assist vulnerable and chronically homeless veterans. Together HUD and VA use data to drive decisions about HUD–VASH allocation, based on both homelessness prevalence and local capacity to administer new vouchers.

Since 2008, nearly 70,000 HUD–VASH vouchers have been awarded to public housing authorities in the every State, District of Columbia, Puerto Rico, and Guam. About 11,000 new HUD–VASH vouchers were awarded in the last several months. The success of HUD–VASH requires new collaborative partnerships locally between VA medical centers, public housing agencies, and nonprofits providing homelessness assistance. As communities identify challenges such as low voucher utilization or a lack of affordable housing, we are helping resolve partnership, policy, and practice issues. By overcoming challenges together, our collaboration is strengthened and better able to address the next challenge.

In order to ensure that HUD–VASH investments are used strategically, HUD and VA have a performance target to use at least 65 percent of HUD–VASH vouchers for veterans experiencing chronic homelessness. These veterans have long histories of homelessness and very poor health and, therefore, typically require long-term housing assistance and support. HUD–VASH supports veterans for as long as they need assistance.

HUD and VA are both committed to Housing First. Housing First means veterans get intensive supportive services to help them, first, find and keeping housing. A homeless veteran can more easily engage in services and address his or her chronic health conditions or find a job once he or she is no longer dealing with the chaos and uncertainty of homelessness. Research has demonstrated that permanent supportive housing, using a Housing First approach, not only ends homelessness for people who, in the past, would live on the streets or in shelters for years, it breaks the costly cycle through shelters, emergency rooms, hospital, detox centers, and jails.

We continue to work with local communities to improve the performance of HUD–VASH. One of HUD's major technical assistance efforts has been boot camps in which community partners are brought together to answer the question: How can we more effectively and efficiently end veterans homelessness locally? Nationwide, over 50 communities have participated in boot camps, which are a collaborative effort between HUD, VA, the U.S. Interagency Council on Homelessness, Rapid Results Institute, and community solutions.

The results are real. In some cities, the time it used to take for a veteran to actually get the keys to an apartment was 6 months or more. After participation in boot camp, communities have shrunk that time to as little as 30 days. Many communities like Jacksonville, Florida, set and met ambitious goals of housing 100 veterans experiencing chronic homeless in 100 days. Large gains can be made in a short period of time when all the partners are at the table.

As Ms. Pape discussed, the VA built on the progress made through boot camps in the 25 cities initiatives will continue to help communities improve the identification, assessment, and housing placement of veterans through HUD's supportive new zero 2016 campaign in 71 cities and four States across the country. Each community is developing specific targets for the number of people they must house each month to end veteran homelessness by December of 2015.

This effort dovetails nicely with the mayor's challenge to end veteran homelessness championed by First Lady Michelle Obama. I am excited to announce that more than 355 mayors, governors, and county executives from across the country have pledged to end veteran homelessness in their communities by the end of 2015 by strengthening the local partnerships.

Mr. Chairman, and members of the committee, thank you for your continued support of this important work. I hope I have been able to portray the unprecedented level of Federal collaboration that is accelerating our progress toward ending homelessness among veterans in America. Thank you very much.

[THE PREPARED STATEMENT OF MS. JENNIFER HO APPEARS IN THE APPENDIX]

Mr. LAMBORN. All right. Thank you.

Assistant Secretary Kelly, you may speak now. Thank you for being here.

STATEMENT OF KEITH KELLY

Mr. KELLY. Good afternoon, Chairman Lamborn, Ranking Member Michaud, and distinguished members of the committee. Thank you for the opportunity to participate in today's hearing, and particularly for this morning's panel. It was very energetic and robust and educational.

My name is Keith Kelly, and I have the honor to serve as the Assistant Secretary for Veterans Employment and Training Services at the Department of Labor. The Department is committed to helping the administration meet its goal of ending homelessness among veterans in 2015.

Secretary Perez and I know that one of the most important ways to prevent homelessness is through a good job. However, employment alone is not a guarantee in preventing veterans from falling back into homelessness. It requires a coordinated effort between our Federal partners such as VA, HHS, SBA, and HUD, as well as other State and local organizations, nonprofits, and the private sector.

Currently chaired by Secretary Perez, the U.S. Interagency Council on Homelessness has helped us in providing a national partnership at every level to reduce ending homelessness in the nation. As you know, and stated in some of your testimony this morning, we have already made substantial progress.

At DoL, our primary program aimed at eliminating homelessness among veterans is the Homeless Veterans' Reintegration Program, referred to as HVRP. In addition, veterans receive priority of service in all of the employment and training programs funded directly, in whole or in part, by the Department of Labor. Through the HVRP, DoL grantees assist homeless veterans in obtaining meaningful and sustainable employment. Each participant receives customized employment and training services to address his or her specific barriers to employment. Services may include occupational, classroom and on-the-job training, as well job search, placement assistance and post-placement follow-up services.

HVRP operates on the principle that when homeless veterans obtain meaningful and sustainable employment, they really are on the path to self-sufficiency. HVRP grantees work with VA, HUD, HHS, and many other types of organizations. Actually, applicants must address how they intend to collaborate with others in their applications for funding.

In fiscal year 2014, the HVRP program received an appropriation of just over $38 million, with which the Department awarded 37 new HVRP grants, 82 option year HVRP grants, and 18 grants for homeless female veterans programs. These grantees are expected to provide services to over 17,000 homeless veterans with an estimated placement rate of 66 percent at an estimated cost per participant of around $2,200.

While my written statement goes into much detail about the Department's procedures for selecting grant recipients as well as measuring their performances, I would just note that HVRP funds are awarded to eligible organizations from a very rigorous competitive process. Following the award, the Department works closely with grantees to ensure they meet all our performance outcomes.

On a personal note, my staff and I routinely visit our HVRP grantees when we travel around the country. And, as you heard this morning, we are consistently impressed with the passion and the creativity these dedicated organizations bring to their work to help homeless veterans. I would certainly encourage you to meet these great men and women as you travel around your districts.

Just one example. We support the Volunteers of America Florida, a local chapter of one of the other witnesses here today. Through the HVRP program, they have successfully partnered with a security firm to put in place a direct referral system of the homeless veterans they are working with, once they are job ready. The grantee's staff assist each veteran with their application based on what the company is looking for, and then the company contacts the veteran directly. This streamlined process has resulted in many formerly homeless veterans getting back on their feet in a relatively short amount of time.

Through HVRP, the Department also supports stand-down grants and technical assistance. The stand-down grant is typically a 2- to 3-day event involving various Federal, State, and local organizations. At these events, grantees provide homeless veterans with a variety of services, such as meals, clothing, employment services, referrals, and counseling. In fiscal year 2014, we awarded 66 stand-down grants for approximately $500,000.

Additionally, the Department awarded two technical assistance cooperative agreements to support our grantees and disseminate best practices. One who testified this morning, The National Coalition on Homeless Veterans. And, finally, the Department of Labor is committed to the administration's goal of ending homeless veterans in 2015, and we look forward with the committee to ensure the continued success of our efforts.

Mr. Chairman and members of the committee, thank you again this afternoon for the opportunity to testify. I would be pleased to answer any questions you have.

[THE PREPARED STATEMENT OF MR. KEITH KELLY APPEARS IN THE APPENDIX]

Mr. LAMBORN. Thank you.

I will now yield myself up to 5 minutes for questions. Ms. Pape, programs to provide assistance to homeless veterans are provided by actually each of the three departments that are represented here in this panel. Earlier this year, VA, in particular, provided the committee with a list of 20 separate programs that VA operates to provide assistance with housing, healthcare, or employment for homeless veterans.

Now, as we all know, large government bureaucracies are not known for being sometimes able to effectively communicate and coordinate efforts. So how do you ensure that these programs work in coordination to provide a seamless continuum of care for veterans in need and do not duplicate services?

Ms. PAPE. Thank you, chairman, for that question. And it is an important question. As you heard on the panel before us, the programs that we listed, the 20 programs are really complementary of each other and may build on each other. That is not to say there is not any duplication. Of course, right, we are constantly working to ensure that there is not, but they are more complementary. And we do many avenues and, even across department, to ensure that folks know about the programs and that we are not duplicating services to an extent that is not helpful in the system. So we track and monitor and evaluate regularly to ensure that the right veteran is going to the right level of service for the right amount of time, which is really key for this population. We also have regular subject-matter expert reviews to ensure that programs are staying in their lanes but complementing each other.

Let me ask if Dr. O'Toole would like to add, this is—evaluation is his area.

Dr. O'Toole. Great. Thank you. And, Mr. Chairman, it is a spot-on question and issue and one that, I think, is extremely important for us to have a focus to. Coordinating care is a challenge in the general healthcare system, not to mention issues specific to homeless and homeless veterans within the VA system.

I am a primary care provider and have been taking care of homeless persons and homeless veterans now for almost 25 years. And tomorrow I will be in clinic and see probably about 10 or 15 veterans in the morning, and each one is going to have a litany of different problems and issues that will likely be crossing into the territory of four or five different programs within each context. And how we connect the dots in those programs is really a significant issue and challenge and, also, an area of very specific focus for us.

Mr. LAMBORN. And how do you do that?

Dr. O'TOOLE. Well, the most important thing is we pick up the phone and talk to each other. And we—when we do pick up that phone, we need to know who it is we are talking to so it is not a cold call. And that is basic primary care, basic care coordination 101, and it is how we have to do it.

And VA has made significant strides within the homeless program arena in the past few years in the context of this initiative in reaching out to community partners and really including them in that process as well. Our local facility has a homeless summit on a quarterly basis where all of the community agencies that we partner with come in, meet. So, again, there is that face time.

From a data and analytics perspective, this is where we are moving in the National Center on Homelessness Among Veterans is specifically directing its energies to how do we find and identify those veterans who are falling through the cracks? It is a complicated, bureaucratic system, and it is easy to have that happen. And being able to use our analytics capacity to identify down to the Social Security number who those veterans are and how can we redirect those services is, right now, where we are really focusing our energies.

Mr. LAMBORN. Okay. Thank you so much. Representative Michaud.

Mr. MICHAUD. Thanks very much, Mr. Chairman. Before I ask the question from Ms. Pape, I want to thank you and the many em-

ployees at the VA for your efforts to care for our veterans and to serve our veterans as well all across the country. I think too often the media headlines level broad accusation against all VA employees, not just the ones who are—have bad performance issues. There are good news stories, and there are good VA employees. So keep up the good work and continue to improve on that as well.

But likewise, with the first panel we had earlier this morning and the veterans service organizations who work with the Department and veterans, I want to thank all of you as well for your continued effort in that partnership working with the Department to make sure that Congress does what we have to do to provide the resources that we need for the Department. And I want to thank you for that, the essential work that each and every one of the VSOs and organizations do for our veterans.

My question is: It seems that further reduction in homelessness will become increasingly difficult as the more severely mental ill and substance-dependent veterans are treated and housed. Is that a fair assumption? And, if so, what is the VA strategy plan for addressing these chronic homelessness?

Ms. PAPE. Thank you, Mr. Michaud, and thank you for acknowledging the work we are doing.

So it is a fair assumption, right, as—as we start to continue to reach into the communities and find every homeless veterans, we find harder-to-reach folks who are living in camps, not directly in urban settings where we have to find them, know them by name, and engage them into services. One of the initiatives Ms. Ho referenced was this 25-city initiative that VA is running with our Federal partners, as well as some other contractors we are working with. It is to build a coordinated entry system at the community level where it literally identifies by name every homeless veteran, so that even if they don't engage, we will know, and the community will know, who they are, so that we can continue to go back to them until we can get them to engage.

Eventually, to our pleasant surprise, many, many of these veterans finally raise their hands and say, We want services. And that is because we have our partners at the table. They may not want it from the VA, but they will take it from one of our partners that you saw at the table and move them in. So it is knowing them by name, engaging them, and building a systemic system. And it cannot be the VA alone. It has to be all of us together.

Mr. MICHAUD. Thank you for your answer. And you are absolutely right, it has to be all of you together. And as—VA can't do it all, and I am glad to see that you are reaching out. And I meant what I said about the VA's employees because I really look at, every time I go to stand down at Togus and Main, you know, and I see Susie Whittington, I mean she has just got so much energy out there and she really cares about all the veterans—homeless veterans in Maine. And I wish we could just bottle that energy and just send it throughout the whole, you know, Department as well. I am sure there are other employees such as Susie throughout the Department.

So, once again, I want to thank this panel for your reference and the previously panel as well. With that, Mr. Chairman, I yield back the balance of my time.

Mr. LAMBORN. Thank you, Representative Michaud.

Representative Walorski.

Ms. WALORSKI. Thank you, Mr. Chairman. And, again, I would like to express my thanks as well for what the VA and the other agencies are doing in the housing and Department of Labor as well as for homeless veterans. I mentioned before, I have a homeless shelter in my town that is privately funded, the Miller Homeless Vet Center. And it has done a phenomenal job being very, very close, on the frontline. And I can't commend them enough for what they do. And they have the same heart and passion as well.

The question I have, though, when we are talking about ending homelessness in veterans by 2015 is: The VA Inspector General came out last week with a report from the National Call Center for Homeless Veterans which identified over 40,000 missed opportunities where the call center did not refer homeless veteran callers to medical facilities or close referrals without making sure homeless veterans actually receive their services. So what is the follow-up on that? What—where is the VA in addressing the concerns of the oversight of the IG?

Ms. PAPE. Good question. You know, we share your concerns. I read the report. It is disappointing for all of us, and frankly, it is just unacceptable. We regret that any veteran who was calling for information and a referral did not get the service that they needed.

That said, you know, this was a journey for us. And when we set up the call center, it was a smart idea. We knew we needed a quick way to get veterans access to information. Frankly, it grew faster than we were able to execute and we didn't grow with it.

Ms. WALORSKI. How many employees are in that call center?

Ms. PAPE. For the homeless hotline——

Ms. WALORSKI. Yes.

Ms. PAPE [continuing]. There are about 60 employees, and it is coupled with the Veteran Crisis Line. That said, we have already—even prior to the IG report coming out, we have already started making improvements because we have to. Our veterans deserve that.

Ms. WALORSKI. So in the improvements that you started to make, were those improvements in holding employees accountable or were the improvements in getting rid of the answering system so that it can't be left on auto to leave—what steps have you taken to keep the employees accountable?

Ms. PAPE. It is both. So we are in the process of finalizing an automated queuing system so that the answering machine can be gone, and that queuing system will allow vets to pick a number, 1, 2 or 3, or stay on the line and talk to a responder.

We have also started looking into a workforce tracking system, which will allow an automated system for us to know how long calls are being talked on, who is doing what, where the documentation is. And all of that is getting worked on right now as we speak.

We have also targeted staffing to come in during the peak hours—I think one of the congressmen said that—so that now they are coming in and staggering hours so that we have staff on duty. Right now, our service level is about 90 percent of the calls are being answered.

Ms. WALORSKI. So those people—well, I guess, the answering system that was in use when the IG came in and looked at that, was that service not adequate to be able to pull all the information from what time the veteran called, what number they called from? Were those kind of—was it possible to go in and retrace and try to find some of these folks? Or are they just—is that information just gone——

Ms. PAPE. No you could—you could——

Ms. WALORSKI [continuing]. And the new system has it?

Ms. PAPE. Right. You could get that information. But it was an answering machine, so some of it was inaudible, right, and it was not automated. So somebody literally had to go in and track that. Now, with an automated system, that information will be at our fingertips. And some of that is at our fingertips right now that we are now tracking.

Ms. WALORSKI. So what did you find out—when you went in to kind of go in and implement the IG's findings, what did you find out those employees were doing when the Inspector General said there was lapses of up to 4 hours where they weren't there but they were obviously being paid? What were they doing? Did you find out?

Ms. PAPE. I know that some of the things the employees were doing were training. They were on training. They were on leave. They were on—they were looking, doing documentation and——

Ms. WALORSKI. For 40,000 phone calls? How long of a period of time does it take to get 40,000 phone calls in there? I mean, will we—we will never find these people. But, you know, that is—it is interesting to me, it is $3.2 million in a department that loses 40,000 phone calls, two-thirds of that money is in the system itself.

So were employees fired? Did somebody talk to them about, you know, are there things on the—are these people all still there, and these are all the people that we are going forward with?

Ms. PAPE. So management is looking at how to address issues in performance and will be addressing that. I don't know if all the employees are still there. I do not think anyone has been fired, but we can get back to you on that. I can——

Ms. WALORSKI. And then whoever is in charge of that department, when that IG report came out and was basically proof to the VA that there was a huge issue going on in that call center and 40,000 call opportunities were missed, what happened to the person in charge of that department?

Ms. PAPE. So leadership, again, is reviewing and assessing the performance. And if there is wrongdoing found, they will be taking care of that.

Ms. WALORSKI. They will be fired?

Ms. PAPE. I won't say they will be fired. There are many ways; counseling, suspension, reprimands. And, of course, if there is something egregious, there could be——

Ms. WALORSKI. I just think it is a huge impediment, Mr. Chairman, that—because we all want homelessness ended by 2015, right? But we want to make sure that the things get corrected in the VA because, I think, the American people have loudly said, That is enough and that has to stop. So I appreciate your interest in looking at it as well.

Ms. PAPE. Thank you.

Ms. WALORSKI. Thank you, Mr. Chairman.

Mr. LAMBORN. Chairman Patrick.

Ms. KIRKPATRICK. Kirkpatrick. That is all right.

Mr. LAMBORN. Kirkpatrick.

Ms. KIRKPATRICK. It happens all the time.

Mr. LAMBORN. I apologize.

Ms. KIRKPATRICK. I want to thank the panel for your—and the previous panel for your hard work toward the goal of ending homelessness for our veterans.

Ranking Member Michaud, I want to thank you and Chairman Miller for your leadership on the committee. Chairman Lamborn, I want to thank you and all my colleagues and the committee staff for your hard work. This has been one of the most productive committees in the 113th Congress, and thank you for that.

For my final remarks in the 113 Congress on this committee, I want to read an email I got this morning. It is from a gentleman, William Putnam, who is the former trustee of Lowell Observatory in Flagstaff who has just now moved to New Hampshire. So if the committee will bear with me. He says, "Ann, I just had a wonderful experience at the VA Hospital in Manchester near here. Some 5 or 6 years ago, I gave up on the VA after it became clear to me that all the people wanted was to take more chest X rays of me. I figured I must glow in the dark already and that piece of iron hasn't shifted its position inside me since the day it got there in the first place nearly 70 years ago.

"However, I will give them another chance, thought I. So I made an appointment and got there in the rain—ugh—at 10 a.m. But hardly had I found a place to park my car than some guy with a courtesy van showed up to offer me a ride some 250 yards to the main entrance. He was right there again when I wanted to go back. I found my way inside, and some other nice guy directed me down a long hall and around a few corners to a waiting room where I showed my paperwork to another polite guy behind a computer. He poked away at his machine. And in a matter of less than a minute, a little man appeared in a nearby doorway and called my name. He introduced himself and said, 'Follow me down to our office area. I think you will find the weather is better there.' In fact, it wasn't raining at his end of the building. And it turned out he was the head technician for primary care pack team 2 of which Dr. Carter Hale is the leader.

Dr. Hale was ready for me and did a few more of the usual high-level medical inquiries. He was a nice guy, friendly, knowledgeable, and radiated a sincere desire to be helpful to an old vet with all the miseries of a tired and lonesome man."

Mr. Putnam just recently lost his wife.

"After his examination, Dr. Hale took me to a nurse's cubicle where he left me to go write up his analysis. And the lady shot me full of flu vaccine, then pointed me down the hall to where the real blood thirsty ones were. They were really nice about it, too, and finally, it has been nearly two hours so far, told me I could go home. The pharmacy people would be in touch with me soon.

"I had barely gotten back home when—a 20-minute drive—when my cell phone rang. I now have a date with the pharmacy people

for next Tuesday. You know, Anne, I misspent much of my youth here is Kyle, Hampshire. It is kind of nice to feel home again. But, mostly, I thought you might enjoy hearing a nice thing said about the Veterans Administration."

I had his permission to read this. And I want to congratulate Ms. Kuster. She's getting a great constituent. So thank you very much. I yield back.

Mr. LAMBORN. Thank you. And thank you, Ms. Kirkpatrick.

That leads to Representative Kuster.

Ms. KUSTER. Well, after that, I would take the risk, but thank you very much. And I think it is appropriate.

And I, too, want to commend our chair, Mr. Miller, and Mr. Michaud, and just what an extraordinary experience this has been for me as a new member.

Both my husband and I have experienced this incredible pride and honor. My father was in World War II. He was a pilot, flew 63 missions, and was shot down on Christmas Eve and spent 6 months in a POW camp. And my father-in-law was landing on the beaches of Normandy when my father was flying overhead. They were both in the Battle of the Bulge. And so this has just been an extraordinary experience for me as a member of Congress to be able to serve on this committee.

So I really don't have any additional questions. I want to thank you for the work that you are doing. I certainly want to thank my colleague, Ms. Kirkpatrick, for that beautiful letter.

And I just want to say that of the people that are out there working for the Veterans Administration, for HUD, for all the private organizations, all of our VSOs to meet people from organizations like Soldier On, I just want our veterans to know how much we do care, how much we do want to solve—this is the most complex issue, poverty, the issues of the brain having dealt with mental health in our family, issues of employment, PTSD, MST, the list goes on and on. And I just want our veterans to know that we have the most bipartisan committee in the 113th Congress and, I hope, in the next Congress as well and that there are people here in Washington, DC who care a great deal.

So I thank you for the work that you do. I thank my colleagues, and I just want to thank the chair and the vice chair for the opportunity to work with you this year. Thank you so much.

Mr. LAMBORN. Thank you.

Representative O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman.

First of all, thank you to each of you for what you do and for your answers to the questions so far.

For Ms. Pape, I wanted to follow-up on a question raised by my colleague, Ms. Walorski, on these 40,000 missed calls. When did you become aware of the OIG report and the number of calls that were missed? Roughly.

Ms. PAPE. While the OIG was finishing up the investigation is when I started to become aware that there was 40,000 calls missed, so the IG and the VA worked together as they start to close out.

Mr. O'ROURKE. How long ago was that roughly?

Ms. PAPE. Several months ago, April, May.

Mr. O'ROURKE. I take you at your word that you are pursuing this and you are going to make sure that we hold those who are responsible accountable and fix the problem?

Ms. PAPE. Yes.

Mr. O'ROURKE. I will say an issue that has consumed this committee has been accountability and the culture at the VA and hearing and knowing there is a little bit more urgency behind these issues and that it doesn't take us months to figure out who is responsible and to hold them accountable but we do it as soon as we have the appropriate information, I think would go a long way to restoring much needed faith and trust in the VA, especially around appropriations time and, obviously, for those whom we serve here, the veterans who depend on these services, so just that would be a message to you in terms of your response on that issue. And I hope you can update this committee sooner than later that you have dealt with this issue and held those accountable who were responsible for the failure here.

Ms. PAPE. Absolutely. Just yesterday having conversations with our leadership about ensuring that this issue gets resolved quickly. None of us want veterans not getting service they need. It is just unacceptable, and we are on it. Thank you.

Mr. O'ROURKE. The latest point-in-time report shows around 56 homeless veterans in El Paso. I have a couple questions around that. One, does that include veterans who are currently in homeless shelters?

Ms. HO. I can take that if you would like. Thank you, Representative, for that. The point-in-time count, communities go out and they count people who are getting homelessness assistance, either in a shelter or a transitional housing program, and people who are outside, so those are the groups that are counted in the point-in-time count.

Mr. O'ROURKE. So what I will want to do is offline, after this hearing, see how I can bridge the divide between what the El Paso Homeless Coalition counts and El Paso for Homeless Veterans, which is 154 who are sheltered with about 60 unsheltered, and so I thought the unsheltered numbers, 56 and 60, were close enough that that is who you are counting in the point-in-time. I just want to make sure I fully understand that.

The kinds of questions I was asking Ms. Crone in terms of what should we be measuring—and I realize it is not all about data, but I do want to be able to measure those things that will give us an indication of where we have successes and where we have problems, where we need to spend our time and our resources.

And then, related to that, prior to my being sworn in in November of 2012, we learned that a very large shelter in El Paso was approached by the VA to provide homeless services exclusively to veterans and to families of veterans who are homeless, and many, many months and maybe even years went by as this shelter tried to meet all of the recommendations and mandates I guess from the VA, and they spent hundreds of thousands of Dollars in doing this, and at the end of the day, the deal fell through. And, essentially, if I could sum it up, the VA said your facility does not meet our criteria, despite the fact that it had passed every single regulation and inspection in El Paso, from the Fire Department, the Health

Department, every city code inspector, et cetera. The capacity for that shelter is exactly the number of those who are unsheltered today in El Paso. I realize this is somewhat of a parochial issue but it is very, very important to me and the people I serve.

I would love your commitment to sit down with us and go through what happened here and how it is we are going to ensure that we shelter and provide services for those who are unsheltered in El Paso right now. In other words, if there was a commitment and funds associated with that, can we get them reintroduced in the community in another way. I am running out of time, so I would love just to have your commitment to sit down with me and go over that.

Ms. PAPE. Committed. I am there. You are so close to ending homelessness, we can get there. I am happy to sit with you.

Mr. O'ROURKE. Thank you.

Ms. HO. I just want to mention that the point-in-time count happens in the third week of January, so an opportunity to participate in that would also I think mobilize the community on that.

Mr. O'ROURKE. Wonderful.

Ms. HO. And that you had 56 unsheltered veterans and 67 sheltered veterans in the January 14 count.

Mr. O'ROURKE. Okay. Thank you. I appreciate that.

I yield back.

Mr. LAMBORN. Thank you.

Representative Walz.

Mr. WALZ. Thank you.

And thank you all for your commitment on this. It is evidence of your passion, your expertise, and you care deeply. And I, for one, am grateful for that. And I said I think what you understand and the folks who have been involved in that issue, the deep implications of that holistic approach in getting that home, because for what it means, it is the restoring the dignity and to be in many cases restoring the life. And in Mankato, the homes I was talking about in Minnesota, Radichel Townhomes there, all the good things, and they had wonderful things to say about everything, but I asked a veteran there, I said, Bill, what is the best part about this. And he said, It is a place where my grand kids come that feels normal. It is that reintegration into the community. It is that grandpa's got a home. It is a place I can go. It is nothing out of the ordinary. It is grandkids visit their grandparent every day, and he is a grandparent.

And so I think your commitment on it is right. I think we are all there. I think there are different approaches to it. And I think when we have setbacks, the commitment to getting them right.

I just had a couple of questions. I want to be clear with all of you, Mr. Kelly especially on this. When I brought up a few years ago this issue of alignment, it wasn't out of criticism of any of your agencies. I think the things you do, you do incredibly well. It was more of a concern at that point in time especially the disparate nature of all of the services that were available. There were many well-intended programs, both governmental and private sector and public-private partnerships, but how to deliver them. So my question is, is the areas of expertise that HUD or DoL, are those so specific to what you do that it is most effective and efficient to reside

there as opposed to bringing the experts over to VA as one stop? I know that is a broad, and it is not meant to be a loaded question. I know it can be. I just want to get my mind wrapped around it if that is the right way to go as we see because we are at a transformation point in VA, and this is the time to talk about these things.

Mr. KELLY. Thank you for the question, and let me respond to it this way. The expertise in the whole employment arena, veterans or nonveterans, is at the Department of Labor. What is most important is collaboration amongst our fellow agencies. DoL brings to the table the employment and reemployment piece of it. Now, that is only one part. You certainly have to have the housing and the healthcare issues. So it was critical, it seems to me, that the U.S. Interagency Council on Homelessness, was created to make sure all of these things are addressed. I would offer, from our point of view, we have dealt with that very same thing at DoL with regards to employment and training. I just got back from a meeting with the Agricultural folks to look at veterans in agriculture training. Probably USDA is the best lead for that on the various programs they have. I would offer that same analogy here. It is just most important that we do TOUCH base with each other, and all come to the table with our expertise.

Mr. WALZ. And I am grateful for that. How do you respond, though, and I am sure this not a new one, and you heard our first panelists, and they are committed just like you are, and they are understanding where you are at, but they expressed that and folks express it to me that it is again navigating that disparate bureaucracy to try to get there. I say that not as a pejorative. It is just the nature of things. Private businesses have bureaucracies. Some of them are good, and some of them are bad, so it is not an either/or. How do you respond to them on that one when you heard some of the comments from the first panelists?

Ms. HO. Congressman Walz, thank you for your leadership on this and for the opportunity to speak to this. I ran a nonprofit in Minnesota for 11 years that had different Federal grants, and so sitting in the Federal Government it is a very different view. HUD knows housing, and as Lisa tells me all the time, the VA is a healthcare system. They are just very different programs. I think the magic of the work that we have done together is by being able to work together not only federally but locally to make those systems sync up so that we are drawing the expertise of the public housing agencies and the homeless assistance providers and the healthcare providers at the VA. You know, could it be done in another way? Perhaps. But the reason that we are getting close to ending veterans homelessness in communities around the country is because they just get the right people around the table focused on the same goal. And so ——

Mr. WALZ. And I agree with you. Is the next piece we are getting is that integration with the folks who were on the first panel of enhancing that? There is always going to be a certain amount of frustration. Again, I get it, if we just handed out the money and told people to do it, this room would be packed with cameras about where did the money go then. And that is our responsibility of trying to do it. Some of it would go to good places; some of it wouldn't.

I understand there is that piece of it. My question is bringing more of them in to hear, and I know you do, of seeing the first panel as partners and equal partners to what you are doing and their expertise to bring it. Mr. O'Toole, my time is almost up if you want to finish with it.

Mr. O'TOOLE. Real quickly. We are in a transformative process within the VA of going out into communities and partnering with communities, whether it is in our integrated primary care teams, all of which are doing outreach, our assertive community treatment teams doing mental healthcare in the community, as well as bringing these community agencies into the VA. It is about de-siloing, the care. I think your observation is spot on, and I think we are making progress. We aren't where we need to be yet, but we are making progress in getting there.

Mr. WALZ. Thank you. I yield back.

Mr. LAMBORN. Thank you, and thank you all for being here, for your work for veterans, for your testimony today. There will be questions for the record, and I would ask that you—oh, I am sorry. We have another member of the committee that just came in the door.

Ms. Brown, you are recognized for 5 minutes.

Ms. BROWN. Thank you, and I was watching you on television. You do this very well. Thank you. First of all, I want to put on the record that I am grateful for the work that Secretary Shinseki did as far as cutting down the homelessness problem that we have experienced in this country for a number of years. And so when history is written, he certainly should get the credit for cutting it down to one-third as we celebrate. And I am also grateful that we just got over $600,000 in my area for the HUD voucher program. One of the questions that I raised earlier is there doesn't seem to be adequate beds for female veterans, in particular those with families. Can we address that, please?

Ms. HO. I would be happy to take that question, Congresswoman. Thank you for that, and thanks for the opportunity to talk about the way that we are targeting towards female veterans. First of all, we track the number of female veterans that are appearing in our shelter system, and we track the number of female veterans that get access to the HUD–VASH program. And so what we know is that HUD–VASH is serving female veterans and their children at a higher rate, and we are doing some specific targeting around that, understanding that a mom with kids is in a uniquely vulnerable situation. So one of the great uses of HUD–VASH is really around targeting around moms and kids.

To the question of how much housing is needed, this really is an area where the work that we are doing with specific communities is very focused because historically, if you took a look at the way that homelessness programs worked, they worked largely in isolation. And one of the big transformations that is going on right now is around this concept of coordinated assessment, kind of a one-stop shop, with kind of a triage referral. But also helping communities recognize every single resource that they have and then looking at the numbers and figuring out what the gaps are and strategizing around how to fill those gaps in a very deliberate way.

It sounds like just good strategic planning, but historically, that is not necessarily the way that communities operated. Homeless programs operated in isolation. Nobody had a good count of all of the resources. There wasn't a good understanding of the difference between the number of people experiencing homelessness on a single night versus people who come through the system over time. So we are getting smarter in all of those areas, and that is helping communities do these gaps analyses to figure how much of what do we need, and equally importantly, are there things that we used to need when we were doing it the old way that we are not going to need as much of any more.

Ms. BROWN. Thank you.

I had read in the paper that they were cutting out meals because the city was cutting back on programs of the State, so I called in the Department of Agriculture. And they came in, and so the groups came together and did a grant. And they are working together. So it is not just HUD. It is all of the stakeholders working together to make sure that we do everything we need to do to fill those gaps in.

Ms. HO. I had the pleasure of working at the U.S. Interagency Council on Homelessness before I came to HUD, and that is 19 Federal agencies working together on a single Federal strategy, and that is the first time that this level of collaboration not only with the partners that I have at the table here today, but the other agencies that are part of it. Everybody shows up, and everybody is trying to figure out what is our piece of getting this job done.

Ms. BROWN. Thank you very much, and thank you for your service.

And, Mr. Chairman, I yield back the balance of my time.

Mr. LAMBORN. Thank you, and I will, once again, thank you all for being here, for your work to help veterans.

There will be questions for the record, and I would ask that you respond to those in writing. The second panel is now excused. I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material. I would also like to thank once again all of our witnesses on both panels and audience members for joining us this morning. Merry Christmas and Happy New Year, and this meeting is now adjourned.

[Whereupon, at 1:52 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE CHAIRMAN JEFF MILLER

Welcome to today's Full Committee oversight hearing—the last of the 113th Congress—"Evaluating Federal and Community Efforts to Eliminate Veteran Homelessness."

At this time of year perhaps more than any other, the thought of anyone—particularly anyone who served our nation in uniform—without a home or a safe place to sleep is simply heartbreaking.

Unfortunately, homelessness—or the constant threat of it—has become a way of life for far too many of our nation's veterans.

In 2009, the Department of Veterans Affairs (VA) initiated a five-year plan to eliminate veteran homelessness and, as that deadline fast approaches, I am pleased

to report that VA has succeeded in reducing veteran homelessness by approximately thirty-three percent.

Yet, as long as a single veteran struggles with housing instability or homelessness, our work remains.

Troubling, a VA Inspector General (IG) report issued just last week found that VA's National Call Center for Homeless Veterans missed well over forty-thousand opportunities to link homeless veteran callers to VA medical facilities and ensure they received needed services.

Some of these missed opportunities resulted from the unavailability of Call Center staff during peak business hours when veteran callers were transferred to answering machines instead of Call Center employees.

This is unacceptable for any government program but particularly for one that serves a population as vulnerable as this. A population that for some, the ability to merely make a phone call is logistically challenging.

I look forward to hearing today how VA is correcting the serious deficiencies that the IG found and holding those at fault accountable for their management and oversight failures.

Unfortunately, the Call Center is just one concern I have with VA's many homeless programs.

Based on information from VA, the Department has roughly twenty different programs designed to get homeless veterans off the streets and provide them with housing, healthcare, and employment assistance.

The Departments of Housing and Urban Development and Labor also have programs aimed at achieving these same goals. I am encouraged to see the level of cooperation between these government agencies.

I understand that homeless veterans are a varied and complex group and one program alone cannot effectively treat the unique needs of them all.

However, the plethora of different programs that are in place today beg the question of whether significant overlap exists that both wastes taxpayer Dollars and limits the effectiveness of any single program's ability to effectively care for veterans in need.

I also have concerns about the increasingly insular focus the Department is placing on "permanent" housing.

Except for the very few veterans for whom housing instability may be a lifelong concern due to underlying health conditions, the foremost goal of every program serving homeless veterans should be providing a bridge to an independent, purpose-filled life—not a permanent, government-sponsored home.

Over the last several years, the American taxpayer has devoted record amounts of their hard-earned Dollars to eliminating veteran homelessness, with funding for targeted homeless programs increasing by almost three-hundred percent and funding for healthcare for homeless veterans increasing by more than eighty percent since fiscal year 2009.

But despite this considerable investment, veteran homeless will never be completely eliminated so long as veterans struggle with underlying health conditions and economic crises.

Quickly and effectively diagnosing and treating those underlying health conditions and providing veterans who are able with job training and placement services is critical to empowering homeless veterans to successfully reintegrate into stable community environments.

To truly honor and respect the service of a homeless veteran is to provide him or her with a pathway to a life of dignity and self-sufficiency, not just four walls and roof.

PREPARED STATEMENT OF RANKING MEMBER MICHAEL H. MICHAUD

Thank you Mr. Chairman.

The VA's goal of ending veteran homelessness by the end of 2015 is an ambitious goal. Remarkable progress has been made by VA to meet this challenge, but there is much still that remains to be done.

As we all recognize, VA cannot meet this goal alone—it will take the concerted action of the Federal government and the assistance of organizations and individuals all across the country.

I look forward to the hearing today so that we can evaluate the effectiveness of this effort, and applaud the real progress that has been made.

According to reports, homelessness among veterans has declined by 33 percent, to roughly 50,000, since 2010.

This is an accomplishment we can all take pride in, but there are still homeless veterans, and it is simply unacceptable that any of our veterans do not have a roof over their head.

I am also concerned that we are not taking adequate steps to address special populations, such as homeless women veterans and those that need serious and sustained assistance.

Today's hearing provides us with the opportunity to continue this discussion. It provides us with the opportunity to discuss how we define the goal of ending veteran homelessness, the resources that need to be committed, and the work that remains to be done in the year ahead.

I am excited about today's hearing, but it is also bittersweet for me.

This marks my last hearing as a Member of this Committee, and this Congress.

Although I am looking forward to the opportunities and challenges that lay before me in the years ahead, I will miss this Committee and the work that it does.

To the incoming Ranking Member, Ms. Brown, in your 22 years on this Committee, you have been a strong voice for veterans and the VA. Congratulations, and I hope you enjoy being Ranking Member as much as I did.

To my fellow Democrats on the Committee, I cannot thank you enough for the work you have done. You have made it very easy for me to serve as Ranking Member. I appreciate the energy and the new ideas you have brought to this Committee. I hope you will all continue our efforts here in the next Congress and in the years ahead.

To my friends on the other side, I applaud you and thank you, too, for your efforts. I cherish the friendships that I have with many of you. This Committee is truly a special place. Although there are times when we share different perspectives on how best to serve our veterans, we often worked together, without regard to party and without the usual rancor that many believe is elemental to the legislative process.

I hope the American people look to this Committee as a model, and insist that their representatives do what we do so easily here—work together to get the job done.

I wish to thank our staff, on both sides of the aisle. They work tirelessly, often with little credit, to make this Committee function and to do their best for veterans. I want to thank Nancy and my staff on this side of the aisle for your tireless effort. I want to thank John Towers and the Republican majority staff as well. The committee staff has done a phenomenal job over the last couple of years. I really appreciate the work that you have done, especially the administrative staff who do the day-to-day tasks that enable everything around here to function, and make us look good.

I wish to thank the many employees at the VA, and their efforts to care for and serve veterans. Too often media headlines level broad accusations against all VA employees, and not just the few who have performance issues. There are good news stories, and there are good VA employees.

I wish to thank the VSOs and veterans who work with us to make real the promises that this nation has made to all of our veterans. You are partners in our efforts and essential to our work. Keep up the good fight!

Finally, Mr. Chairman, I really do appreciate our friendship over the years. And as you mentioned, we meet a lot of individuals here in Congress. A lot we consider friends. There are some we consider friends in a more special way. I consider you a very good friend. We have switched roles over our time as Members of Congress; me being chair, you being ranking member and vis-α-vis. And I really appreciate your openness, your willingness to listen to me as a minority member and as a ranking member. I want to thank you very much.

I know you have talked on the House floor, and in this committee about coming to the State of Maine, about how you want to be able to shoot a moose. Hopefully, you will not forget that dream. In the meantime, I have something I would like to present to you, Mr. Chairman.

In Maine, in the woods, moose lose their antlers. I have a constituent that goes through the woods to collect discarded moose antlers to carve. This is the half of a moose antler carved with an eagle's head.

Mr. Chairman, I would like to present it to you in your drive to actually get a full moose in the State of Maine. And I would like to present this to you as a parting gift for your friendship and your loyalty. But also, for the work you have done for veterans over a number of years, putting aside partisan politics to do what is right for our veterans. So here is a freedom antler with an eagle from the State of Maine. Thank you, Mr. Chairman.

Thank you, and I yield back the balance of my time.

PREPARED STATEMENT OF BAYLEE CRONE, NATIONAL COALITION FOR HOMELESS VETERANS

Chairman Jeff Miller, Ranking Member Michael Michaud, and distinguished members of the House Committee on Veterans' Affairs:

Thank you for the opportunity to appear before this Committee today. My name is Baylee Crone and I am the Executive Director of the National Coalition for Homeless Veterans. On behalf of the more than 2,100 community and faith-based organizations NCHV represents, I would like to thank all of you for your steadfast commitment to serving our nation's most vulnerable heroes.

This testimony will focus on our understanding of the progress made to end veteran homelessness in this country, particularly:

- National progress made toward ending veteran homelessness.
- Matching services to the needs of homeless and at-risk veterans.
- Successes of permanent housing, transitional housing, employment, and prevention interventions.

Additionally, this testimony will outline the benefit of coordinated outreach and intake systems in rapidly directing veterans to the local services that meet their most immediate needs.

National Decline in Veteran Homelessness

The national decline in veteran homelessness since 2009 is without precedent. The success we have seen to date, and our future success relies on the strengths of VA's front lines—the community providers and VA case managers who fight the daily battle to do more, better and faster. The momentum is on the side of rapid change, and we are closer than ever to achieving our mission of effectively ending veteran homelessness. However, ending veteran homelessness is not a moment; it is a moving target.

To make progress toward our mission, we must see drops in the Point in Time (PIT) count, but that is not the only aspect of change we must see. We must see immediate engagement of services when a need arises, rapid response to those on the streets, and a continuation of successful permanent housing placement. We must empower community agencies to meet specific needs of individual veterans using targeted services through data-driven programs.

As the number of veterans on the street and in temporary shelter goes down, we will need to be more, not less, diligent in ensuring that we provide a hand up to those who remain on the street and find themselves at high risk. We will end veteran homelessness, but reaching that benchmark happens when the systems in place are ready and able to immediately meet a veteran's needs should he fall into homelessness or be at high risk. As we make progress, resources will need to be redeployed, not withdrawn.

Across the country, our community organizations and VA partners are stepping in with a safety net and a hand up to self sufficiency and independence. We are fostering empowerment, we are halting cycles of abuse, and we are educating and protecting. These activities may not show up in a point in time count, but they are, and will continue to be, the actions protecting against homelessness for many veterans.

National Declines: The Point in Time Count

Looking at one measure, the 2014 PIT count, tells an important part of this story: on a single night in January, 49,933 veterans were homeless. This 33 percent decline since 2009 is more than a statistic—it represents a real, measurable, downward trend in homelessness among veterans. Veteran homelessness dropped 10 percent in one year, representing the steepest decline since veteran homelessness dropped 12 percent from 2010 to 2011. Homelessness among unsheltered veterans dropped 14 percent in one year, representing a greater than 40 percent decline since 2009. These significant drops happened as community organizations and VA Medical Centers (VAMCs) have improved outreach and targeted services for those with the most significant barriers. The challenges remain daunting, but they are surmountable with close coordination of complementary programs on the local level.

While the PIT count presents a useful benchmark for tracking progress, it only shows part of the picture of who experiences homelessness throughout the year and who receives services from VA and other community programs. The PIT count is a snapshot; other data build out a more nuanced scene of the challenges we face and the road ahead.

National Declines: Beyond the Point in Time Count

In FY 2014, 80 percent of unsheltered veterans moved out of unsheltered status within three days. As VA stated in their annual report, "this metric pushes the sys-

tem to move literally homeless veterans off the streets and into safe and stable temporary housing." In that same period, 50,730 veterans achieved permanent housing through the Supportive Services for Veteran Families (SSVF) program, far outpacing the VA's goal of 40,000. These data points begin to show us the full picture: veterans are engaging VA when they need help, are moving rapidly off the streets, and are successfully moving into permanent housing.

The VA has also innovated to improve efforts on the ground. The VHA Programs Office updated its Homeless Gaps Analysis to include quarterly actual data and VAMC operational strategies. They also launched the 25 Cities campaign to promote community-based solutions to ending veteran homelessness in high-need areas. The picture gains more clarity: results are being meticulously and consistently tracked to improve targeting to meet specific local and individual needs. The system has improved, and it is working.

Looking at the PIT count, service usage trends, and changes in data processing helps us to track progress, but still, the full picture of change is not clear with this information alone. The stories of homelessness are pervasive in our work: an elderly veteran on a fixed income loses his roof in a bad storm but cannot afford to fix it; a mother with debilitating post-deployment headaches is unable to work and must choose between asking for help and keeping her family together; a recently transitioned young veteran living in his car struggles to keep up in school to retain his GI Bill.

Matching Needs to Services

At NCHV, we demand that individual needs match specific services. We do not have a "homeless veteran population"—we have individual veterans who are homeless and who have specific and unique needs profiles to be addressed through a coordinated system of care. Wherever chronic, episodic and recent, or at-risk homelessness exists, the VA and its community partners must be ready and armed.

Needs of Chronically Homeless Veterans

We see veterans who are chronically homeless. Those individuals make up the majority of the unsheltered point in time count numbers, and are those targeted through the HUD–VASH program. As of September 30, 2014, 91 percent of vouchers allocated to local communities for HUD–VASH led to permanent housing. Of those admitted into the HUD–VASH program, 71% met the definition for chronically homeless. By exceeding its target of 65%, VA showed a commitment to ending homelessness for those most vulnerable veterans in need of the intensive services offered by HUD–VASH.

These data points are built on a foundation of behind-the-scenes coordination. Progress has required collaboration between the local Public Housing Authorities, local landlords, and VA personnel and grantees. Through this collaboration, they have identified high-need homeless veterans, streamlined verification, inspection, and approval processes, and rapidly placed these veterans into available housing units.

Needs of Episodically and Recently Homeless Veterans

We see veterans who are episodically or recently homeless. Those individuals make up a large portion of the sheltered homeless count, a smaller portion of the unsheltered count, and a significant portion of those needing services who are outside of formal counting systems. They are couch surfing and in and out of transitional housing, shelters, and treatment programs.

These veterans connect to services through an extensive local outreach network. In communities across the country, homeless veteran service providers partner with the VAMC, community clinics, and Continuum of Care partners to ensure that homeless veterans seeking care encounter a "no wrong door" approach to outreach: no matter where the veteran accesses services, he is assessed and referred to the local agencies that can best meet his specific needs.

If the veteran needs a place to sleep that night and services while a housing plan is developed, intake workers can refer him to residential treatment programs through VA, like Grant and Per Diem (GPD). As of the end of FY2014, VA had reached its annual goal for discharging veterans into permanent housing from GPD. If the coordinated intake process identifies the need for employment assistance, the veteran can be referred to a local Homeless Veteran Reintegration Program (HVRP). This program placed over 10,000 veterans into gainful employment in FY2013, with a cost per placement under $3,000 per veteran.

Again, improved results rest on the shoulders of behind the scene changes. GPD programs across the country are lowering barriers to entry to make services more accessible. They develop service menus based on each individual veteran's goals so that the transition from homelessness to stable housing is a rapid and sustainable

one. HVRP grantees have integrated innovative employment placement strategies into their programs, continuing to successfully place homeless veterans in competitive employment even in a challenged economy.

Needs of At-Risk Veterans

We also see those who are at risk of homelessness. These veterans may be one lost paycheck, one expensive utility bill, one broken down car away from losing their housing stability. They are often not counted in the Point in Time count, but they are here at our doorsteps and are often engaged in services through the Supportive Services for Veteran Families Program (SSVF). In FY 2013 alone, over 44,000 veterans and veteran family members were assisted through homelessness prevention SSVF resources. The data shows that these individuals obtained and maintained housing: among veterans receiving SSVF prevention services and exited to permanent housing destinations, 90 percent did not use VA homeless services within a year after their exit from the SSVF program.

Magnifying Impact through Coordination of Services

We can end chronic homelessness; we are already doing it through HUD–VASH and Housing First. We can functionally end episodic and recent homelessness; rapid rehousing infrastructure, transitional housing, and income interventions are joined together to make this happen. We can get ahead of homelessness through prevention; SSVF serves more veterans and their families more cost effectively every single year. The full picture is complicated, but it is lit up with hope.

Ending veteran homelessness starts with the veteran, and people are complicated. Some individuals with complicated needs profiles will be served by several programs. This does not mean that services are being duplicated, but rather that organizations and programs work together to address specific barriers to permanent housing.

Serving Chronically Homeless Veterans

Targeting chronically homeless veterans for rapid placement sometimes requires utilization of other programs to fill needs when no other resources exist in a community; this could include SSVF for security deposits in competitive rental markets or GPD as bridge housing between living on the streets and moving into housing while a unit is inspected and approved.

Serving Episodically and Recently Homeless Veterans

Serving episodically or recently homeless veterans, especially those who do not qualify for HUD–VASH, requires bridge housing and employment and income services to make affordable housing within reach. This could include pairing the vocational services of an HVRP case manager trained in labor market information and employment placement with the benefits and transitional housing services of a GPD program. A veteran may be referred to both programs, but for complementary, not duplicative, services. Utilizing some aspects of both programs, the veteran will obtain enough income to afford an apartment on his own.

Serving At-Risk Veterans

Sustaining at-risk veterans in the housing they have requires quick action and creative coordination; this could include a utility bill paid through SSVF and the intervention of another community organization with a strong landlord relationship to prevent an eviction. Because of their longstanding reputation for service in local communities, this community organization is often a GPD provider.

Evolving Needs, Evolving Programs

Needs will never disappear, but they are already evolving—and programs are adapting to them. SSVF has evolved based on constant feedback and best practices, and it is serving more vulnerable veterans per Dollar every year. HUD–VASH's integration of Housing First principles gives strong case management and consumer choice the driver's seat in collaborative care. HVRP's adoption of Job-Driven Training and connection to American Job Centers and DOL labor market information allows homeless veterans to receive front-line connection to gainful employment.

We believe in and will defend effective deployment of targeted resources to fuel research-based interventions when and where they are needed. We must be diligent in the collection of empirically sound data so programs and the organizations executing these programs are responsive locally. They will need to continue to magnify impact by simultaneously addressing various barriers. Local programs are our force multipliers, pulling the entire community into the mission of ending veteran homelessness through the gravity of its importance.

At NCHV, we do not advocate for the unqualified growth of resources for the sake of expanding programs. We believe a surge is still needed now, not because we set a goal for 2015 and want to check a box, but because we have the momentum now

to make it happen. Building and sustaining those strongholds requires maintenance of infrastructure so homelessness is not simply paused, but truly stopped.

In Summation

Thank you for the opportunity to present this testimony at today's hearing. It is a privilege to work with the House Committee on Veterans' Affairs to ensure that every veteran in crisis has access to the support services they have earned through their service to our country.

Baylee Crone, Executive Director,
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NCHV Disclosure of Federal Grants

Grantor:	U.S. Department of Labor
Subagency:	Veterans Employment and Training Service
Grant/contract amount:	$450,000
Performance period:	February 2014 – February 2015
Indirect costs limitations or CAP limitations:	20 percent
Grant/contract award notice provided as part of proposal:	No

PREPARED STATEMENT OF STEVEN R. BERG, VICE PRESIDENT FOR PROGRAMS AND POLICY NATIONAL ALLIANCE TO END HOMELESSNESS

Chairmen Miller, Ranking Members Michaud, and members of the Committee, on behalf of our Board of Directors, our President Nan Roman, and our thousands of partners across the country; thank you for providing the National Alliance to End Homelessness the opportunity to testify today. We are grateful to you for holding a hearing on veterans homelessness and what we are doing and can do to end it. The National Alliance to End Homelessness works closely with federal policymakers as well as with state and local government, businesses, nonprofit organizations and many others who believe that homelessness should not be tolerated in the United States.

Homelessness Among Veterans

Our nation witnesses far too many veterans living on the streets. The number of homeless veterans has declined substantially in recent years, but is still far too high. While most veterans are well housed, a substantial minority are burdened with high housing costs, which combined with other factors can leave them at risk of homelessness. As a nation we have undertaken a concerted effort to solve the problem, which is a good thing, since without that effort there are many reasons to believe that the problem would become worse. Thousands of Americans are returning from the Middle East, with the kinds of demographic traits and disabilities that we know to be risk factors for homelessness, to an economy with unemployment that is still too high. Without continued hard work, there would be a grave possibility that an entire new generation of veterans will become stuck in homelessness.

It is important to recognize that not all homeless veterans are the same. At the one extreme, some homeless veterans have severe disabilities, particularly related to behavioral health, and have lived on the streets or in shelters for long periods of time. This pattern has been referred to as "chronic homelessness," and it costs taxpayers substantial money in emergency healthcare, jails, shelters and other emergency "services." Returning these veterans to safety and housing often requires long-term rent subsidies, and intensive social services and medical care.

While this is probably most Americans' stereotype of what a homeless person is like, and while there are certainly a percentage of homeless veterans who are like this, it is a minority. Most veterans and other Americans who experience homelessness do so because of personal economic crises. They do not have profound disabilities. Their lack of housing is often a serious barrier to getting their lives back on track; but program models knows as "rapid re-housing" have shown that if that barrier is removed through return to housing, they can succeed through their own devices or with short-term help to afford housing.

The Alliance is enthused and hopeful in light of the work that has already been done and the reductions that have already occurred. The federal government's part in this work is being carried out pursuant to a commonsense plan, organized around

a clear understanding of the problem and a commitment to solve the problem. The rest of this testimony will review what has happened so far, and what needs to happen between now and the end of 2015 to bring about the best possible results.

What's Been Done, What Remains to do to House All Homeless Veterans

In 2008 the Alliance presented testimony at a hearing held jointly by the Senate Appropriations subcommittees with jurisdiction over VA and over HUD. The topic was what to do about homelessness among veterans. At that point we talked about how we as a country needed to take four big steps in order to end homelessness for veterans. I am happy to say today that VA, HUD and Congress have taken three of those steps, and are in the middle of step four. We could still stumble, we could still not succeed; but if we finish what's been started in the right way, we can see the number of homeless veterans fall substantially, to the point where communities that use the help available to them and follow through can end veterans homelessness by the end of 2015.

Step one: "command and control" infrastructure. Step one was to put in place a national plan and monitoring system that would be based on real data to determine what is working, what isn't, and how much progress is taking place. That piece is in place. The creation of the National Center on Homelessness Among Veterans has been extremely important in this regard. The Center, a joint project of VA and the University of Pennsylvania, provides a context for leading national experts on homelessness to use the rich data that is available on the use of VA programs, combined with other research and data on homelessness. The close cooperation of the National Center with the program offices within the Veterans Health Administration, and with staff in the Secretary's office, provides a "command and control" function that is essential.

Step two: a full range of interventions. Step two was to expand the range of program models to make effective practices available for the full range of veterans who are homeless. This, too, has been accomplished. At the time, in 2008, most housing for homeless veterans was being provided through the Homeless Grants and Per Diem program, a two-year transitional housing model. This is a model that works very well for certain people, but we believe anyone running such a program would agree that it is not for everyone. To end homelessness requires a range of programs so that everyone can get what he or she needs. As noted above, some homeless veterans, particularly those experiencing chronic homelessness, have permanent disabilities combined with other issues that make a transitional program unrealistic for them. The HUD–VASH program was put in place to address these needs. On the other hand, people who become homeless due to a short-term economic emergency can escape homelessness with short-term help to deal with that crisis. The "rapid re-housing" model, implemented at VA through the Supportive Services for Veteran Families program, has proven extremely effective at ending homeless for this group, at substantially less cost than either permanent or transitional supportive housing programs.

It is important to note that there are eligibility issues. Not everyone who served on active duty in the military is eligible for these programs, because of discharge status or the complex rules relating length of service and the era in which a veteran served. This has been further complicated by recent statements by VA. Our hope is that some of these issues can be resolved by Congress; and that better coordination of discharge upgrade programs carried out by veterans service organizations with homelessness programs will resolve the issues for some; and that HUD-funded and other programs can, despite the financial stress that they are under, re-house the rest.

Step three: Go to scale with program capacity. Step three was to fund those various interventions at the scale necessary to get the job done. As of this writing, VA budget requests and Congressional appropriations are on the verge of getting this done as well. Our estimate is that if Congress funds VA's FY 2015 budget request, it will finish the job of putting money on the table for communities to be able to provide housing, through HUD–VASH, GPD, and SSVF, for every veteran who experiences homelessness today and through the end of 2015. SSVF is the newest of these programs, and it has proven to do exactly what it sets out to do. VA has requested permission to move funding from other parts of its budget to increase grants to communities for SSVF, based on the latest solid data about what is needed.

Step four: making it work at the community level. That brings us to step four, which is for every community to organize itself so that every homeless veteran is located, identified, and matched up with the right intervention to end his or her homelessness; and that these interventions work at peak efficiency, focused on quickly re-housing every homeless veteran they serve. We as a country are in the

process of taking that step. VA is mobilizing its staff at local medical centers to make this happen. Mayors are taking part in campaigns to get other mayors to commit to this. Providers from the HUD-funded homelessness system are reaching out to VA-funded providers to share information and coordinate their work. The Alliance, based on years of work with communities that have succeeded in reducing the number of people who are homeless, believes that there are five key things that need to happen at the community level:

- Leaders in each community need to oversee the effort, using a solid plan and data to monitor progress.
- Communities need to set clear numerical goals for how many veterans need to be housed, how quickly.
- Leaders, program operators, and others need to be accountable for taking the specific actions they have committed to.
- Proven strategies need to be implemented in a skillful way: outreach, crisis housing, rapid re-housing, permanent supportive housing, and a coordinated system to ensure that each veteran gets access to the program that's right for him or her.
- Leaders need to communicate with the entire community about what is getting done, and what help is needed, particularly by landlords and employers in the community.

VA needs to make every possible effort to get its employees, grantees and contractors behind making sure that these five things are happening. VA has a number of efforts under way to provide technical assistance that will help make that happen.

Making Sure Homelessness Stays Ended

When these four steps are complete, there will be few if any veterans who remain homeless on a given night. Which leads to the next step, the first step beyond veterans homelessness—to put in place a system that will find vulnerable veterans before they ever become homeless, and prevent their homelessness entirely. We are quite a way from having such a system. For the time being, ending homelessness will mean that while additional veterans may become homeless, as soon as a homeless veteran is discovered, help is there to provide whatever is needed in order to end that instance of homelessness. Programs to find veterans who become homeless, ensure their safety, and rapidly rehouse them will need to continue in place. This system will need to transition over time into an effective system of homelessness prevention. In the end, a prevention system will employ the kind of research and data analysis that the National Center already has under way. It will require careful thought about the right kinds of interventions, and how they should be targeted to veterans who would most likely become homeless without them. It will require work by this Committee and others to redeploy these resources so that we can all say, never another homeless veteran.

Congress's Part

Besides oversight of the ongoing effort, there is work for Congress to do in order to bring this result about. Most important are the following:

Ensuring that funding remains available. The appropriations committee has responded well to VA's budget requests for these efforts. There is, however, great uncertainty over the federal budget over the next few years. As those discussions take place, it will be important to stand behind the work to end veterans homelessness.

Short-range fixes. There are some minor changes needed to federal statutes to remove certain barriers to implementation. These changes should be made via the earliest possible legislative vehicle. They are the following:

- Provide VA with more flexibility to use funds for the programs that are needed most at the time. The current limit of $300 million per year for SSVF, in particular, underfunds this program and should be raised to "such sums as are necessary."
- Codify existing eligibility rules for VA homelessness programs. For many years, the GPD and now the SSVF program have served homeless veterans with various other-than-dishonorable discharges, even if, because of complicated rules regarding era and length of service, the veterans are not eligible for the full range of VA health services. A recent communication from VA, now suspended, called this practice into question, based on a new reading of statutes. Estimates by providers indicate that as many as 15 percent of homeless veterans would be left without help from these effective programs is this ruling were to go into effect. Congress should at least clarify that these veterans are eligible for these homeless services.

- Authorize the National Center on Homelessness Among Veterans. As noted above, this Center provides a forum for expert examination of VA and other data and research, ensuring that VA's practices are informed by the best possible analysis. To have it authorized in statute would ensure ongoing support as the U.S. makes the challenging transition from solving the problem of veterans homelessness, to ensuring the problem never recurs.
- Ensure VA has waiver authority to allow changes in GPD. Many GPD providers are finding that reductions in the number of homeless veterans, and the focus by VA on moving further in that direction, are causing severe difficulties. Congress should provide VA with waiver authority to allow GPD providers in communities where veterans homelessness has declined substantially to experiment with different models, including very short term housing for veterans experiencing housing crisis; and recovery housing for veterans who were but are no longer homeless, but are recovering from addiction or other severe difficulties.

Longer term statutory change to prevent veterans homelessness from recurring. Existing VA programs that were designed to serve homeless veterans will need to do different things and serve different people when the number of homeless veterans is very small. They will, however, need to be there, to provide help when veterans have crises that leave or threaten to leave them without places to live. To move to a prevention-based homelessness system, there will need to be careful thought about what services are needed, which veterans need them, and how incentives can be established that will reward providers for effective work. This project should be undertaken and completed by the next Congress.

Promote the local efforts. Every member of the U.S. Congress is a leader in his or her local community. As noted above, success at ending homelessness requires local commitment and local action. The Alliance encourages members of this Committee, and all members of Congress, to get involved with the issue locally, and do what they can to make sure that the communities they represent understand what they have to do to bring the number of homeless veterans down to zero.

Steven R. Berg

Curriculum Vitae

Experience:

Vice President for Programs and Policy, National Alliance to End Homelessness, October 1997 to present (previously Director of Programs).

Senior Policy Analyst, Center on Budget and Policy Priorities, September 1996 to September 1997.

Staff Attorney, Connecticut Legal Services, September 1990 to August 1996 (Norwalk and Bridgeport Offices).

Executive Director, Legal Aid Foundation of Santa Barbara County, August 1987 to August 1990 (previously Staff Attorney).

Staff Attorney, Contra Costa Legal Services Foundation, September 1983 to August 1987.

Education:

Harvard Law School, J.D. 1982.

Lewis and Clark College, B.A. 1978.

Disclosure

The National Alliance to End Homelessness is party to a subcontract to provide technical assistance to communities, as part of a contract with the U.S. Department of Veterans Affairs. Under this subcontract the Alliance will be paid a maximum of $130,000 for its work.

PREPARED STATEMENT OF JOHN F. DOWNING, CHIEF EXECUTIVE OFFICER

Chairman Miller and members of the Committee, I am honored to be here today on behalf of Soldier On and the 3,815 veterans we serve each year. Soldier On has become the largest provider of supportive services to veterans in the United States and operates eight SSVF (Supportive Services for Veteran Families) grants throughout five eastern states. This was accomplished with early assistance from Congressmen Richie Neal and James McGovern of Massachusetts. With the help of Congressman Chris Smith of New Jersey and Congressman Chris Gibson of New York, Soldier On has also been able to expand its SSVF services to 36 counties in New York and 8 counties in New Jersey. In addition, Soldier On serves 76 Counties in Mis-

sissippi, 23 counties in Pennsylvania, and the four counties of Western Massachusetts.

Next year, we are slated to increase our breadth of service and assist more than 5,315 veterans and family members with a special focus on the chronically homeless veterans whose lives are reduced by an average of 20 years compared to their stably housed counterparts.

The Department of Veterans Affairs' goal to end veteran homelessness by 2015 was not a goal that could take place without examining and combatting the underlying effects of poverty that cause homelessness. The lack of safe, affordable housing with services on-site has allowed veterans in poverty and those suffering from untreated and undertreated mental health and addiction disorders to be left forgotten and alone in their prolonged states of homelessness. Eliminating homelessness requires society to look at the causes of poverty, which are rooted in a capitalist society and its impact on the standard of living and lack of educational/vocational training opportunities. The reality is that our goal has been to bring each homeless veteran back to the center of their life.

With great help from the National Director of Homeless Programs, Lisa Pape, Soldier On became a leading Grant/Per Diem shelter bed provider for the VA and realized that we needed to provide veterans with a stable living facility with services delivered where they live. Soldier On has built a first of its kind limited equity cooperative in Pittsfield, Massachusetts that has become home for 39 formerly homeless veterans. The safe, sustainable, affordable housing development was honored with a HUD Doorknocker award in 2011 for its quality and innovation in assisting veterans. Transportation and case management, along with medical and mental health services are delivered to each veteran where he or she lives so that appointments are met and the veteran receives the support necessary to ensure success and dignity. Currently, Soldier On is in the development phase of constructing eight more of these facilities throughout the East Coast including one on the grounds of the VA in Leeds, MA. This enhanced use lease project received great support from Paul Macpherson and will utilize VAi2 funds and will be a first of its kind project in which the VA and Soldier On will partner to serve veterans in limited equity units of their own.

Soldier On has made a commitment to partner in SSVF with agencies which have a history with tenancy preservation and housing search upgrades for eligible veterans as well as mentoring programs that train and enable veterans to provide services to keep them safely housed. We couple these services with a housing resiliency stabilization program that works with "high risk" veterans in need of rapid rehousing and support. These veterans can call into our hotline which is staffed 24 hours of the day so that a case manager can be sent to a veteran's home within 48 hours to address their individual needs. As a result of this, we found our costs were driven down. These SSVF supportive services cost an average of $2,400 to $4,400 for at-risk veterans in need of housing who are not getting VA care compared to the $42,000 it costs for a veteran who is in GPD care.

The VA is continuing to try to provide services using a medical model which does not and cannot help all homeless and at-risk veterans, and often leaves the most disconnected of them unserved. Following a model promoted by Vince Kane and the VA National Center on Homelessness Among Veterans in Philadelphia, we must divert the current VA funding to proactive programs such as Housing First with services delivered to veterans where they live. The VA needs to become more community based and responsive to partnering with community providers in offering integrated housing, healthcare and employment services where the veteran lives so that we can create an environment in which veterans can heal. We must look at the mind, body, and spirit together. We can't just divide a person into parts and disorders that we can treat in different silos. This creates a cost system that is dehumanizing and degrading to the men and women who served our country. Delivering services to people where they live eliminates decompensating episodes, non-compliance, and relapse.

By providing veterans with Housing First, services delivered to where they live, and training for employment opportunities, we can strengthen our veteran communities and restore the dignity and support that has been taken from veterans after years of neglect and disservice.

Thank you for your time.

John F. Downing, Chief Executive Officer Soldier on, 421 North Main Street Building 6, Leeds, MA 01053, 413–822–8364

The Fight Doesn't End When They Get Home,

421 North Main Street Building 6 Leeds, MA 01053 (413) 582–3059 and 360 West Housatonic Street Pittsfield, MA 01201 (413) 236–5644 *www.wesoldieron.org*

PREPARED STATEMENT OF PHIL LANDIS, PRESIDENT AND CEO VETERANS VILLAGE OF SAN DIEGO

As a matter of disclosure you should be aware that I am a member of the VA Advisory Committee on Homeless Veterans and I am neither speaking for the VA nor the Advisory Committee today.

VVSD is a nationally recognized non-profit and non-governmental organization that has served veterans since 1981. Using five pillars: prevention, intervention, treatment, aftercare, and employment services, VVSD assists veterans who have substance abuse and mental health issues, including men and women recently returned from Iraq and Afghanistan. Working with addiction case managers and mental health professionals, residents rebuild lives, repair relationships, and return to society as productive citizens.

Veteran Treatment Center (VTC)

Factors underlying Veteran homelessness such as mental health issues and substance use disorders are often related to conditions and experiences veterans encounter during their time in service to our country. (e.g., Military Sexual Trauma (MST), Combat injuries treated with opiates). All too often, the very medication used to treat their pain leads to a physiological dependency on opiates. When the opiate medication is stopped, many experience withdrawal symptoms and seek out ways to 'self-medicate'. Unfortunately, many of these men and women "treat" their withdrawal symptoms by using street drugs, such as heroin. This predictable path often results in failed drug screens and separation from military service. They are often denied honorable discharge making them ineligible for VA Healthcare benefits. This administrative separation results in lost jobs, lost income, lost housing, and lost benefits which results in addicted veterans being homeless on the streets and unable to obtain lifesaving services. The VA is committed to three month long research studies with veterans to determine new evidence based practices and treatment protocols. These 12 week group treatment research programs unfortunately do not provide for ongoing individual therapy or follow up.

The emphasis on permanent housing first is an admirable and reasonable idea for many homeless veterans. However, for veterans with co-occurring disorders, housing without treatment is a major risk factor for those in need of higher level of services. The absence of Shelter Plus Care options for these homeless veterans makes remaining sober and stabilized on psychotropic medications nearly impossible if housed alone. If untreated or unmanaged, these diseases are progressive and life threatening.

Citation:

Protective Factors and Risk Modification of Violence in Iraq and Afghanistan War Veterans. (767–773) Eric B. Elbogen, PhD.; Sally C. Johnson, MD; H Ryan Wagner, PhD; Virginia M. Newton, PhD; Christine Timko, PhD; Jennifer J Vasterling, PhD; and Jean C. Beckham, PhD. 2012 Physicians Postgraduate Press, Inc.

This study shows that treatment and rehabilitation services such as those offered at VVSD support that " ... clinical intervention directed at treating mental health and substance abuse problems, psychosocial rehabilitation approaches aimed at improving domains of basic functioning and psychological well-being may also be effective in modifying risk and reducing violence among veterans."

Although the VA provides comprehensive medical care to those who meet the criteria for immediate services, veterans with less urgent problems are not viewed as a priority and have two choices: (1) Wait several months for an appointment or (2) be seen at the hospital Emergency Department. This results in veterans feeling devalued, acute problems not receiving necessary medical attention, and excessive cost for emergency room care that could have been handled on an urgent care basis. An urgent care walk-in system is desperately needed to address the day to day medical issues veterans experience.

Many medical providers working at the VA seem to lack in-depth knowledge about substance use disorders and the risks involved with prescribing large amounts of controlled substances. (e.g., one day outpatient procedure results in a veteran filling his prescription for 180 Oxycontin).

Grant Per Diem and Employment

The VA is putting most of their Dollars into Rapid-Rehousing & VASH. They have eliminated new funding for GPD. GPD funding focuses on treatment and employment combined with transitional housing. I feel there is a need for both. The VA continues to fund existing GPD Programs which are essential to serving the range of needs of homeless veterans. The SSVF Program requires that GPD referrals be made during the first 30 days of living in such programs and requires all GPD veterans secure permanent housing within 90 days. This is often too early to know if

SSVF is an appropriate referral source and should be reviewed as a mid-course correction. HUD has put more emphasis in recent years on reducing the length of stay for homeless people (including veterans) who reside in transitional housing programs which may not always be in the best long term interest of some veterans.

Joint HVRP/HUD: These 2 programs work well together. HVRP is focused on veterans securing jobs. HUD is focused on Housing for Homeless Veterans and other homeless people. The challenge is that with the high rate of PTSD and unemployment among younger veterans, evidence suggests there is a need to increase HVRP funding.

SUPPORTIVE SERVICES FOR VETERAN FAMILIES (SSVF)

Since the inception of our Supportive Services for Veteran Families (SSVF) Program in 2013, we have to date enrolled 180 veteran households who were homeless or at risk of becoming homeless. Of the 180 veteran households, we were successful in placing 90% of these families into permanent housing. We've seen that more and more veterans are struggling to find employment and it has become even more difficult for them to secure sustainable income when there is not a roof over their head. The SSVF program is a great tool in fighting homelessness amongst the veteran population. The program prevents homelessness amongst veteran families and works with those who are homeless to rapidly enter permanent housing utilizing the Housing First model; this model is centered on placing homeless families into permanent housing, and then providing the appropriate services tailored around addressing their housing barriers.

This model works very well for the Post 9/11 generation who only need a "hand up". Many of the Post 9/11 veterans that come across SSVF seeking services don't need the totality of our assistance. One of the benefits of the Housing First model is that the singular focus is on addressing the participant's housing crisis. However, we've seen that SSVF participants who are not ready to address their primary cause of homelessness, whether it's substance abuse or mental health issues, are not ready to maintain long term housing stability. Therefore, having the option to be in a formal treatment setting or transitional housing program benefits them in the long run and gives them the opportunity to work on their barriers prior to obtaining permanent housing.

One of our goals at VVSD is to break the cycle of homelessness amongst veterans and their families. In order for us to succeed in our efforts, we think it's crucial that we address the various reasons veterans become homeless. Not all veterans are ready to sustain themselves in housing and not every veteran will have substance abuse or mental health challenges, but having both SSVF and the VVSD Veteran Treatment Center in the same agency allows VVSD to make a difference in the veteran community. One size does not fit all and homeless veterans deserve the opportunity to choose the program that is most appropriate to meet their needs.

In conclusion: At Veterans Village of San Diego (VVSD), we believe intensive treatment leads to self-sustaining independence, the maximizing of human potential and a meaningful, fulfilling life. Our veterans are worthy of nothing less. Furthermore, we believe in providing services tailored to the veteran's needs and desires utilizing a client-centered approach focused on addressing their primary causes of homelessness.

Respectfully,

Phil Landis, President & CEO

PREPARED STATEMENT OF DR. CASEY O'DONNELL

Good morning Chairman Miller and esteemed committee members. My name is Dr. Casey O'Donnell. I am currently the Chief Operating Officer of Impact Services Corporation in Philadelphia. For the last 20 years Impact has been providing both housing and employment focused programs to homeless Veterans who suffer from both mental illness and alcohol and/or drug abuse. Impact's current continuum of housing include one-hundred fifty (150) beds of supportive transitional housing under the VA's Grant and Per Diem (GPD) Program and supportive permanent housing under HUD's Supportive Housing Program (SHP). Impact's program was one of the first and is one of the few programs in the nation exclusively serving dually diagnosed formerly homeless Veterans. Since, 1994, Impact has also been providing employment services to over three hundred (300) homeless Veterans annually under the Department of Labor's Homeless Veteran Reintegration Program (HVRP). In addition to these programs, Impact has recently received a "Surge" Priority 1 grant under the VA's Supportive Services for Veterans Families (SSVF) Program

and Impact has been a partner in collaboration with Project HOME and the Veterans Multi-services Center in Philadelphia in SSVF for the last three years. Over the last year, Impact has been extremely active in the VA's Boot Camp and Twenty-five Cities initiatives working to end Veteran homelessness in Philadelphia. Finally, Impact will break ground on twenty-six units of affordable, permanent housing for low-income Veterans and their families on Monday, December 15th. This new permanent housing for 26 Veteran families will be available in September 2015 and will contribute to ending Veteran homelessness. We are working in close collaboration with the VA National Center on Homelessness among Veterans to provide all of these services from a Trauma Informed Care model. Along with other community based housing providers I was invited to participate in the National Center's workgroup to implement Trauma Informed Care across the nation both within the VA and among community based partners. The National Center has been an invaluable collaborative partner in the provision of care to homeless veterans and the Center's work related to training and implementation will been critical to success. We believe that our testimony is derived from a place of competence and experience.

Men and women who have proudly served our country through military service should not be allowed to suffer in their addictions and mental illnesses on the streets of any city for one night longer. It is all of our job to find Veterans a safe place to live, recover from trauma and substance abuse, and improve the quality of their lives. In fact it is believed by those of us who are providers that "trauma informed care is necessary to eradicate homelessness among veterans".

Setting the deadline of December 31st, 2015 to end homelessness among Veterans has become a critically important milestone for our country. The deadline has provided us with a sense of urgency and dedication. The deadline is producing hard work, determination and teamwork where previously there was disconnection and a lack of accountability. Over the last eleven (11) months, in partnership with our many collaborative partners, we have placed 556 homeless Veterans in permanent housing in Philadelphia. We have approximately 540 Veterans left to house before the deadline of December 31st, 2015.

The goal of ending Veteran homeless in Philadelphia is within our sights.

We are ending Veteran homelessness in Philadelphia by developing a "Safety Net" system that "catches" Veterans before they become homeless, provides intervention when necessary to keep them housed, gets them housed again if they have slipped back into homelessness and most importantly, addresses their mental health challenges and/or addiction in an appropriate manner at whatever level needed as early as possible to prevent or address long-term homelessness. This safety net is critically important as we look at the Veterans of Iraq and Afghanistan who are potentially vulnerable, may be suffering, and may be headed towards homelessness. Research provided by the National Center on Homelessness Among Veterans suggests that this rapid safety net approach is allowing approximately 80% of Vets to stay housed after ninety days of case management and temporary financial assistance through SSVF. Recent data provided by the City of Philadelphia's Office of Supportive Housing also shows that the number of actual homeless Veterans on the streets and in many programs has decreased by 15% from 2013 to 2014. We expect that percentage to dramatically decrease in 2015 and to come to "functional zero" by January 2016.

This Safety Net system has only been possible within the context of real partnerships that are being forged between the community and the VA as part of the Boot Camp and Twenty-five Cities Initiatives in response to the December 31st, 2015 deadline. These partnerships have brought HUD, the VA, local municipalities, housing authorities and community organizations like Impact, to a common table where systems have been changed by bringing two continuums (the City and the VA) into alignment on outreach and assessment and eventually on placement and retention to ensure that Vets are being moved into housing.

Further, I would like to say that housing without jobs or increased benefits is only a short term strategy. Supportive housing integrated with programs to get Vets into jobs and/or access to benefits or increased benefits provides a long-term recipe for self-sufficiency. We would like to see the VA and the Department of Labor work closely to integrate community based job training and job development into the current housing activities funded for Veterans. A good place to start would be a pilot with community-based Veteran organizations like Impact to better integrate SSVF, GPD, and HUD–VASH housing with the HVRP Program.

Finally, Impact currently operates four (4) Grant and Per Diem (GPD) programs that move homeless Veterans with a mental health diagnosis and drug and/or alcohol addiction through various stages of recovery to self-sufficiency according to their needs. Our program is currently full. It is full because there remains a critical need for GPD to provide stable housing and services for Veterans suffering from mental

illness and substance abuse and/or dependency. Impact is extremely interested in working with Congress and the VA to test out several additional models of housing utilizing the VA's GPD program as the foundation of funding. Specifically, we would like to see a percentage GPD beds converted to provide supportive services and permanent (as opposed to only transitional) housing for formally homeless Veterans with mental health and substance abuse issues that require a higher degree of support than independent living can provide. We would also like to operate additional Safe Haven beds in Philadelphia that would have the ability to provide "wet" housing for chronic alcohol addicted veterans during a flexible period from ninety (90) days up to two (2) years. This will provide adequate time to work with the Veteran to get them stabilized and ready for recovery. Graduates of "wet" Safe Haven housing could move into Impact's current GPD transitional housing and eventually into independent living or supportive, permanent housing funded by HUD and/or the VA.

In conclusion, on behalf of my colleagues at Impact, myself, and the veterans that we serve I would like to thank the members of Congress for this opportunity to testify.

Sincerely,

Casey O'Donnell,

PsyD Chief Operating Officer Impact Services Corporation, *codonnell@impactservices.org*, 215–423–2944 ext. 152

STATEMENT BY

JONATHAN E. SHERIN, M.D., PH.D.

EXECUTIVE VICE PRESIDENT FOR MILITARY COMMUNITIES

AND CHIEF MEDICAL OFFICER,

VOLUNTEERS OF AMERICA

ON

ENDING VETERAN HOMELESSNESS

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON VETERANS' AFFAIRS

DECEMBER 11, 2014

U.S. House Committee on Veterans' Affairs: "Ending Veteran Homelessness"

Thank you Chairman Miller, Ranking Member Michaud and committee for convening today's hearing on ending veteran homelessness. My name is Jon Sherin. I am a psychiatrist and neurobiologist by trade. Though not a Veteran myself, I have been called to serve, and have spent my entire professional life serving, veterans of the U.S. military.

It was just five months ago that I testified in this same forum on the issue of suicide in the veteran community and it honors me deeply to be here again testifying on homelessness, the other true emergency facing too many of the men and women who constitute this courageous and deserving American subpopulation. The noble campaign to end all veteran homelessness by the end of next year, loudly articulated far and wide by General "Ric" Shinseki, continues to compel an imperative of the highest order for our country.

I worked for over a decade in the Veterans Administration (VA), last as chief of mental health at the Miami VA. Three years ago I left this post to take on my current role. I now serve as Executive Vice President, Military Communities, and Chief Medical Officer for Volunteers of America. Volunteers of America is a large, longstanding national non-profit whose legacy in this arena dates back to serving Civil War veterans. Today, providing for veterans is one of our top national priorities though we focus our efforts on helping veterans regardless of their housing status, this past year alone we housed and supported more than 20,000 homeless veterans. The size and scope of this work, much of it conducted in close partnership with VA, will increase again next year.

Given my professional experiences inside and outside of VA, I have a unique perspective for seeing the varied nature of the problems that face homeless veterans, as well as the many challenges that our country faces in meeting these problems with tailored solutions. With this context in mind, let me begin my testimony with a reminder that this undertaking requires more than finding a place to live for all veterans who are homeless on this day. It also requires making sure that they have ready and timely access to a full range of services when needed (including family support, mental health care and addiction treatment in addition to education, benefits, legal and financial assistance) in order to keep them from ending up back on the street. Further, to truly complete the task at hand, homeless veterans, like all Americans, deserve jobs and/or other opportunities to contribute to society as they have in the past through service to the nation.

In the end, ensuring that all veterans have access to a full range of support services and gainful opportunities (in addition to housing) will not just get homeless veterans off the street, it will, in many cases, prevent veterans at risk from becoming homeless in the first place. As such, we must actively embrace a philosophy, create a culture and insist on policies that hold us accountable for addressing the vast array of challenges known to emerge for some veterans in the context of civilian life. Such challenges (which include family distress, inadequate finances, difficulty getting benefits, substandard education, under-employment, substance dependence, unaddressed or sub-optimally treated health conditions and legal problems) predictably precede the loss of a place to call "home," something all Americans need for life, liberty and the pursuit of happiness.

Summary of Current Situation

HUD's most recent point in time count estimates that on any given night the total number of homeless veterans nationally is roughly 50,000. Annual estimates are basically twice that number and it must be recognized up front that certain homeless veteran populations (for example, those who couch surf and/or live out of their cars) elude current methods of calculation. In addition, a significant portion of the estimated 200,000 veterans who are incarcerated in our jails and prisons are at high risk of becoming homeless upon release. These factors deserve consideration in modeling the current problem and solution.

For strategic purposes, it is useful to divide the population of homeless veterans and veterans at imminent risk of becoming homeless into two primary groups based on the interventions they often need to leave homelessness. The first and larger group (by sheer number) needs short-term interventions, responding in most cases to homeless prevention and rapid rehousing efforts. The second and smaller (but in many ways more challenging) group needs longer-term interventions, responding in most cases to housing first models that facilitate engagement and offer ongoing support to promote stability.

Ultimately, we must account for these two groups, those who are at risk of becoming homeless and those who are already homeless. For those at risk of becoming homeless, we must build systems into the fabric of our communities to prevent homelessness from ever occurring in the first place. For those who are already homeless, we must know them by name (as well as by needs) and use data driven processes to get them connected to the right housing, with the right care for the right amount of time to get the right outcome.

At present, there are a number of federal programs being administered to end veteran homelessness, many in partnership with community-based providers such as Volunteers of America. These efforts have been effective at bringing homeless veteran numbers down substantially over the past few years, for which Congress and VA should be applauded. That said, there is a pressing need to accelerate the current speed of progress to reach our collective goal and it is incumbent upon all of us, alongside VA, to make it happen.

Solutions Going Forward

Coined most recently as "Zero 2016" by our colleagues at Community Solutions, the campaign to end veteran homelessness over the next year must continue to pick up the pace. Based on my experiences working in VA and community, there are many reasons to believe that we can make faster progress. Keys to picking up the pace include creating better alignment within existing public-private partnerships in addition to redesigning, repurposing and expanding the scope of existing programs based on best practices.

In addition to optimizing existing partnership and program activities, there are other means for accelerating progress through efforts that include: optimizing conditions and mechanisms for a broader partnership going forward, expanding the role of peer support services, intensifying outreach and improving access by capitalizing on existing

community infrastructure and technology, growing inventory, getting support from the states, and pushing forward with new funding models for sustainability of the effort. Details on these solutions follow, starting with an analysis of existing federal programs.

Program Findings and Recommendations

Both formal and informal interviews with community providers working in directly relevant federal partnership programs were conducted to better understand the current trench realities. This information was compiled to inform alignment, redesign, repurposing and expansion strategies going forward. Below are findings that were consistently reported from the field, as well as recommendations for improvement.

Grant & Per Diem (GPD):

Summary Experiences with VA differed widely re: GPD because the program is heavily dependent on local VA Medical Centers and Veterans Integrated Service Network (VAMCs and VISNs). The efficiency with which local VA homelessness teams can approve and refer clients, as well as their ability to consider the specific community needs of the local veteran population, dictate program effectiveness.

Program Strengths

- Good for certain subpopulation of homeless veterans, especially those who may be capable of, but need preparation for, quasi-independent or independent living
- Tremendous amount of high quality inventory nationwide

Program Challenges

- GPD inspection process is confusing and delays getting service to veterans who are in need of the program but may end up waiting in the street or local shelter
- Eligibility processing and referral is burdensome for VA staff and can lead to unnecessary vacancies
- Unclear, varying expectations for length of stay
- Per diem is insufficient for adequate staffing and programming to meet veteran needs
- Per diem is not adjusted to account for geography such that in some areas funding is on par with that at local emergency shelters
- Unable to serve veteran families
- Placement to permanent housing is below expectation

Recommendations

1. **Systematize VA-community relationships, decrease constraints on populations being served, and allow for multiple resource streams to supplement per diem.** By and large, providers report good outcomes with GPD but struggle daily to meet the needs of individual clients due to the bureaucratic and prescriptive nature of the program, as well as inadequate funding for services. As above, current per diem amounts limit the ability to tailor services for individual clients. It is suggested that

VA allow for multiple funding streams to enhance services and individualize care at a higher level. This suggestion is especially important as easier to serve veterans are placed into permanent housing leaving providers to struggle with meeting the needs of the "hardest to serve" population.

2. **Repurpose GPD facilities and/or units to meet the needs of a more diverse set of homeless and/or at-risk veterans, based on local conditions.** Though GPD currently meets a housing need for many veterans, the program must evolve to meet the changing landscape as indicated by census issues in a number of communities around the country. The most common suggestions for repurposing of GPD are bridge/rescue/triage housing, safe haven for chronic homeless, assisted living for older veterans with chronic medical conditions, and permanent housing. Per report, VA is considering a bridge housing pilot program with existing GPD inventory but intends to maintain the GPD payment model, a model that is not financially feasible to manage bridge programs. On a related note, some providers report that VA is now referring homeless veterans with chronic medical conditions, providing no additional resources, and expecting the same rates of successful permanent housing placement.

Housing Urban Development-Veterans' Affairs Supportive Housing (HUD VASH):

Summary
HUD VASH is a program in communities for housing the most chronic homeless veteran population. As it is administered (almost) exclusively through the federal government, provider feedback relates to program perception, not direct experience. With this caveat, concern was expressed (mostly in larger markets) about the assignment of vouchers in certain cases and the rates at which veterans "fall out" of their apartments based upon a lack of adequate (housing first) support services as well as a lack of adequate relationship with landlords. In both scenarios, there is the opinion that primary support and overall coordination by community providers would solve these problems. There is also a clear consensus that more project-based vouchers are required for highest need individuals.

Program Strengths
- Designed for and prioritizes the most difficult, chronic homeless population
- Prioritizes post-9/11 and female veterans
- Provides resource for families
- Funds some basic levels of support services
- Has both client- and project-based mechanisms

Program Challenges
- Sporadic use of vouchers by veterans who don't really need support services and thereby waste resources that would be better used by more vulnerable homeless veterans
- Support services are inconsistent, inadequate and time limited
- Program not operating in a manner consistent with the housing first model, a model that has proven to be effective in addressing needs of many chronic homeless veterans

- Vouchers are not accepted by some landlords due to myriad concerns about wanting more support services and misperceptions about the veteran population (could become more and more problematic with an improving real estate market)
- Small percentage of project-based vouchers that can be used for facilities in order to capitalize on economies of scale and get intensive services to those veterans with the most needs

Recommendations (most important in large markets)

1. **Adopt housing first strategies where possible.** HUD-VASH vouchers for chronic homeless veterans will be most effective with full implementation of the housing first model including integration of case management, peer support and mental health services. Though it can be difficult for landlords initially to accept veterans as tenants right off the street, education and reinforcement of the housing first model of support plus an accountable and transparent relationship between veteran, landlord and team will make it easier.
2. **Contract case management out to community providers.** Social workers and peer support specialists from community based organizations like Volunteers of America offer advantages in the role of primary team for veterans in HUD-VASH programs: Community organizations have broader relationships with local landlords as well as other non-VA providers across the human service spectrum; more community-based staff can be hired per dollar; community-based providers can offer tours of duty that allow for coverage 24/7, a preference of many landlords; primary contacts in local community promotes reintegration, a process that by definition occurs in community.
3. **Increase the percentage of project-based vouchers (and encourage development of facilities through use of federal properties. See later).** Many chronic homeless veterans prefer to live in proximity to one another, especially as it provides a kinship dynamic for those who are estranged from their family of origin. As such, some chronic homeless veterans become isolated and do not do well with client-based vouchers that support "scattered site" housing in mixed-use residential properties. Of equal significance, facilities that provide for multiple vulnerable veterans allow for a more efficient means of delivering the intensive services that are required at times.

Safe Haven (SH)

Summary
This low-barrier, low-demand model for transitional housing is relatively new as a program in VA. Pioneered (before VA investment) out of necessity for the chronic homeless veteran population by Volunteers of America-Greater New York and Volunteers of America-Greater Los Angeles, SH has been received with ringing endorsements in the field. By loosening the parameters of operation and at the same time offering a nurturing place for rehabilitation, SH has been demonstrating success rates above and beyond its more rigorous transitional counterpart, GPD. This finding is of particular importance given that SH residents tend to be the most recidivistic of all veterans in the homeless population.

Program Strengths

- Targets most needy populations, including chronic homeless veterans with comorbid substance abuse, mental health issues, and various social challenges who tend to fail in other program types
- Program census' tending to be full with waiting lists in currently operational programs, unlike GPD
- Accommodates residents in a novel manner that aims to drive motivational change
- Unusually good success rates for placement into permanent housing

Program Challenges

- Foreign and difficult model for providers who are not experienced with and/or not educated on the SH model
- Inadequate inventory at present to meet the needs of intended population (contrast with GPD)
- Not enough resources to support the programs which, unlike GPD, need to have high staffing ratios
- Activates "NIMBYism" in communities making it difficult to secure proper facilities

Recommendations

1. **Decrease the stigma associated with SH model of transitional residence.** Educate communities, community providers and VA alike on the philosophy, operations and importance of SH programs for chronic homeless veterans in particular.
2. **Expand the SH footprint in markets with significant chronic homeless veteran populations.** Such an effort can be accomplished most easily by diverting resources from other programs for the development of SH facilities (could have implications for repurposing of certain GPD programs that are struggling with unacceptable success rates and/or unused units. Note: They are both transitional residence programs.)

Health Care for Homeless Veterans Program (HCHV)

Summary

HCHV is a powerful program in principle because it was developed as a means for tailoring services and programs based on local community needs. Due to systemic issues with contracting and procurement at VA, the program is less impactful than it could be.

Program Strengths

- Can be used for housing based upon specific needs of local veteran population
- Designed to integrate and tailor wrap-around services for homeless veterans

Program Challenges

- Contracting process is almost invariably slow and unresponsive
- Locus of control and sources of information are unclear
- Opportunities to compete for contracts are poorly advertised

Recommendations

1. **Revisit the structure of contracting and procurement at VA.** With all good intention, certain logistic functions in VA have been centralized in recent years to the detriment of VISN/VAMC leadership, middle management, front-line staff and, most importantly, veterans in need.
2. **Assemble local content experts, including veterans, community providers and VA staff, to identify the need for and design of HCHV contracting opportunities.** This approach to achieving the HCHV mission will encourage buy-in of all parties, increase the likelihood of a tighter match between supply-demand, and sets up to better leverage existing community infrastructure.

Supportive Services for Veteran Families (SSVF)

Summary

Unlike most other programs that rely upon the VISN and VAMC chain of command, SSVF is administered through Veterans Affairs Central Office's (VACO) National Center for Homelessness Among Veterans (NCHAV), based in Philadelphia. Providers are unanimously pleased with the SSVF program and see it as an effective tool for addressing homelessness through prevention and rapid rehousing. Themes include a lack of bureaucracy and constraining regulations as well as a clearly defined process with logical, targeted outcomes. The NCHAV staff was recognized for its responsiveness to inquiries and willingness to facilitate processes on a case-by-case basis to promote successful outcomes; along these lines, it is noteworthy that NCHAV staff has developed a reputation for being consistent and transparent in their communications. Aside from voicing direct support of SSVF, several providers remarked that veterans in the program have been vocal about the ease with which they have gotten help. These findings are borne out by the massive number of veterans served through the program since its inception several years ago and the success rates it has achieved as a nascent program. A great deal of interest was expressed in expanding the SSVF program by loosening eligibility requirements as well as widening the scope of service in order to provide a larger population with a more complete range of reintegration services (for example, veteran peer support, mental health and family counseling, pro-bono legal, benefits assistance, job training and financial management).

Program Strengths

- Ease of offering resources
- Providers are less dependent on VA staff
- SSVF staff out of NCHAV are accessible and responsive
- Updates and modifications are communicated regularly
- Expectations and regulations are standard across the country
- Data is collected and reviewed, feedback provided and course corrections made in a transparent manner

Program Challenges

- Some providers question the 60/40 split for rapid rehousing and prevention
- Employment and mental health services need to be incorporated alongside housing, particularly for homeless post-9/11 veterans
- Does not allow for medium-term assistance which would be helpful, especially for rapid rehousing clients
- Concern about losing ability to serve VA-ineligible veterans
- Families of deceased veterans are not eligible

Program Recommendations

1. **Community providers and veterans alike voiced strong support for expanding SSVF as the mainstay in ending non-chronic veteran homelessness.** Certain modifications were suggested, including a loosening of eligibility requirements and allowing for medium-term support of SSVF clients in addition to short-term interventions.
2. **Leverage an SSVF-like mechanism as the primary means for VA to resource and manage relationships with community partners.** One consideration, in line with the mission of SSVF, would be to expand its scope by creating a "Reintegration Support for Veteran Families" (RSVF) grant through which allocations can support the spectrum of services needed in communities to fully address veteran reintegration.

Homeless Veterans Reintegration Program (HVRP)

Summary

Most providers operating the HVRP program expressed satisfaction with the responsiveness and flexibility of the Department of Labor staff but serious concerns over the rigidity of the program's outcome requirements and the lack of program adjustments to maintain fidelity with current needs since its inception nearly 30 years ago.

Program Strengths

- HVRP staff are responsive and knowledgeable
- Program is particularly effective when paired with a housing component such as GPD or additional supportive services through SSVF (especially for vets coming directly from the street)

Program Challenges

- Clients get "cherry picked" given rigidity of required outcomes
- Lack of innovation in the program over years
- Not possible to comply with performance requirement in first quarter but DOL demands it
- Penalties for performing outside of prescribed range, even in the case of over-performance (it is reported that 90% of HVRP programs in CA have performance improvement plans due in most part to penalties for over-performing)

Program Recommendations

1. **Revise the performance requirements of HVRP grantees in order to serve the most, and the most needy, veterans.** Discontinue the need to complete a corrective action plan for exceeding projected numbers. Consider incentivizing the placement of more veterans in jobs than projected.
2. **Encourage the co-location of HVRP with VA's homeless programs.** Develop strategy for getting HVRP programs to providers that have, or can partner with organizations that have, SSVF and/or GPD funding.

Summary of Federal Program Recommendations

Based on reported experience across numerous community providers, a number of recommendations can be made regarding VA homeless programs (abbreviations as above).

1. GPD: Repurpose, rather than dismantle, to match local supply with local demand
2. HUD VASH: Leverage community partners to support a housing first model
3. SH: Grow inventory according to demand, and support with adequate resources
4. HCHV: Streamline contracting and stakeholder involvement to improve efficiency
5. SSVF: Expand scope to include mental health, legal and employment services
6. HVRP: Redefine outcome measures to mitigate unnecessary, wasteful reporting

Additional Considerations

Aside from the above, it is my strong contention that there are unexplored means for moving the campaign to end veteran homelessness more quickly. In particular, I believe there are more opportunities for leveraging mutual infrastructure, programming and expertise to increase the depth, breadth, and efficacy of our efforts. It is in this light that I communicate additional considerations as below.

Charge the NCHAV to optimize and expand partnership activities between VA and community

Summary
NCHAV hosts a team of national experts who develop, test and implement models of care for homeless veterans, and have created mechanisms such as the SSVF grant that allows VA to work directly and efficiently with communities around the country. With the establishment of NCHAV, VA has entered into a new era for creating and nurturing public-private partnerships that includes: a streamlined announcement, review and selection process with quick turnaround times; well-trained regional directors who actively engage community providers in a consistent, responsive and flexible manner; technical as well as implementation assistance to facilitate program continuity and navigate relationships between local VAMC's and community providers as needed; a research arm that, in affiliation with several academic institutions and community providers, excels in collecting and analyzing data to measure their impact and course correct on a regular basis.

Recommendations

1. Have NCHAV work with SSVF grantees to use funds for mental health counseling as well as legal, benefits, employment and financial coaching services, so as to increase the likelihood that veterans who go through the program will be able to sustain housing. Such a program, which aims to provide wrap around reintegration services, could be renamed the Reintegration Support for Veteran Families (RSVF) program.
2. Leverage NCHAV to expand activities between VA and community generally.

Expand the role of peers

Summary
As exemplified nationally by the chairman and his congressional colleagues' home state of Florida, community-based peer-peer programming can play a key role in facilitating the reintegration process for veterans. Along these lines, the creator of the housing first model, Sam Tsemberis, has previously demonstrated the effectiveness of Veteran Peer Support Specialists (VPSS) as core providers in the housing first model.

On a related topic, a *New York Times* article published this past weekend, entitled "A Depression-Fighting Strategy That Could Go Viral," describes the impact of peer-peer counseling for depression. Now that veteran peer support services have been established as being evidence-based, they are being embraced more and more by VA and communities alike. With advocacy from stakeholders such as Dan O'Brien-Mazza, the VA Peer Support program's National Director, almost 1,000 veterans were hired into VA with this specialty over the past two years. A similar push is needed to develop a VPSS workforce within community provider networks that would add capacity to teams working with homeless veterans and build a powerful bridge, supported by peers, between VA and community.

Recommendations

1. Cultivate a robust peer-peer workforce through an expanded SSVF-like grant that resources the training, certification and support (both infrastructural and clinical) to embed VPSS in community-based organizations. In this role, VPSS would help drive outreach, resource navigation and advocacy for homeless veterans.
2. Add language to future NOFA's indicating that proposals with VPSS components will receive additional points.

   (Note: At Volunteers of America, we see these recommendations as a workforce development initiative and are working closely with the University of Southern California's Center for Innovation and Research for Veterans and Families to study the impact of working as a VPSS, and employment in general, as a mitigating factor for bad outcomes including homelessness, incarceration, ER use and recidivism).

Intensify outreach to, and improve access for, homeless veterans by leveraging existing infrastructure alongside peer programming

Summary
Certain properties in larger markets, including VA Campuses, GPD facilities and VA service centers, set up well for hosting open access "stand downs" for homeless veterans in a sustained manner. Similarly, telephonic and technology-based portals can be better used to provide a key link for homeless veterans 24/7 at the convenience of veterans in need. Lastly VPSS can provide a highly effective means for improving the trajectory of justice system-involved veterans in veteran courts. Whatever the case, existing infrastructure can be used to connect homeless veterans with VPSS in real time so that they can obtain assistance with housing needs. In this model, VPSS teams function as a 24/7 "community concierge" poised to engage homeless veterans, help them navigate community resources, and advocate for their housing needs.

Recommendations

1. Equip suitable VA campuses, GPD facilities and service centers to stand up "rally points," staffed by VPSS and tightly linked to both VA and community services in the 25 cities that have the highest number of homeless veterans.
2. Connect the (homeless) crisis line as well as community-operated 211 exchanges and web-based portals such as PosRep directly, and in real time, to VPSS employed and supported as above by community-based organizations.
3. Embed VPSS in veterans' courts to expedite resource navigation.

   (Note: In light of the recent IG report on the crisis line, I recommend as I did for veterans at risk of suicide that the call center be connected directly to the community. VA can capitalize on the infrastructure and flexibility of community partnerships by downloading the responsibility of following up on calls and internet requests, preferably through trained and certified VPSS working in community for organizations like Volunteers of America, US Vets, Easter Seals and many others, rather than indirectly to VAMC's. Now is the time to capitalize on partnerships

through which VA can push homeless services that supplement, complement and create synergy with VA operations to increase access thru outreach, engagement, and resource navigation.)

Grow housing inventory

Summary
Certain communities have an inadequate quantity of affordable housing stock available for occupancy. In some cases, the federal government has an opportunity to use its own properties to activate unused housing, particularly if project-based HUD-VASH vouchers can be brought to the table as part of the funding plan.

Recommendations

1. Conduct an environmental scan to analyze the quantity of open housing stock and contrast with unused housing available on federal properties in the 25 cities with the highest number of homeless veterans.
2. Activate unused housing on federal properties on an as needed basis to make up for the lack of inventory in the local community.

Compel states to bring resource and infrastructure to bear

Summary
The state of California, well represented on this committee, deserves recognition for its efforts on behalf of homeless veterans. California Proposition 41, passed this year, enacted the Veterans Housing and Homeless Prevention Bond Act of 2014 to authorize $600 million in bonds to provide multifamily housing, such as apartment complexes, to low-income veterans and supportive housing for homeless veterans. Also, in partnership with VA, the California Department of Veterans Affairs (CDVA) has agreed to use a portion of its state nursing home on the West Los Angeles (WLA) VA campus as domiciliary beds to house homeless veterans. Lastly, CDVA hired professional benefits assistance staff to help federal VA knock down the backlog for veterans in California.

Recommendations

1. Inquire with state officials as to the availability of resources that might be redirected for housing homeless veterans.
2. Consult with state veteran affairs departments as to the possibility that they have available state nursing home inventory that can be used for homeless veterans.

Support pay for success efforts that focus on prevention of veteran homelessness

Summary
Ongoing allocations to combat veteran homelessness will continue into the foreseeable future. Pay for success models, if they work, offer solutions for long-term sustainability which will allow for continuation of this vital national effort and at the same time decrease taxpayer burden.

Recommendations

1. Write and/or support policies that facilitate pay for success mechanisms.
2. Support allocations to fund pay for success feasibility studies that focus on programming for homeless veterans.
3. Encourage the private sector to leverage human service organizations and create a profitable social economy by helping homeless veterans.

Concluding Remarks

My experience working in this field from inside the VA and now outside the VA gives me a great deal of perspective as to the nature of the problems facing homeless veterans, as well as some possible solutions. Many solutions will rely upon this committee continuing its unprecedented commitment to overseeing VA's internal program operations and its overall performance. In addition, part of this oversight must include optimizing VA's ability to engage in multi-sector partnerships. I applaud this committee for inviting input from community providers to pursue this effort.

It is through your informed stewardship and legislative reform that our country can promote conditions in which governmental and non-governmental sectors come together in cohesive American communities that welcome veterans home, ensure they receive the services they need and have ample opportunities to thrive. It is in this context that we can setup proactive systems to disrupt the processes leading to homelessness on the front end.

STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

December 11, 2014

Good morning Chairman Miller, Ranking Member Michaud, and Members of the Committee. I appreciate the opportunity to discuss the Department of Veterans Affairs' (VA) commitment to ending homelessness among Veterans. I am accompanied today by Dr. Thomas O'Toole Acting Director, National Center on Homelessness among Veterans.

Ending Veteran homelessness is a key objective of this Administration and other dedicated leaders and individuals throughout our Nation. Our goal is a systematic end to homelessness, which means there are no Veterans sleeping on our streets and every Veteran has access to permanent housing. Should Veterans become or be at-risk of becoming homeless, we will have the capacity to quickly connect them to the help they need to achieve housing stability. The ultimate goal is that all Veterans have permanent, sustainable housing with access to high-quality health care and other supportive services.

To meet this challenge, VA launched a comprehensive, evidence-based, and outcome-driven strategy consistent with the first-ever Federal strategic plan to prevent and end homelessness, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, which was published in May 2010. VA's long-range plan to end Veteran homelessness is to emphasize rescue for those who are homeless today and prevention for those at risk of homelessness. We have complemented this strategy with unprecedented partnerships with Federal and local partners that have greatly increased access to permanent housing, a full range of health care including primary care, specialty care and mental health care; employment; and benefits for homeless and at-risk for homeless Veterans and their families.

VA, together with Federal and local partners, is making progress toward preventing and eliminating homelessness. Since the 2010 launch of *Opening Doors*, VA, together with our Federal, state, and local partners, has reduced the estimated number of homeless Veterans by 33 percent as noted in the Department of Housing and Urban Development (HUD) 2014 Point-in-Time Estimate of Homelessness. .

We are now poised to build upon the progress achieved thus far. Strong interagency collaboration, building on *Opening Doors*, is resulting in successful policies and programs such as Housing First in the Community (Housing First), Rapid Re-Housing, Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), and Supportive Services for Veteran Families (SSVF). These programs have been critical to achieving the reduction thus far. Since 2009, we have broadly expanded the array of services and supports aimed at identifying, interceding, and rapidly engaging these Veterans in housing, clinical care, and social services, as well as resources aimed at preventing homelessness from occurring. As a result of these investments, in fiscal year (FY) 2014 alone, VA provided services to more than 260,000 homeless or at-risk Veterans in VHA's homeless programs. The needs of the more than 260,000 Veterans varied and not all required an intensive homeless program intervention, but for those that did require a more intensive intervention, over 72,000 Veterans were either placed in permanent housing or prevented from becoming homeless. When we include their family members, that number rises to over 100,000.

I will begin today by detailing VA's six–pillar strategy and then discuss the many accomplishments over the past year. Furthermore, we will outline our program efforts to end homelessness by the end of 2015 and discuss the innovations VA has made in homelessness research and models of care. Before I conclude, I will present VA's way forward in our efforts to end Veteran homelessness.

VA's Six Strategic Pillars to End Veteran Homelessness

VA's focus on ending Veteran homelessness is built upon six strategic pillars, which are aligned with *Opening Doors.*

Outreach and Education

VA conducts homeless outreach at shelters and community events, and in courts, local jails, and state and Federal prisons. VA also collaborates with community organizations at Stand Downs—outreach events designed to connect homeless Veterans with community resources and VA health care and benefits assistance. These efforts also complement one of the most critical methods for engaging homeless Veterans in services: sending VA outreach staff to the streets, shelters, homeless camps, and soup kitchens to work with them directly. Many Veterans, but particularly those who have battled chronic homelessness, need skillful and repeated attempts to engage them in the care they need. Along with our community partners, VA has over 600 staff members across the country engaged in outreach every day.

Prevention and Rapid Re-Housing

VA believes the most efficient way to eliminate homelessness is to prevent its occurrence. Unlike VA's traditional homeless programs, which focus on the treatment and rehabilitation of the individual Veteran, our homelessness prevention and rapid re-housing efforts, address those Veterans and their families who are at immediate risk for becoming homeless or have recently become homeless.

VA's Supportive Services for Veteran Families (SSVF) program is a critical aspect of our strategy to prevent and end Veteran homelessness. This program provides both prevention and rapid re-housing services to Veterans and family members. SSVF grants to private non-profit organizations and consumer cooperatives provide a range of supportive services to include outreach, case management, assistance in obtaining VA benefits, and assistance in obtaining and coordinating other public benefits. SSVF also enables VA to help Veteran families stay together by serving

the entire family. This also means that VA is minimizing exposure to and the trauma of homeless that are experienced by the children of homeless Veterans.

A history of incarceration is a powerful predictor and risk factor for homelessness; thus, homelessness and criminal justice involvement have a reciprocal relationship. As a result, outreach to justice-involved Veterans is a key part of VA's prevention strategy. The mission of VA's Veterans Justice Programs is to engage Veterans involved in the justice program at any point in the continuum (arrest, involved in a treatment court, incarcerated in jail, or in prison serving a sentence), in comprehensive VA and community services that will prevent homelessness, improve social and clinical outcomes, facilitate recovery, and end Veterans' cyclical contact with the criminal justice system.

VA also works hard to help Veterans and their families stay in their homes. The Veterans Benefits Administration's (VBA) Home Loan Guaranty program helps to prevent homelessness by assisting Veterans who fall behind on mortgage payments to avoid foreclosure by intervening early in the default process, and working with Veterans and their loan servicers to pursue all available loss-mitigation options. VBA monitors every loan continually, throughout the default process, to resolve defaults and avoid foreclosures whenever possible. Where foreclosure is unavoidable and where VA acquires the property, VA offers Veteran borrowers relocation assistance to assist them in transitioning to alternative housing.

Housing Opportunities

The Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program combines Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA).. VA case managers provide clinical visits to these Veterans to ensure they remain in housing and do not become homeless again. Veterans served by HUD-VASH are the most vulnerable. The majorities of participants are experiencing chronic homelessness and suffer from serious mental illness, substance use disorders, and chronic medical conditions. This partnership with HUD

and community partners has helped to ensure that HUD-VASH is a highly effective tool for reaching the most vulnerable Veterans, and is a critical component of our strategy to move homeless Veterans from the streets to safe and stable homes.

The Homeless Providers Grant and Per Diem (GPD) program is VA's largest transitional housing program. The GPD program helps fund community agencies providing services to homeless Veterans with the goal helping them achieve residential stability, increase their skill levels and/or income, and obtain greater self-sufficiency, independent living, and employment as soon as possible. The GPD program utilizes a community-based transitional model, which includes time-limited, comprehensive supportive services with the goal of transitioning Veterans to independent housing.

VA's Health Care for Homeless Veterans (HCHV) Contract Residential Services program provides same-day access to safe and stable temporary housing for 1) homeless Veterans transitioning from street homelessness, 2) those who recently became homeless, and 3) those being discharged from institutions. Additionally, VA recently issued a proposed rule that would open HCHV Contract Residential Services to all homeless Veterans who are enrolled in or eligible for VA health care, regardless of whether they have a serious mental illness, ensuring that VA can immediately engage homeless Veterans and get them off the street. HCHV also implemented the Low Demand/Safe Haven model, which incorporates evidence-based strategies, as a new element in our continuum that targets the population of hard to reach homeless Veterans with severe mental illness and substance use problems. Low Demand/Safe Haven is a community-based, early recovery supportive housing model, which serves individuals who find it difficult to engage in traditional treatment and supportive services.

Treatment

VA recognizes that a plan to end Veteran homelessness will not be effective without comprehensive services for those with chronic health, mental health, and substance abuse disorders. Many Veterans who are homeless struggle with mental health and addiction; in fact, VA data indicates that approximately 68 percent of homeless Veterans have a mental health diagnosis or an addiction disorder, which, if

untreated, can keep them from returning to or sustaining independent living and gainful employment.

VA established four new Domiciliary Care for Homeless Veterans (DCHV) programs in Denver (June 2013), Atlanta (January 2014), San Diego (February 2014), and Philadelphia (July 2014). VA is also developing an additional DCHV in San Juan, Puerto Rico, which we expect to open in the first quarter of FY 2016, and constructing a new DCHV on the grounds of the West Palm Beach VA Medical Center, which we expect to open in the fourth quarter of FY 2016. These facilities provide state-of-the-art, high quality residential rehabilitation and treatment services for homeless and at-risk-of-homeless Veterans with multiple and severe medical conditions, mental illness, addiction, or psychosocial problems.

VA provides a continuum of outpatient, residential, and inpatient mental health services across the country. We have many entry points for care: through our 150 medical centers, 830 community-based outpatient clinics, 300 Vet Centers that provide readjustment counseling, the Veterans Crisis Line, and VA staff on college and university campuses. VA offers expanded access to mental health services with longer clinic hours and telemental heath capability to deliver services.

Financial and Employment Support

Homeless and at-risk Veterans need access to employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts. VA is committed to supporting this critical component to eliminating homelessness through Homeless Veterans Community Employment Services (HVCES). Within the HVCES framework, each VAMC has been funded to hire a Community Employment Coordinator (CEC) for homeless Veterans. The CECs are central figures responsible for the ongoing orientation and training of the Homeless Services continuum in order to connect Veterans to the most appropriate and least restrictive VA and/or community-based services to improve employment outcomes. Each VAMC CEC serves as a liaison to local community providers of employment and support services including DOL grantees and private sector employers.

Access to disability compensation and pension benefits is a key component in providing financial support to homeless and at-risk Veterans and their families. In an effort to increase outreach to homeless Veterans and prevent at-risk Veterans from becoming homeless, VBA is committed to every VBA regional office (RO) having either a Homeless Veterans Outreach Coordinator (HVOC) or Homeless Veterans Claims Coordinator responsible for case management and expediting the processing of homeless Veterans' claims. VBA has placed 20 full-time HVOCs at the ROs with the highest homeless Veteran population and prioritizes the processing of these claims. HVOCs conduct outreach at homeless shelters, community events, and VA medical facilities; assist homeless Veterans with filing claims; and ensure homeless Veterans are properly identified at the ROs to expedite their claims. Furthermore, HVOCs have an effective network and referral system to VHA's Homeless Coordinators and local community homeless providers to facilitate delivery of VA benefits, healthcare, and other supportive services.

In addition to the above noted efforts, in FY 2014 the SSVF program trained its 319 community partners regarding the implementation of Supplemental Security Income / Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR), a national project funded by the Substance Abuse and Mental Health Services Administration to increase access to SSI/SSDI benefits.

Community Partnerships

VA is committed to fostering strong partnerships with community organizations to prevent and end Veteran homelessness. For example, the GPD and SSVF programs rely significantly on the expertise, experience, and ingenuity of local community organizations. GPD and SSVF community providers collaborate with local continuums of care to link Veterans to community services.

VA recognizes that no single Federal or state agency of government or local organization can end homelessness among Veterans. To that end, VA has long maintained close working relationships with Federal partners, such as HUD, the Department of Labor (DOL), the Department of Defense, the Department of Health and

Human Services, the Small Business Administration, the U.S. Interagency Council on Homelessness, and others, as well as state, local, and tribal governments. Veterans Service Organizations also fill a critical role, as do community- and faith-based organizations and the business community. One example of these efforts is VA's work to develop better connections with prosecutors and judges in the criminal justice system. Another example is the Homeless Veterans Reintegration Program (HVRP), through which DOL's Veterans Employment and Training Service offers funding to state, local, and tribal governments, non-profit organizations, and others to help Veterans return to gainful employment. DOL requires all HVRP grantees to collaborate with VA.

Furthermore, VA medical centers and ROs engage in meetings with thousands of individuals and organizations across the country to enhance collaborations and improve communications. VA is committed to reaching out and building partnerships with organizations and individuals who are interested in being part of a collaborative solution to ending Veteran homelessness.

Recent Accomplishments

Since January 2010, HUD's 2014 Point-in-Time Estimate of Homelessness indicates that we have achieved an unprecedented 33-percent decrease in the number of homeless Veterans from 74,770 to 49,933. During this same time, the Nation's overall homeless rate was reduced by 10 percent.

VA views this as a significant step in our goal to eliminate homelessness among Veterans in 2015. In addition, our efforts in FY 2014 resulted in the following outcomes:

- HUD-VASH provides permanent housing with case management and supportive services to promote successful recovery and housing stability. In FY 2014, VA provided comprehensive case management services to support over 10,000 new HUD Housing Choice Vouchers, made available for use by the most needy and vulnerable Veterans through the HUD-VASH Program. As of September 30, 2014, nearly 55,950 Veterans were being assisted by the HUD-VASH Program.

On October 1, 2014 HUD announced an additional 8,276 Tenant-Based HUD-VASH Vouchers for rental units in the private market, and 730 Project-Based Vouchers (PBV) for existing units or new construction in specific developments. These vouchers will help more than 9,000 homeless Veterans find permanent supportive housing. An additional 1,900 Tenant- Based vouchers were released on December 8, 2014, from the FY 2014 allocation.

- VA has adopted Housing First, an evidence-based practice that prioritizes access to permanent housing, and through which VA provides case management and treatment services that homeless Veterans need to maintain housing and improve health care and quality of life. Adopting the Housing First approach has contributed to VA's ability to serve increasing numbers of chronically homeless and vulnerable Veterans in HUD-VASH. In FY 2014, VA exceeded its target of 65 percent chronically homeless Veteran entries to HUD-VASH.
- The GPD program utilizes a community-based transitional housing model, which includes time-limited, comprehensive supportive services with the goal of transitioning Veterans to stable housing. In FY 2014, the GPD program operated over 675 projects providing approximately 15,500 operational beds nationwide. In FY 2014, 45,167 unique Veterans were provided services through GPD. During FY 2014 there were 14,652 Veterans who exited to permanent housing from GPD programs.
- The SSVF program gives VA the capacity to act before very-low income Veteran families become homeless or to act quickly if the Veteran family actually becomes homeless. In FY 2014, the SSVF program awarded $507 million in grants that allowed SSVF to expand from 319 community agencies to 383 community agencies, serving all 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. In FY 2014 alone, SSVF grantees exceeded the number of projected participants by serving nearly 130,000 Veterans and their family members who were homeless or at-risk of homelessness. Of these individuals, approximately 80,000 were Veterans; over 48,500 were Operation

Enduring Freedom / Operation Iraqi Freedom / Operation New Dawn Veterans; over 11,700 were women Veterans; and, approximately 30,000 were children.

- By the end of FY 2014, 14,600 homeless Veterans were enrolled in Homeless Patient Aligned Care Teams at 51 sites with the goal of eliminating barriers to quality health care, and improving housing outcomes for Veterans who are homeless or at imminent risk of homelessness. These Veterans' disease complexity was almost twice that of the general population within VA. VA observed a 25-percent reduction in emergency department visits and a 25-percent reduction in hospitalizations among Veterans engaged in needed clinical care.
- In FY 2014, VA served 41,630 justice-involved Veterans through the Veterans Justice Outreach Program (jail and court outreach and case management services). Additionally, 16,772 incarcerated Veterans were served through Health Care for Re-Entry Veterans (prison outreach and case management) in FY 2014. This includes work with Veterans involved in drug treatment courts, mental health treatment courts, and the 266 Veterans Treatment Courts that local communities have developed around the country in response to communities' desire to connect justice-involved Veterans with treatment rather than incarceration.
- VA's National Homeless Registry is a comprehensive data warehouse of Veterans who have been identified as homeless, or at risk of for homelessness, since October 1, 2005. It is designed as both a robust repository and data management tool that provides longitudinal information on Veterans housing and healthcare status. The registry also contains data on geographic and benefit information relevant to the Veterans' housing stability. The Registry is now populated with the names of over 800,000 current or former homeless or at-risk Veterans.
- In FY 2014, benchmarks for exits to competitive employment were included in performance measures for Homeless Residential Programs for the first time. This resulted in over a 5 percent increase in employment rates at exit from GPD,

DCHV, and Compensated Work Therapy/Transitional Residence (CWT/TR) as compared to FY 2013.

- VA's HCHV program has been successful in expanding contract residential treatment services. In FY 2014, the HCHV program provided these services to over 15,600 Veterans and over 4,000 operational beds in support of homeless Veterans. Also, HCHV provides extensive outreach services, and under this element of the program, over 158,000 Veterans were served.
- Based upon the latest projections, VA representatives will attend more than 320 homeless Stand Downs in calendar year 2014, which will result in improved Veteran access to resources, benefits, and support.
- The number of compensation and pension claims for homeless Veterans completed in FY 2014 increased by 12-percent as compared to completed claims in FY 2013.
- In FY 2014, VA helped 79,814 Veterans in default retain their homes or avoid foreclosure, an 8.5-percent increase from FY 2013.

Innovations in Homeless Models and Research

Led by the VA National Center on Homelessness among Veterans, VA has made extraordinary advances in recovery-oriented care for homeless and at-risk Veterans by promoting data-driven, evidence-based solutions to end Veteran homelessness. A primary example of VA's data-driven approach is its decision to adopt, as national policy, a Housing First approach for its homeless programs. In permanent supportive housing, Housing First means providing access to permanent housing with as few barriers and restrictions as possible, while simultaneously wrapping supportive services around the individual to assist them in their recovery. Early on in VA's Ending Veteran Homelessness initiative, VA established a 14-site pilot to evaluate the effectiveness of a Housing First approach in the HUD-VASH Program. VA's evaluation revealed pronounced cost savings and efficiencies from employing a Housing First approach, with the number of emergency room visits decreased by 27 percent and the number of acute inpatient hospitalizations decreased by 33 percent. The evaluation further

indicates substantial reductions in VA health care costs for homeless Veterans, showing a 32-percent reduction in total direct VA health care costs, with a significant 54-percent reduction in more intensive inpatient costs.

VA continues to research and analyze the effectiveness of all aspects of VA homeless programs. For example, VA recently conducted a return on investment (ROI) analysis of VHA-funded homeless programs. The ROI analysis purposefully employed more conservative, short-term (1-year) impact effects that were not accrued over time. The ROI modeling shows substantial, direct positive returns on investment for the obligated funds budgeted to the VHA Homeless Programs Office. These returns on investment are possible, in part, because the costs of an episode of homelessness can be extremely high. The ROI analysis strongly suggests that the ending Veteran homelessness initiative is both effective social policy and fiscal policy that is having a meaningful impact within our local communities and with Veterans in-need.

Additionally, through research and testing, VA has implemented a homeless screening tool that helps identify a Veteran likely to become homeless. Based on this research, VA instituted a procedure that requires VA medical centers to ask a set of questions as a part of their initial interaction with all Veterans who seek health care services. When a Veteran's response indicates there is risk of homelessness, VA staff refers the Veteran to clinically appropriate programs.

VA recently undertook a gap analysis across all our homeless programs to ensure prudent distribution of resources to where they can be most effective, and to identify any possible shortfalls. The gap analysis identifies VA, Federal, state, and community assets currently available in cities to address the needs of homeless Veterans and determine whether VA and communities within the service areas of medical centers have sufficient resources to meet the estimated need of Veterans needing housing placement. The gap analysis is an ongoing effort designed to ensure targets are met, gaps are identified, solutions are developed, and resources are allocated appropriately.

The Way Forward

VA has made significant progress in its Plan to End Veteran Homelessness, and we are now closer to our goal than at any point in our history. Based on science and practice we have identified a number of the risk factors that lead to the downward spiral of homelessness and that complicate the pathway back to community and health. We know that the solutions to ending homelessness include programs that promote immediate access to permanent long-term housing with the right dose and duration of services to promote stabilization and community reintegration. We know that access to permanent housing with appropriate supportive services "wrapped around" the Veteran is the most clinically effective and cost-efficient way to end homelessness. We know that Housing First is an evidence-based practice for ending chronic homelessness and that we are making it a common practice. We know that there is not one solution that fits all, and that a coordinated entry system that prioritizes coordination and targeting resources with community partners is essential to achieving the goal.

Most social scientists and policy experts agree that barring the eradication of an affordable housing crisis, unemployment, poverty, family decompensation, and mental illness that often precipitate the downward spiral into homelessness, we will still have Veterans and other individuals and families falling into homelessness. The difference now is that we have the ability and capacity to identify them earlier to prevent homelessness and to rapidly rehouse and connect them to healthcare and other supportive services if they should become homeless. We have the knowledge and the support to ensure that homeless Veterans are no longer our invisible citizens.

Although we have made significant progress to date, we recognize fully that our goal to prevent and end homelessness among Veterans is a complex and difficult task, one requiring consistent, measurable, and sustained effort from VA, other Federal agencies, State agencies, and community partners. In the coming months, we are focused on the 25 Cities effort. This effort is tailored to – and builds upon – progress already being developed at the local VA medical centers and continuums of care. The effort is being designed to enhance coordination and minimize redundancies between VA and the community. The effort is designed to know Veterans by name and rapidly connect them to the right dose and duration of support needed to achieve and sustain

housing in the community. Recognizing that communities are working to develop and implement coordinated assessment systems as a result of HUD's Continuum of Care Program interim rule requirement, VA has partnered with Community Solutions and HUD to assist 25 priority communities to develop and implement their own system based upon their local needs and resources. The 25 Cities effort is building that coordinated entry system. In this effort, VA, through its National Center on Homelessness among Veterans, partnered with Atlas Research, Community Solutions, and Rapid Results Institute to facilitate permanent housing placement for all homeless Veterans and chronically homeless individuals in 25 cities nationwide with the highest needs in terms of homelessness. This effort will provide the opportunity to sustain and advance the systemic changes initiated during the HUD-funded Rapid Results Boot Camps, a continuous process improvement program, and through other Federally-funded technical assistance activities.

Through these types of coordinated efforts, we are well on the path to ending homelessness among Veterans. VA has continued its focus on prevention and rapid rehousing by awarding approximately $300 million in SSVF grant awards in August 2014. In September, VA built on this commitment by awarding an additional $207 million targeted as "surge" funding targeted at 56 high need communities. The SSVF program is the only VA homeless program that is national in scope that can provide direct services to both Veterans and their family members; however, the current law (38 United States Code (U.S.C.) § 2044) only provides an appropriation authorization for up to $300M. VA urges Congress to amend section 2044 to authorize appropriations up to $500M in FY 2015 and beyond

VA is also proposing legislation to extend VA's Homeless GPD program to support a "transition in place model" toward permanent housing. By allowing Veterans to "transition in place" to permanent housing, the Department would provide a valuable alternative for Veterans who may not need or be interested in participating in HUD-VASH. Proposed legislation would allow VA to fund per diem payments for transitional housing at 1.5 times the maximum per diem rate, to enable Veterans to remain in their

housing unit, i.e., "transition in place."[1] This enhancement in the per diem rate will help to cover the additional operational costs associated with this model of transitional housing and will allow more Veterans to convert to a permanent housing unit.

VA also proposes legislation to establish homelessness as a criterion for the provision of temporary lodging. This proposal would allow VA to provide temporary lodging in the form of emergency hotel stays to homeless Veterans awaiting placement in permanent and/or transitional housing or other suitable housing alternatives. Veterans placed in such temporary lodging would also receive case management and other forms of treatment and support from existing homeless case managers.[2]

Conclusion

Through Congress' ongoing support, VA has made substantial progress in ending Veteran homelessness. Congress' support of VA's Plan to End Veteran Homelessness, as part of the Administration's overall Federal strategic plan to end homelessness, has allowed the creation of the housing and services that we have used to drive significant reductions in the number of Veterans experiencing homelessness.

My testimony today details VA's commitment to prevent homelessness among Veterans at-risk in the years to come. All of this facilitates both the rapid placement in housing and the delivery of the care to homeless Veterans needed to maintain permanent housing. Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer your questions.

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[1]FY 2015 VA Congressional Budget Submission, LegSum-68.
[2]FY 2015 VA Congressional Budget Submission, LegSum-72.

U.S. Department of Housing and Urban Development

Washington, DC 20410

Written Testimony of Jennifer Ho

Senior Advisor on Housing and Services to Julian Castro

Secretary of U.S. Department of Housing and Urban Development

Hearing before the House Committee on Veterans Affairs

on

"Evaluating Federal and Community Efforts to Eliminate Veteran Homelessness"

Thursday, December 11, 2014

Good morning Chairman Miller, Ranking Member Michaud, and Members of the Committee. Thank you for this opportunity to discuss how the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the U.S. Interagency Council on Homelessness (USICH)—along with our community partners—are working together to eliminate Veteran homelessness in the United States.

Since launching *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* in June 2010, ending Veteran homelessness has been a high priority goal for HUD. The latest 2014 Point In Time count estimates that the number of Veterans experiencing homelessness on a single night has dropped by 33 percent in five years – from 74,770 in 2010 to 49,933 in 2014. The significant progress made thus far would not have been possible without funding from Congress and working closely with our Federal and local partners. While much more needs to be done, we know that collaboration and sufficient resources strategically

deployed are the keys to being able to address the housing and service needs of any Veteran who experiences homelessness.

Collaboration

HUD, VA, and USICH are working together in innovative ways to combat a problem that cannot be solved by one agency alone. Both VA and HUD administer programs that target a range of Veterans from those at risk of losing their housing to the Veterans experiencing chronic homelessness who have lived on the streets for years and even decades. To align our programs and formalize our joint commitment to ending Veteran homelessness, HUD, VA, and USICH created an interagency committee known as *Solving Veteran Homelessness as One (SVHO)*. SVHO meets frequently and has dedicated staff to work on Veteran homelessness issues on a daily basis. This group also reports to senior leadership at both Departments and USICH to discuss progress on meeting goals and to identify any potential barriers to success.

To ensure that limited resources are used as efficiently as possible, HUD and VA are aligning programs so they are not redundant or duplicative. For example, HUD strongly encourages Continuums of Care (CoCs) to coordinate with their local VA and nonprofit partners executing VA programs, so that CoC resources are prioritized for those who are ineligible for VA programs. This helps ensure that Veterans who do not meet the eligibility criteria for VA programs can receive assistance through other programs in the community. While this is not something that can be required, HUD incentivized this level of coordination by scoring CoCs on the extent to which they were doing this through the FY 2013-FY 2014 CoC Program Competition Notice of Funding Availability.

HUD-VASH

The greatest collaborative effort is the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program, which is key to meeting the goal of ending Veteran homelessness in the United States in 2015. HUD-VASH is a robust resource that combines Housing Choice Voucher (HCV) rental assistance from HUD with intensive case management and clinical services provided by VA to assist the most highly vulnerable Veterans who have experienced homelessness for extended periods of time. Since 2008, nearly 70,000 HUD-VASH vouchers have been awarded to Public Housing Authorities (PHAs) in each of the 50 states, the District of Columbia, Puerto Rico and Guam, with nearly 11,000 of those vouchers being awarded in the last several months. As of September 2014, almost 52,000 Veteran families are being assisted through HUD-VASH vouchers and another 3,300 families have been issued vouchers and are searching for housing. In addition to HUD-VASH, there are other resources for Veterans with fewer barriers to housing who have experienced homelessness for shorter periods of time, such as the HUD's transitional housing and rapid re-housing programs, and VA's Supportive Services for Veteran Families (SSVF) and Grant and Per Diem (GPD) programs.

HUD and VA use data collected by both agencies to allocate HUD-VASH vouchers based on need. This information includes the number of Veterans experiencing homelessness in communities and the performance of the PHAs and VA Medical Centers (VAMC). This data-driven approach to allocating HUD-VASH ensures this scarce resource goes to areas with the greatest need that also have the ability to effectively administer the influx of new vouchers.

Of course, HUD-VASH is only as successful as the local partnerships between VAMC staff, PHA staff, and the local CoC. The partnerships required in the HUD-VASH program often involve a new, challenging way of doing business, but I'm pleased to report that the relationships between VAMCs and PHAs are thriving in many communities. When requested or needed, Federal staff at either or both agencies are available to resolve policy issues or to help identify solutions regarding procedures or practices that could be improved. In the last two years, local partnerships with CoCs have greatly expanded in many communities, and CoCs are often at the table when PHAs and VAMCs work to improve the HUD-VASH program. As communities identify challenges, such as low voucher utilization or lack of housing stock, HUD, VA, PHAs, and community partners are working together to find solutions to overcome the obstacles. By overcoming challenges together, the collaboration between the groups is stronger and better able to address the next challenge.

In order to ensure the HUD-VASH resource is used as effectively as possible, HUD and the VA maintain a performance target to use 65 percent of HUD-VASH vouchers for Veterans experiencing chronic homelessness. To meet the definition of chronically homeless, a Veteran must have a disabling condition and must have been homeless continuously for at least one year or experienced at least four occasions of homelessness in the last three years. These Veterans tend to have high rates of behavioral health problems, including severe mental illness and substance abuse disorders, which may be exacerbated by physical illness, injury or trauma, and typically require long-term housing assistance and supportive services. The housing assistance offered through HUD, in conjunction with the intensive case management and supportive services offered through VA, are able to support the housing and service needs of these Veterans for as long as is required. This type of supportive housing enables Veterans to live as

independently as possible in a permanent setting. Research has demonstrated time and again, including several studies published in the Journal of the American Medical Association, that permanent supportive housing not only ends homelessness for people who in the past would live on our streets and in shelters for years, but also saves taxpayers money by interrupting the costly cycle through shelters, emergency rooms, hospitals, detox centers, and jails.

HUD and VA are both committed to *Housing First* in HUD-VASH, a model that has been identified as the most successful intervention for people who have been homeless for years and have complex disabilities. This evidenced-based model has several key characteristics, including immediate access to permanent supportive housing from the streets or shelters, while providing intensive supportive services to help residents achieve and maintain housing stability and improve their lives. *Housing First* targets Veterans experiencing chronic homelessness who are considered the most vulnerable and does not require residents to undergo psychiatric treatment or maintain sobriety prior to obtaining housing. Vulnerable Veterans can more easily engage in services and address their chronic health conditions once they are no longer dealing with the chaos and uncertainty of homelessness. VA has provided guidance to VAMC case managers not to require Veterans to demonstrate sobriety or to receive treatment for underlying addiction or mental health issues as a precondition for receiving housing assistance. To support appropriate targeting, HUD has eliminated all criminal history screening requirements for HUD-VASH vouchers except for the ban on lifetime sex offenders.

The collaboration between HUD, VA, and USICH on the HUD-VASH program is unprecedented and reaches from the top leadership at each Agency to national program staff to local offices on the ground. I thank Secretary McDonald and Dr. Clancy for their leadership and collaboration.

Working together to improve performance

HUD and its Federal partners are committed to working with community officials to improve the performance of HUD-VASH through technical assistance and shared best practices. HUD and VA have delivered multiple national-level trainings and webinars on HUD-VASH policies and procedures since 2008. These efforts have been supplemented by dozens of local trainings and conferences carried out by HUD field offices and VA regional staff. One of HUD's major technical assistance efforts has been community boot camps in which HUD, in collaboration with VA, USICH, the Rapid Results Institute, and Community Solutions, invested almost $900,000 and conducted trainings for 20 communities in 2012. "Boot Camps" are 2.5 day planning sessions followed by 100 days of intense and coordinated effort to streamline the process of operating the HUD-VASH program, to accelerate housing placement, and to improve the targeting of those vouchers to the most vulnerable Veterans experiencing homelessness. The teams are made up of key leaders from HUD, VA, PHAs, local government and CoCs, who work together to come up with local solutions based on individual community circumstances and need.

The methodology of the boot camps is based on the belief that the persons closest to the ground are in the best position to recommend improvements and that having multiple stakeholders in the community—including local government, CoCs, PHAs and VAMCs—is necessary to eliminate homelessness among Veterans. These boot camps demonstrate that large gains can be made in a short period of time when these partners are all at the table. For example, the Houston team increased their housing placement rate by 68 percent, issued 100 percent of HUD-VASH vouchers to Veterans experiencing chronic homelessness, and expedited access to those units. Many communities like Jacksonville, Florida, set ambitious goals of housing 100 Veterans experiencing chronic homelessness in 100 days and succeeded in their efforts. Based

upon the success of the first round of boot camps, HUD invested $1.3 million in 6 boot camps in 2013 for both Veterans and others experiencing chronic homelessness.

The work and progress made through the boot camps is being leveraged by the VA-funded 25 Cities initiative. Working in partnership with HUD and USICH, VA's 25 Cities effort enlists communities with the highest concentration of persons experiencing chronic homelessness and Veterans experiencing homelessness to continue their strategic work to end Veteran homelessness. Forty-six percent of Veterans experiencing homelessness are located in major urban areas. New York and Los Angeles alone account for 17 percent of all Veterans experiencing homelessness in the United States. These 25 communities account for more than 40 percent of Veterans experiencing homelessness. This effort builds off previous boot camps and technical assistance and helps local communities strengthen coordinated, community-based assessment systems for assisting Veterans experiencing homelessness to access appropriate housing and supportive services options.

Zero: 2016 Campaign

HUD and our Federal partners will continue to help communities improve the identification, assessment, and housing placement of Veteran, as well as non-Veterans experiencing chronic homelessness through HUD's technical assistance support of the Zero: 2016 Campaign, a targeted initiative which includes 67 communities from across the country. This campaign is a rigorous follow-up to the 100,000 Homes Campaign and involves hands-on coaching, the implementation of transparent data and performance management strategies, and a shared learning environment for these 67 communities, who are committed to ending Veteran and chronic homelessness. Each community will develop "take down" targets, specific targets

for the number of people they must house each month, to end Veteran homelessness by December 2015 and chronic homelessness by December 2016. This effort dovetails nicely with other large-scale initiatives helping communities end homelessness, including the 25 Cities initiative and the Mayor's Challenge to End Homelessness, championed by First Lady Michelle Obama.

Mayors Challenge to End Veteran Homelessness

The Mayors Challenge is a great example of how HUD has collaborated with our federal partners, the National League of Cities, and with local governments to commit to ending Veteran homelessness. I am excited to announce that, as of last week, more than 350 mayors, governors, and county executives from across the country have pledged to end Veteran homelessness in their community.

Conclusion

Mr. Chairman and members of the Committee, I hope this discussion has been helpful to your understanding of how HUD, VA, and USICH collaborate on ending homelessness among Veterans, and how we work together on the HUD-VASH program in particular. Thank you for this opportunity and I'm prepared to answer any questions you may have.

STATEMENT
OF
KEITH KELLY
ASSISTANT SECRETARY OF LABOR
VETERANS' EMPLOYMENT AND TRAINING SERVICE
U.S. DEPARTMENT OF LABOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

December 11, 2014

Introduction

Good Morning Chairman Miller, Ranking Member Michaud and distinguished Members of the Committee. Thank you for the opportunity to testify here today on the Department of Labor's (DOL or the Department) commitment to ending homelessness among veterans and our efforts to provide these brave men and women with the services and support they need to succeed in the civilian workplace.

The Department is committed to helping the Administration meet its goal of ending homelessness among veterans in 2015, as guided by *Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness*. In leading this effort, the U.S. Interagency Council on Homelessness (USICH) has generated powerful national partnerships at every level to work toward ending homelessness across the nation. Currently, Secretary Perez serves as the Council Chair. Through these interagency efforts and many others, the Administration has achieved historic progress. According to Housing and Urban Development's (HUD) 2014 Annual Homeless Assessment Report to Congress, homelessness among veterans has declined from 74,770 veterans experiencing homelessness, both sheltered and unsheltered, in 2010, to 49,993 on a single night in January 2014 – a decrease of 33 percent. For 2014, veterans represented 11 percent of the total 442,723 homeless adults. Most veterans experienced homelessness as individuals, 38,985 people or 96 percent. However, there were 1,708 veterans, or 4 percent, were homeless as members of families with children. Female homeless veterans accounted for 10 percent of both the sheltered and unsheltered homeless veteran populations. While homelessness among veterans has improved, much work remains to be done.

To help meet this goal, the Department's Veterans' Employment and Training Service (VETS) works every day to help veterans through the Homeless Veterans Reintegration Program (HVRP), providing grantees with the services necessary to assist in reintegrating homeless veterans into meaningful employment within the labor force and to stimulate the development of effective service delivery systems that will address the complex problems facing homeless veterans. Also, the Department brings to bear programs operated at nearly 2,500 American Job Centers (AJCs) nationwide, including the Jobs for Veterans State Grant (JVSG) program. At the AJCs, veterans receive priority of service in all employment and training programs funded directly, in whole or in part, by DOL.

Secretary Perez and I know that one of the most important ways to prevent homelessness is through a good job. However, employment is not the only factor in preventing veterans from

falling back into homelessness. Long-term stability requires a coordinated level of care between many federal partners like the Departments of Veteran Affairs (VA) and Housing and Urban Development (HUD), state and local organizations, non-profits, and the private sector to ensure veterans are successful in overcoming the barriers created by homelessness.

Homeless Veterans Reintegration Program

The goal of HVRP is to provide employment and training services to homeless veterans so that they can be reintegrated into the labor force, and to stimulate the development of effective service delivery systems which address the complex problems homeless veterans face.
The HVRP is authorized by 38 U.S.C. § 2021. The HVRP is one of the few nationwide federal programs focusing exclusively on helping homeless veterans to reintegrate into the workforce.

HVRP funds are awarded annually on a competitive basis to eligible applicants, including: state and local Workforce Investment Boards, tribal governments and organizations, public agencies, for-profit/commercial entities, and non-profit organizations, including faith and community based organizations. HVRP grantees provide an array of services to homeless veterans through a holistic case management approach, which includes critical linkages to a variety of support services available in local communities.

Successful HVRP grant applicants must specifically describe how their outreach to homeless veterans will build an effective level of collaboration with other entities, such as VA's Grant and Per Diem (GPD) grantees, the HUD-VA Supportive Housing (HUD-VASH) Program, VA's Supportive Services for Veteran Families (SSVF) grantees, Health and Human Services (HHS) grantees, and VA's Homeless Veteran Supported Employment Program (HVSEP).

HVRP operates on the principle that when homeless veterans attain meaningful and sustainable employment, they are on a path to self-sufficiency and their susceptibility to homelessness is diminished. HVRP is employment-focused; each participant receives customized services to address his or her specific barriers to employment. Services may include, but are not limited to, occupational, classroom, and on-the-job training, as well as job search, placement assistance, and post-placement follow-up services.

Historically, through HVRP, the Department has funded two additional types of grants designed to address difficult-to-serve subpopulations of homeless veterans: the Homeless Female Veterans and Veterans with Families Program (HFVVWF) and the Incarcerated Veterans' Transition Program (IVTP). In addition, through HVRP the Department supports "Stand Down" events and technical assistance grants.

The Homeless Female Veterans and Veterans With Families Program

HFVVWF are competitive grants that specifically target the subpopulation of homeless female veterans and veterans with families who are "at risk" of becoming homeless. As noted in HUD's 2014 Annual Homeless Assessment Report to Congress, homeless women veterans accounted for 10 percent of the overall homeless veteran population. The program provides direct services through a case management approach that leverages federal, state, and local resources. Eligible

veterans and their families are connected with appropriate employment and life skills support to ensure a successful integration into the workforce.

HFVVWF grantees incorporate support services to address the specific needs of their target population. Some examples of the types of programs and services these grantees offer include the following:

- Established networks of providers that offer safe, transitional housing support for up to two years and staff who have experience in serving female homeless veterans and/or the capability of providing family counseling and youth development services for homeless female veterans with families;
- Childcare and/or after school care support to assist while the veteran is engaged in work-related education and employment programs or scheduled for appointments relating to their individual development plans;
- Linkages with mental health, primary care, substance abuse treatment, access to pediatric care, sexual trauma therapy, Post-Traumatic Stress (PTS) therapy, and other health-related services through VA medical facilities or accredited community health service providers;
- Community resources which provide legal assistance in areas of family law, domestic violence, child support enforcement, and poor credit history counseling and repair; and
- Coordination with the VA to ensure participants apply for benefits and have support if they appeal their VA benefits claim.

The Incarcerated Veterans' Transition Program Grants

The IVTP was last funded in FY 2010. Those grants continued up through September 30, 2013, when authority to provide services under the program expired. IVTP grants were designed to support incarcerated veterans who are at risk of homelessness by providing referral and career counseling services, job training, placement assistance and other services. Eligible IVTP participants included veterans who were incarcerated and were within 18 months of release, or were released less than six months from a correctional institution or facility. For Program Year (PY) 2012, IVTP grantees enrolled 1,408 participants and had a placement rate of 63.4 percent with an average hourly wage of $10.69 at placement.

Stand Down Grants & Technical Assistance Grants

Through HVRP, the Department also supports "Stand Down" events. These events, typically held over one to three days in local communities, provide an array of social services to homeless veterans. Stand Down organizers partner with federal and state agencies, local businesses and social services providers to offer critical services, including temporary shelter, meals, clothing, hygiene care, medical examinations, immunizations, state identification cards, veteran benefit counseling, training program information, employment services, and referral to other supportive services. Funding for employment services and incentives for homeless veteran participants, such as hot meals and climate appropriate clothing, are provided through non-competitive grants awarded on a first-come, first-served basis until available funding is exhausted.

The HVRP grant also provides funding to the National Veterans Technical Assistance Center (NVTAC). The NVTAC is a Technical Assistance (TA) center which provides a broad range of technical assistance on veterans' homelessness programs and grant applications to existing and potential HVRP, HFVVWF, and Stand Down grantees; interested employers; Veterans Service Organizations (VSOs); and federal, state, and local agency partners.

HVRP Program Performance & Best Practices

HVRP's client-centric, hands-on approach has successfully helped place thousands of previously-homeless veterans, some of whom were chronically homeless, on a path to self-sufficiency. In FY 2013, DOL was allocated $36,187,711 for HVRP. With these resources, DOL funded 35 new HVRP grants, 90 option-year HVRP grant extensions, 22 HFVVWF grants, 14 IVTP grants, and 90 Stand Down grants. These grantees enrolled 16,133 participants, placing 63.4 percent into employment, with a cost per placement of $2,965.39.

In FY 2014, the HVRP program received an appropriation of $38,109,000 with which the Department awarded 37 new HVRP grants, 82 option year HVRP grants, 18 HFVVWF grants, and 66 Stand Down grants. These grantees are expected to provide services to over 17,000 homeless veterans, with an estimated placement rate of 66 percent, at an estimated cost per participant of $2,200. In addition, to support grantees and disseminate best practices, the Department awarded two technical Assistance Cooperative Agreements.

The Department has taken significant steps to ensure that grantees provide job-driven training to participants. In its FY 2014 grant competition, applicants were required to identify training strategies based on local labor market information and collaboration with employers. In addition, the Department is modernizing its HVRP grant review process, converting it to a streamlined electronic grant review process that can be conducted online. Grant reviewers will be able to participate in an on-line review from remote locations, which could result in significant savings in time and resources. Finally, DOL plans to launch online competitive grant training to train all staff on grant oversight and administration. This training will help DOL to maintain a high quality of Federal oversight of competitive grantees and improve our ability to provide technical assistance and customer service to grantees.

HVRP grant recipients are measured against four performance outcomes outlined in our policy guidance. The performance outcomes are: (1) Number of Enrollments; (2) Number of participants placed in unsubsidized employment; (3) Placement Rate; and (4) Cost per Placement. DOL staff works closely with grantees to help them succeed and to achieve their goals for all four performance outcomes. A significant portion of the PY 2014 HVRP grant scoring criteria required applicants to develop formal job-driven employment and training service plans for their participants, based on the elements found in Vice President Biden's Job-Driven Training Initiative. HVRP grant recipients also report on the average earnings for individuals who retain employment. In addition, Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representatives (LVER) staff support HVRP grantees by helping grantees achieve entered employment goals through case management, direct employer contact, job development, and follow-up services.

The HVRP program succeeds, not only because of the hard work and local connections of our grantees, but also because of the collaborative efforts of our government partners at the Federal and State levels. These efforts help ensure that homeless veterans receive a robust, comprehensive network of support.

Jobs for Veterans State Grants (JVSG)

Finally, DOL awards the JVSG as a formula grant to each state, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. These grants support two types of staff positions in the AJC network: DVOP specialists and LVERs. DVOP specialists provide intensive services targeted at meeting the employment needs of disabled veterans and other veterans with significant barriers to employment, which includes homeless veterans. DVOPs also work in close cooperation with the Department of Veterans Affairs through the Vocational Rehabilitation and Employment (VR&E) program to provide employment support to veterans who have completed rehabilitative training. In addition, DVOP specialists often refer veterans who experience homelessness to other AJC services such as the Workforce Investment Act Adult and Dislocated Workers services and training. AJCs provided services to 17,734 homeless veterans in PY 2013 (July 2013 – June 2014). For their part, LVERs conduct outreach to employers and engage in advocacy efforts with local businesses to increase employment opportunities for veterans, and encourage the hiring of veterans.

Conclusion

We, at the Department of Labor, remain committed to the Administration's goal of ending veteran homelessness in 2015 and we look forward to working with the Committee to ensure the continued success of our efforts. Mr. Chairman, Ranking Member Michaud, and Members of the Committee this concludes my statement. Thank you again for the opportunity to testify today. I am happy to answer any questions that you may have.

STATEMENT OF
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SUBMITTED TO THE
Committee on Veterans' Affairs
U.S. House of Representatives
Hearing on Ending Veteran Homelessness

December 11, 2014

Chairman Miller, Ranking Member Michaud, and Members of the Committee, as executive director of a community-based nonprofit organization that partners with the Department of Veterans Affairs, I thank you for inviting me to present our perspective on progress toward VA's goal of ending veteran homelessness by the end of 2015.

Founded in 1991 by a grassroots coalition of businesses, congregations and concerned community members, Friendship Place is a leader in Washington, D.C., in developing and implementing innovative solutions to homelessness that have demonstrable results and a lasting impact. Our customized, person-focused programs include street outreach, drop-in, free medical and psychiatric services, job placement, case management, transitional shelter, rapid rehousing, homelessness prevention, permanent supportive housing, specialized services for homeless youth and young adults, and rapid rehousing and homelessness prevention for veterans and their families. In 2013, we helped 1,000 people and in 2014, more than 2,000.

In October 2014, The Community Partnership for the Prevention of Homelessness (the agency responsible for coordinating DC's homeless services Continuum of Care) presented its 25th Anniversary Award "for extraordinary service to homeless single adults" to Friendship Place.

We accomplish our mission – to empower individuals and families experiencing or at risk of homelessness to rebuild their lives with the involvement of the community – with the help of more than 300 volunteers, who contributed almost 20,000 hours of service in the past year, and the support of 26 neighboring congregations, several of which partner with us to provide shelter or housing.

Friendship Place has participated in the DC VA Medical Center's annual January Stand Down, Winterhaven, since 2010. In October 2011, we received a small grant (as a subcontractor to another organization) to provide homelessness prevention and rapid rehousing services under VA's Supportive Services for Veteran Families (SSVF) program. In October 2012, we applied directly to VA and received a $1 million SSVF grant for fiscal year 2013. Based on our successful outcomes, VA awarded Friendship Place Mentor Status, increased our SSVF funding to $2 million for 2014, and renewed our contract at the same level for 2015. We call our SSVF program "Veterans First."

On June 18, Friendship Place launched Families First, a pilot project for veteran families in Prince George's County, Maryland, who need more support than SSVF can provide. With funding from the Maryland Department of Housing and Community Development and the Freddie Mac Foundation, Families First will serve 40 to 45 veteran families over the next three years. The goal of the program is to end both homelessness and poverty for the participating families. Case management places a special focus on increasing income through education, job placement, and benefits. Eligible families must have at least one dependent child and be below 50 percent of the Area Median Income. They are provided intensive case management for six months with possible re-certification for up to three years.

The Director of our Housing First Division and I are both members of the 25 Cities – a joint initiative of VA, the Department of Housing and Urban Development (HUD), the U.S. Interagency Council on Homelessness (USICH), Community Solutions, and the Rapid Results Institute – whose aim is to achieve VA's goal of ending veteran homelessness nationwide by the end of 2015 through implementing Coordinated Entry. Friendship Place has assumed a leadership role in implementing Coordinated Entry for DC through Veterans NOW and the 25 Cities Initiative (which will be folded into Zero:2016 in January 2015).

Based on our four years of experience working closely with both the DC VA Medical Center and VA's National Center on Homelessness among Veterans, we would like to present our perspective in four areas concerning Federal efforts to end veteran homelessness: (1) the SSVF program, (2) the joint VA-Department of Housing and Urban Development Supportive Housing Program (HUD-VASH), (3) the Department of Labor's Homeless Veterans Reintegration Program (HVRP), and (4) character-of-discharge issues in the SSVF program.

1) SSVF

In the previous year of our provision of SSVF services in DC and eight surrounding counties in Maryland and Virginia (fiscal year 2014):

- Our Veterans First program served 415 veteran households – 89 percent of them with Extremely Low household incomes (less than 30 percent of the Area Median Income)
- We exited 267 households, representing 461 individuals (including 147 children).
- 92 percent of those who exited (425) graduated to stable permanent housing.
- The average length of time from intake to exit was just under three months (88 days) for homelessness prevention and just over three months (104 days) for rapid rehousing.

In other words, 425 people who would have remained or become homeless but for our intervention are now safely housed and rebuilding their lives. The average cost per household served is less than $5,000 – a small price to pay for stability for an entire family.

We know that the program is effective. The annual Point-in-Time enumeration reveals that the number of homeless veterans dropped by 23 percent in DC and by 20 percent in the Metro area from 2012 to 2014, at a time when homelessness among the general population has risen.

We would like to draw your attention to key features of the SSVF program that, from our perspective as a community provider, make it successful:

- It is based on nationally recognized best practices, including the Housing First service model.
- It is empowering. In the words of one of our Veterans First graduates, the program is a "hand up," not a "hand out." The service model recognizes that the individual or family is resilient and can rebuild quickly with the right kind of help.
- It is individualized and participant-centered. SSVF does not dictate that we deliver services in a cookie-cutter manner but gives us flexibility to provide exactly what each particular household needs – no more and no less – to transition rapidly into stable housing.
- Clinically, the program is backed by CARF, the national gold standard for rehabilitation services.
- SSVF is flexible, allowing us as the service provider to adapt services to the local community and allowing veterans to transfer agencies and even regions.
- As a community-based organization, we can leverage additional resources – volunteer support, private donations, and in-kind contributions – to enhance the assistance we are able to provide.

More than anything, the success of the SSVF program is due to the outstanding expertise of the national VA leadership and their unfailing commitment to working collaboratively with their local grantees, including Friendship Place, to continually refine and improve the service model so as to ensure that we are achieving the desired results as effectively and efficiently as possible. We would like, in particular, to recognize the contributions of Mr. Vincent Kane, Director of the National Center on Homelessness among Veterans; Mr. John Kuhn, National Director of VA Homeless Prevention Services; Mr. Dennis Culhane, Director of Research; and Ms. Adrienne Melendez, who is the Regional Coordinator for SSVF for our region.

We applaud this VA team for providing excellent training (monthly webinars, regional meetings, SSVF universities), for fostering collaborative relationships among SSVF providers (coordinating regional meetings in which we can share our best practices), and for soliciting and being responsive to our feedback.

Here in DC, VA has moved quickly to establish a system of Coordinated Entry, while the DC VAMC has developed productive partnerships with community providers and successfully cut the time for HUD-VASH lease-ups.

2) HUD-VASH

The success of SSVF provides ample evidence that VA can make effective use of community-based organizations to get results in its efforts to end veteran homelessness. We believe that VA could adopt the same model – contracting out to community providers – to achieve outstanding outcomes in the HUD-VASH program, as well.

There would be several advantages to contracting out HUD-VASH case management services to community providers:

- Community providers can have smaller caseloads and, therefore, more intensive case management. In Housing First programs, the larger the caseload, the less likely it is that those served will achieve long-term housing stability; smaller caseloads produce higher housing retention rates. Programs with low retention rates are more costly to the taxpayer in the long run, because participants who return to the streets then seek out other services elsewhere.
- Community providers have maximum flexibility to adapt their programs to local needs and conditions.

- Successfully linking program participants to community resources is key to the success of any Housing First program, and community providers are more familiar with and connected to resources in the local community.
- Separating the funding source and the service provider allows for better checks and balances; the funding source can more objectively evaluate programs that are run by an outside provider.
- Unfortunately, some veterans are uncomfortable seeking services at VA because of negative experiences they may have had in the past.

Friendship Place has been providing Housing First services under a contract with the DC Department of Human Services since 2008, with an annual housing retention rate that consistently tops 98 percent. Our Housing First Director and I would be happy to meet with any interested Congressional or VA staff to provide greater detail on what makes our Housing First program successful and how a community-based model could be implemented by VA.

3) HVRP

In 2013 and again in 2014, Friendship Place considered applying to Department of Labor's Homeless Veterans Reintegration Program (HVRP) for funding to provide employment services to expedite the reintegration of homeless veterans into the labor force. We would like to share with you the reasons we decided not to pursue this funding opportunity.

We read in the Department of Labor's RFAs (SGA-13-02 and SGA 14-02/PY 2014) that we would have to require 80 percent of participants to take part in job training activities. This requirement runs counter to the philosophy and practice of client-centered programming, which eschews one-size-fits-all requirements in favor of tailoring services around the needs of the individual participant to facilitate achievement of his or her goal, which, in the case of an employment program, would be a stable job.

Friendship Place has considerable experience helping homeless individuals, both veterans and otherwise, transition successfully back into the workforce. Our Veterans First (SSVF) staff includes an Employment Specialist, who has placed 100 SSVF participants into jobs since October 2012. His experience has revealed the following:

- Only three or four of the veterans he has worked with had any interest in or need for job training. The rest had marketable skills and wanted to get into jobs as quickly as possible; they were aware of the clock ticking on the financial support they could count on from

SSVF and wanted to know that they would be earning an income soon to be able to pay the rent to keep their families housed.

- Requiring people to complete training they do not want or need delays their entrance into the workforce. It creates a barrier that is frustrating and discouraging to the veteran, especially when there is no promise of a job at the end of the training program.
- Requiring job training is disempowering; it fails to acknowledge that the veteran may have acquired valuable skills and knowledge during their service or previous work experience, let alone previous educational or training experience.
- The veterans who seek our help may have any of a number of barriers to employment that they need help addressing: lack of childcare, gaps in their employment history, lack of a resume, poor job interview skills, lack of transportation, health or disability issues, problematic background checks, and so on. Providing or paying for training that is not needed diverts valuable staff and financial resources away from systematically addressing these urgent issues.
- The veterans we work with need a job now. Empowering them to achieve that goal does not preclude future training to get a better job later. In fact, many of them tell us they intend to do that, but putting a roof over their heads and food on the table for their families is their first priority.

Just as VA's housing services have moved to Housing First in order to remove all barriers for veterans in need, the vocational system needs to move to Employment First, to ensure that veterans can access employment as quickly as possible. We at Friendship Place recommend that Congress consider a job placement program for veterans that would be implemented by community-based organizations and would be consistent with the client-centered, Housing First philosophy and practices of SSVF and HUD-VASH. Such a program would help veterans find and pay for training programs if they want and need job training, but it would not require them to participate in job training if they do not need or want it. Instead, it would give the service provider flexibility to work with the veteran on an individualized basis to move him or her into stable employment as quickly as possible. Job development – building relationships with employers in the community to create job opportunities for veterans whose resumes might not otherwise be considered – would be a key part of such a program.

We have found that targeting resources in this way is cost-effective. In addition to the employment services that Friendship Place provides as part of our SSVF program, we also run a privately funded job placement program called AimHire. In just over three years, AimHire has placed 308 people – either homeless or at risk of eviction – into jobs, while securing or stabilizing the housing of 302 of them. Focusing on job development and job placement rather than job training, employing the client-centered approach described above, and making use of a

cadre of skilled volunteers with human resources and business experience, AimHire has achieved this at a cost of about $4,000 per household (individual or family), which includes placement into both employment and housing.

Our Veterans First Employment Specialist, AimHire Director and I would be happy to meet with any interested Congressional or VA staff to provide greater detail on what makes our employment programs successful and give input into the design of a similar VA or DOL program.

4) Character-of-Discharge Issues and SSVF

We would like to bring to your attention one final matter of great concern to all of us at Friendship Place.

Veterans with other than honorable discharges are among the most vulnerable of all the veterans that seek the help of our SSVF program. Eddie is a typical example; he was nearing completion of his enlistment with a record of exemplary service when his squad was attacked in Afghanistan and he was one of only a few survivors. He began self-medicating his PTSD, and ended up being discharged under other-than-honorable conditions.

It is our understanding that VA is currently reviewing its policies and authority to serve veterans with other than dishonorable discharges. If SSVF eligibility is limited to only those veterans that are eligible for VA health care, veterans like Eddie would be left out in the cold. Fortunately, we were able to get him legal assistance and walk him through the process of upgrading his discharge status, so that he is now VHA-eligible and can receive the help he needs and deserves.

Summary

We are excited and energized by VA's impressive progress toward ending veteran homelessness and are honored to partner in this admirable – and much-needed – work.

We believe that the following recommendations, if implemented, could expedite the success of VA's efforts:

1. Extend the authorization of appropriations for the highly successful SSVF program.
2. Contract out the provision of case management services for HUD-VASH to community providers.

3. Adopt the Housing First service model – low-barrier, client-centered – in employment programs offered to veterans (VA or DOL).
4. Continue to allow SSVF providers to serve any veteran with an honorable or other than honorable discharge.

These recommendations not only are aligned with best practices in the field of homeless services, but would, we believe, make VA's entire system of services for homeless and at-risk veterans and their families both more cost-effective and more humane.

Thank you for the opportunity to participate in this important discussion.

Written Testimony

By

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On behalf of the National Rural Health Association

For the

United States House

Committee on Veterans' Affairs

December 11, 2014

The National Rural Health Association (NRHA) is pleased to provide the United States House Committee on Veterans' Affairs with a statement for the record on Evaluating Federal and Community Efforts to Eliminate Veteran Homelessness.

NRHA is a national nonprofit membership organization with a diverse constituency of 21,000 individuals and organizations who share a common interest in rural health. NRHA's mission is to improve the health of rural Americans and provide leadership on rural health issues through advocacy, communications, education, and research.

The members of NRHA have maintained a special concern for the health care needs of rural veterans for many years. NRHA was one of the first non-veteran service organizations to develop a policy statement on rural veterans, and strongly advocates expanding access to care for rural veterans, including improving the ability of providers to treat rural veterans, enhancing care delivery mechanisms, expanding access, and promoting provider understanding of the special needs of rural veterans. NRHA is pleased to have been one of the first national organizations to support the creation of the VHA Office of Rural Health and enjoys an ongoing and highly productive relationship with this office within VA.

While only 20% of Americans live in rural areas,[1] a disproportionate number of those serving in the military come from rural communities. Currently, there are approximately 22 million living veterans in the United States, with about 5.3 million (24%)[2] living in rural areas. Rural Americans also comprise 36% of the total enrolled veteran population in the U.S. Department of Veterans Affairs (VA) system, and 15% of

[1] U.S. Census, 2010. Washington: Government Printing Office, 2010.
[2] Veterans Health Administration Office of Rural Health (May 2014). Fact Sheet: Information about the Office of Rural health and Rural Veterans.

veterans live with at least one service-connected disability.[3] The most common of these disabilities are tinnitus and hearing loss, post-traumatic stress disorder (PTSD), diabetes mellitus, musculoskeletal issues, and traumatic arthritis.[4] Rural veterans are also aging significantly – the median age is 62, compared with 44 in urban areas.[5] While rural veterans generally mirror their rural population cohort, many times they experience layered complexities that their urban counterparts may not experience, such as a lower median income and fewer housing options.

Unfortunately, it is not true that all veterans have local access to comprehensive care. Combat veterans in need of specialized physical and behavioral care returning to their rural homes will likely find that access to care is extremely limited. Because of the disproportionate number of rural Americans serving in the military, there is a greater need for veteran-centered care in rural areas, making it difficult for rural veterans to receive timely, appropriate services.

When rural veterans are unable to get adequate care, their challenges can compound. Lingering effects from untreated PTSD and other psychological injuries can often contribute to veteran homelessness. Among Iraq and Afghanistan veterans who screen positive for PTSD or depression, 19% report possible TBI, 45% have mental illness, and 70% suffer from substance abuse issues.[6] The lack of access to trained professionals in rural areas may also be a contributing factor to the observed increase in homelessness in these areas. Support networks are key in the reintegration process, and homeless veterans are more socially isolated than the nonveteran homeless population.

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[3] Veterans Health Administration Office of Rural Health (April 2013). Fact Sheet: Information about the Office of Rural health and Rural Veterans.
[4] Veterans Benefit Administration (June 2013). Annual Benefits Report Fiscal Year 2012.
[5] Minnesota Population Center. Integrated Public Use Microdata Series: Version 3.0. Minneapolis: University of Minnesota, 2010.
[6] Henry, M. Cortes, Al, and Morris, S. The 2013 Annual Homelessness Assessment Report (AHAR) to Congress. US Department of Housing and Urban Development.

Many rural veterans face significant geographical barriers to obtaining their care. Driving long distances is a challenge for veterans with poor health or limited financial resources, veterans needing specialized or routine care, or those needing emergency care. In addition to geographical challenges, veterans in rural areas may face further barriers to accessing care such as unemployment, lack of health insurance, and limited finances. Also, the social determinants that can result in overall poorer health status, are prevalent in many rural areas across the country. The health disparities emerging from these issues are further compounded for those rural veterans who are additionally burdened with combat-related stress, chronic disease, mental health challenges, homelessness, and/or substance abuse. In their lifetimes, an estimated 50% of rural homeless veterans will experience mental illness and 70% will have a substance use disorder.[7]

These barriers to care in rural America contribute to the fact that veterans make up a greater portion of the homeless population in rural areas.[8] Rural homelessness comprises 7% of total homelessness,[9] and these populations are more invisible to the general public and current efforts to identify rural homeless veterans do not adequately address the extent of the geography that must be covered and the high-level resources needed to accurately count them.

Rural homelessness presents a unique and difficult problem. Rural areas harbor fewer employment opportunities, lower wages, and longer unemployment periods, and also generally lack emergency or temporary homeless shelters and targeted service

[7] DeLong, Katie. "Wisconsin receives $1.2 million federal grant to help homeless veterans." November 11, 2014. Fox News.
[8] U.S. Department of Housing and Urban Development. 2012. The 2011 Annual Homeless Assessment Report to Congress.
[9] Jackson, A. and Shannon L. Examining Social Support in a Rural Homeless Population. Journal of Rural Social Sciences, 29(1), 2014, 48-74.

providers.[10] Again, to collect accurate data on the rural homeless is a more nuanced prospect, and the situation does not often fit federal or other official definitions.[11] In 2009, nearly eight million rural residents lived below the poverty line[12] – in addition to facing a lack of affordable housing, the rural homeless must also contend with substandard housing, rent increases, lack of public transportation, limited subsidized housing programs, and long distances between affordable housing and job opportunities.[13] All these factors contribute to veteran homelessness.

While homelessness has historically been significantly more prevalent in the urban veteran population, the issue is an increasing concern in suburban and rural areas. Though 21% of Americans live in rural places, 25% of all veterans live in these communities.[14] The year-over-year increase for 2009-2010 in the number of sheltered homeless veterans, as reported by the VA in 2012, was approximately 18.5% for suburban and rural areas, compared with only 1.3% for urban areas.[15] Veterans in general are overrepresented among the national homeless population, and rural veterans face unique barriers. Rural veterans are more likely to be homeless for longer and have serious medical issues, and face limited opportunities for adequate shelter and care.

Homelessness often takes unique forms in rural areas, and rural veterans face different challenges than their urban counterparts – geographic isolation being a key component of these difficulties. Though the 2014 Point-in-Time (PIT) Count, declared

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[10] Ibid.
[11] Jackson, A. and Shannon L. Examining Social Support in a Rural Homeless Population. Journal of Rural Social Sciences, 29(1), 2014, 48-74.
[12] National Law Center on Homelessness and Poverty, 2011.
[13] Jackson, A. and Shannon L. Examining Social Support in a Rural Homeless Population. Journal of Rural Social Sciences, 29(1), 2014, 48-74.
[14] Oberdorfer, Eric. "In Rural America, Veterans Continue to Fight for Housing Aid." November 12, 2013. Rooflines.
[15] National Center for Veterans Analysis and Statistics (September 2012). Profile of sheltered homeless veterans for fiscal years 2009-2010.

that the number of homeless veterans dropped to 57,849, it is unclear how much progress has been made against veteran homelessness in rural America.[16]

Inadequate housing and lack of affordability are also significant challenges to rural veterans. About 38% of veterans in rural areas are cost-burdened, and 23% live in inadequate housing. Veterans in nonmetropolitan areas are also more likely to live in substandard housing than veterans in general, and overcrowding can be a proxy to homelessness.[17] In addition, rural veterans are on average 18 years older than urban veterans (70% of rural veterans are 55 or older[18]), and thus face expenses in home modernization, which may force them into poorer living conditions.[19] 83.3% of rural veterans own their homes, and aging makes it more difficult to sustain independent living in their homes – grants for home modifications and caregiving subsidies may not be readily available in their areas. Younger returning veterans also struggle to find and sustain affordable housing in rural areas, which have less rental options. Not all these veterans qualify for the VA loan guaranty program for home buyers – in 2012, 16.8% of VA loan applications were not granted for rural America.[20] Supportive housing vouchers, a small proportion of which are allocated to VA Medical Centers (VAMCs), come with restrictions on where veterans can find housing – "within a reasonable distance from a VA facility" – such that appropriate shelter may be more difficult to locate.[21]

Though new programs, VA and otherwise, have provided innovative solutions to homelessness, not all of them reach rural places as well as urban centers. The U.S.

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[16] Shane III, Leo. "Homeless vets in rural areas lack options, advocates say." April 11, 2014. Army Times.
[17] Housing Assistance Council (2014). From Service to Shelter: Housing Veterans in Rural America.
[18] Oberdorfer, Eric. From Service to Shelter: Housing Veterans in Rural America. Housing Assistance Council. September 11, 2014.
[19] Shane III, Leo. "Homeless vets in rural areas lack options, advocates say." April 11, 2014. Army Times.
[20] Oberdorfer, Eric. "In Rural America, Veterans Continue to Fight for Housing Aid." November 12, 2013. Rooflines.
[21] Ibid.

Department of Housing and Urban Development, for example, has issued about 60,000 VA Supportive Housing vouchers over the past five years, but only three percent of these vouchers were distributed to VAMCs in rural areas.[22] NRHA strongly supports specific solutions to meet the challenges of providing quality care to our rural veterans and preventing homelessness. NRHA believes that improving access to care must be a priority for both the Administration and Congress, and submits the following recommendations:

1. Expanded Non-VA Care Program

In order to enable rural veterans to obtain care more easily, the VA should develop and implement policies that encourage use of the Non-VA Care Program in rural areas in a consistent manner across all Veterans Integrated Service Networks (VISNs) and that reflect a "best interest of the veteran" standard for utilization determinations.

In some rural areas local providers are inconsistently included in VHA networks, meaning that many veterans do not have access to these routine specialty services unless they are willing and able to travel significant distance to a central VA facility. Given the most prevalent conditions for which veterans seek treatment, the lack of availability of specialty providers in these areas is particularly concerning. In response to Veteran wait times and access issues created by long distances to VA facilities, the VA created the "Veterans Choice Card" as part of the "Veterans Access, Choice and Accountability Act of 2014. These cards were sent to eligible Veterans this past November and as more rural Veterans are enrolled and receive the Veteran Choice Cards for coverage by non-VHA providers, more efforts are needed to educate non-VHA providers about this who is eligible for this coverage and the requirements for provider participation. Community

[22] Ibid.

based education efforts in rural areas are needed to increase the awareness of both rural Veterans and non-VHA providers to the benefits of this coverage.[23]

Additionally, the increasing number of female veterans is creating new demand for women's health services, including basic obstetric and gynecologic services. Between 1992 and 2011, the percentage of rural women veterans more than doubled, rising from 3% to 7%.[24] The general critical shortage of obstetric and gynecological providers for all women in rural areas combine with the fact that VA-sponsored Community Based Outpatient Clinics (CBOCs) are not always staffed to provide obstetric and gynecological services causes female veterans to often travel significant distances to VA Medical Centers (VAMCs) for women's health services. In addition, female veterans are often at higher risk of homelessness than nonveteran females and male veterans, and are more highly concentrated in rural regions.[25] The Non-VA Care Program's network of fee-based specialty providers should be evaluated and expanded to ensure alignment with the most prevalent outpatient specialty needs of rural veterans.

VA should standardize and streamline policies regarding use of non-VA providers to better facilitate provider participation in the Non-VA Care Program and to expedite access for veterans to locally provided health care services, particularly specialty services.

VA should expand training programs for non-VA rural providers on evidence-based military, deployment, and post-deployment health and mental health diagnoses and treatment.

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[23] Philpot, T. "How 'Choice Card' and $15B will help veterans get care." Stars and Stripes. July 31, 2014.
[24] U.S. Department of Agriculture, Economic Research Service. Rural Veterans at a glance. Economic Brief 25.
[25] U.S. Department of Housing and Urban Development. 2012. The 2011 Annual Homeless Assessment Report to Congress.

2. Expanded Training and Education for TRICARE

Creating the best health care system for rural veterans requires that both patients and providers are aware and informed of the options available in the system. A key barrier to care is the lack of provider awareness and acceptance of TRICARE benefits. An April 2013 report found that 1 in 3 beneficiaries had difficulty finding a civilian provider who would accept TRICARE, and that only 39% of these providers would accept TRICARE patients.[26] Therefore, the U.S. Department of Defense (DoD) and VA should also develop a TRICARE health care provider education and awareness program to inform providers about the program and how to participate. Rural health providers should be particularly targeted for this provider education and awareness program.

Through its Office of Academic Affiliations, VA should increase its role in the training of undergraduate and postgraduate health professionals' education in evidence-based diagnosis and treatment of military-related health and mental health conditions and treatments across the trainee populations.

In addition, VA should develop a benefit education outreach program that provides clear information for patients and providers on what services, especially emergency services, are covered by VHA. Materials need to be readily accessible, easy to understand, and structured to encourage health and mental health-seeking behavior rather than deter seeking of care.

3. Mental Health Care

DoD and VA should develop a strategy specifically focused to materially increase the percentage of mental health providers willing to participate in the TRICARE

[26] U.S. Government Accountability Office. TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries. GAO-13-364.

program. Because of the link between mental health and homelessness, these initiatives are especially important.

Access to mental health specialists is even more limited for rural Americans and warrants specific attention. Rural areas in general suffer from a shortage of mental health specialists and face significant difficulties in recruiting and retaining qualified personnel to meet population needs.[27] Inadequate participation of available providers in VHA networks and a decreasing number of civilian providers who participate in the military's TRICARE system compound these shortages.

VHA has been increasingly using telemental health services to provide specialty mental health services in underserved areas. Telemental health services involve the use of communication technologies, particularly videoconferencing technology, to deliver various mental health services including diagnostic assessments, psychotherapy, and medication management. Advances in telemedicine capabilities holds potential to facilitate earlier identification and care of geographically isolated veterans affected by TBI and potentially reduce negative outcomes, including rates of suicide and homelessness.[28]

VA should continue to invest in research and application of telemedicine technologies to advance care, particularly mental health and brain injury care, for rural veterans. VA should also establish and report on quantitative and qualitative metrics that evaluate improvement in rural veteran health care access and health outcomes generated by Office of Rural Health (ORH) strategic plan initiatives. The approach to any mental

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[27] Jameson JP, Blank MB. The role of clinical psychology in rural mental health services: defining problems and developing solutions. *Clin Psychol.* 2007;14(3):283-298.
[28] Cote MJ, Siddharta SS, Vogel WB, Cowper DC. A missed integer programming model to locate traumatic brain injury treatment units in the Department of Veterans Affairs: a case study. *Health Care Manag Sci.* 2007;10:253-267.

health outreach program should recognize the cultural stigma associated with mental health care in rural communities, along with the role that rural and military values play in veterans' desire or lack thereof to seek certain types of care. This approach should also recognize the intrinsic support role of the clergy, peer veterans, and family in rural communities and incorporate these groups in this outreach. The VHA Office of Rural Health's Rural Veterans Outreach Tool Kit is an excellent example of outreach strategies that recognize rural culture and rural veteran care-seeking behaviors and should be more widely used in VHA outreach programs and services in rural areas.

4. Funding VHA's Office of Rural Health

Congress should affirm its commitment to rural veterans by funding ORH at requested levels for FY2015 and FY 2016, demonstration projects related to increasing use of telemedicine and related remote care delivery systems, expanding the CBOC network, and aligning service offerings with the needs of rural veterans. Research and reports on rural veteran experiences also provide deeper insight into population health and barriers to care, as care issues are likely magnified in rural settings. Continued funding and interest in ORH ensures that resources are directed to areas where they can most benefit rural veterans. ORH should be funded and encouraged to work with VHA Homeless Programs, U.S. Department of Housing and Urban Development (HUD), U.S. Interagency Council on Homelessness (USICH), Housing Assistance Council (HAC), and other national stakeholders on pilot programs to specifically develop a Point In Time (PIT) Count or other appropriate methodology in targeted rural communities that will accurately reflect the picture of rural veteran homelessness. This type of work and interaction across federal agencies could lead to a broader and clearer understanding of

the issues and needs of rural homeless veterans and the rural homeless population in general.

5. Chronic Homeless Classification

HUD should continue efforts to implement policies to expand the classification of "chronic homeless" to maximize the number of rural homeless veterans eligible for homeless services within HUD, VA, and other federal, state, and local programs.

Conclusion

Health care for rural veterans continues to be most affected by issues of access. Barriers are most commonly related to geographic distance, availability of specialty and primary care providers, and health benefit considerations. There is also a concerning lack of understanding by patients and providers regarding VA benefits (i.e., what is covered and where), and there is an equally concerning lack of awareness in the provider community of the TRICARE system. These barriers can lead to veterans forgoing care entirely because of difficulty accessing VA facilities. Rural veteran homelessness, while a multifaceted matter, can be attributed to the lack of access to health care, as well as PTSD.

Providing health care in rural communities requires unique solutions, and we must all be mindful of long-term needs of our servicemen and women. The wounded veterans who return to their rural communities today will not need care for just the next few fiscal years – it is estimated that caring for Iraq and Afghanistan veterans alone could cost between $600 billion to $1 trillion over the next 40 years.[29]

The National Rural Health Association appreciates the opportunity to provide our recommendations to the Committee on Veterans' Affairs. These programs are critical to

[29] Blimes LJ. Current and Projected Future Costs of Caring for Veterans of the Iraq and Afghanistan Wars (2011). Harvard University.

the rural health delivery system and for veterans to maintain access to high quality care in rural communities. We greatly appreciate the support of the Committee and look forward to working with Members of the Committee to continue making these important investments in the health of our rural veterans.

Statement for the Record

Evaluating Federal and Community Efforts to Eliminate Veteran Homelessness

Committee on Veterans' Affairs
United States House of Representatives

Laura Green Zeilinger

Executive Director

U.S. Interagency Council on Homelessness

December 11, 2014

Chairman Miller, Vice Chairman Bilirakis, Ranking Member Michaud, and Members of the Committee, thank you for the invitation to offer a statement for the record regarding the status and sustainability of the Federal government's goal of ending Veteran homelessness in 2015. This statement reflects the insights of the U.S. Interagency Council on Homelessness (USICH), the Federal agency responsible for coordinating and leading the Federal response to end homelessness.

In 2010, the Federal government, through the coordination of USICH, launched and began implementation of *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*. According to the latest available data, between 2010 and January 2014, we have reduced homelessness among Veterans by 33 percent, which includes a 43 percent reduction in unsheltered homelessness among Veterans. Veterans who lived for decades on the streets, in cars, abandoned buildings, and other places are now in safe, stable homes of their own.

We have achieved this progress through strong collaboration and by ensuring Federal resources are directed towards evidence-based solutions like Housing First, permanent supportive housing, and rapid re-housing. We have built and continue to strengthen a network of partnerships at all levels of government and with the private and not-for-profit sectors to provide an approach to ending homelessness that puts the needs of Veterans front and center.

We are effective at preventing and ending homelessness when Veterans receive a set of services that are tailored to meet their individual needs, regardless of where they seek assistance or where they are engaged by outreach teams. *Opening Doors* provides a Federal framework for this Veteran-centric approach, leading the way for a growing list of communities on track to end Veteran homelessness in 2015.

USICH and *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*

USICH is an independent agency within the Federal executive branch and is responsible for coordinating the Federal response to homelessness and creating a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation. USICH maximizes the effectiveness of the Federal Government in contributing to the end of homelessness. The Council consists of 19 Federal Cabinet secretaries and agency heads. The current Council Chair is U.S. Department of Labor (DOL) Secretary Thomas E. Perez and U.S. Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell serves as the vice chair.

USICH coordinates across Federal agencies and partners with state and local governments, businesses, faith-based and non-profit organizations, advocates, service providers, and people experiencing homelessness to achieve the goals of *Opening Doors*, the first ever comprehensive Federal strategic plan to prevent and end homelessness. Recently, the Government Accountability Office recognized USICH as one of four interagency groups that met GAO's key practices for enhancing and sustaining collaboration necessary to achieve meaningful results (GAO-14-220).

In 2010, USICH and Council agencies released *Opening Doors*, based on the vision that no one should

experience homelessness, and no one should be without a safe, stable place to call home. *Opening Doors* sets forth four bold and measurable goals, including the goal to prevent and end homelessness among Veterans in 2015. The Department of Veterans Affairs' goal to prevent and end homelessness among Veterans is aligned with *Opening Doors*. Furthermore, the plan states that Veterans should never find themselves on the streets, living without care and without hope.

An End to Homelessness among Veterans

An end to homelessness among Veterans does not mean that a Veteran will never experience a housing crisis again. Changing economic realities and the unpredictability of life may create situations where a Veteran could experience, re-experience, or be at- risk of homelessness. An end to veteran 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.

An end to homelessness among Veterans will be achieved when the Point-In- Time (PIT) count identifies that zero Veterans are experiencing unsheltered homelessness and no more than 12,500 Veterans, at any point in time, are on the pathway from housing crisis to housing stability. The 2016 PIT count will measure our progress through 2015. Already, a growing list of communities are on track to end homelessness among Veterans ahead of the Federal goal.

Through our national network of partners who implement evidence-based best practices, we can prevent homelessness among Veterans by identifying those who are most at-risk and quickly connecting them to programs that provide temporary financial assistance, access to housing, and to the health care, employment assistance and other supportive services that help them obtain and sustain housing.

The ultimate goal is that all Veterans have permanent, sustainable housing with access to high-quality health care, including primary care, specialty care, and mental health services, job training and employment, and other supportive services.

Evidence-Based Practices to End Veteran Homelessness

We know what is working to end homelessness among Veterans. Implementation of *Opening Doors* focuses on building unprecedented national collaboration around a Veteran-centered approach, using data to drive results, leveraging mainstream systems, targeting resources to the Veterans in greatest need, investing new resources strategically, connecting Veterans to opportunities that increase their economic success, and bringing evidence-based best practices—Housing First, permanent supportive housing, and rapid re-housing—to scale in communities.

Housing First

Effective Council collaboration and operationalizing lessons learned from HUD and Substance Abuse and Mental Health Services Administration (SAMHSA) funded programs have informed the interagency adoption of Housing First as a proven method of ending homelessness. The Department of Veterans Affairs (VA) also transformed its service delivery model, improving the effectiveness of programs aimed

at reaching the 2015 goal to end homelessness among Veterans. Fundamental to this transformation has been the adoption of a Housing First approach, an evidence-based and cost-effective strategy that immediately addresses the housing needs of individuals and families, providing them with a foundation from which to access other services and achieve stability.

Housing First is a proven method of ending all types of homelessness, including Veteran homelessness. The approach focuses on providing individuals and families experiencing homelessness with immediate access to permanent housing. Housing First yields higher housing retention rates, lower returns to homelessness, and significant reductions in the use of costly, crisis services and institutions by removing barriers to entry, such as prerequisites like completion of a treatment course or evidence of sobriety.

Using a Housing First approach, the HUD-VA Supportive Housing (HUD-VASH) Program is driving reductions in homelessness among Veterans while reducing costs. An evaluation of a 14-site pilot that began in FY 2012 serving approximately 700 Veterans showed that provision of assistance through Housing First resulted in positive health and housing placement outcomes at 36 months for participating Veterans and significant VA health care cost reductions, including:

- 32 percent reduction of total VA health care costs;
- 54 percent reduction in intensive inpatient costs ;
- 27 percent fewer emergency room visits;
- 33 percent fewer acute inpatient hospitalizations.

Communities that are fully implementing Housing First are demonstrating remarkable progress. USICH and Council agencies continue to build capacity to support Housing First. USICH maintains that, wherever possible, barriers to housing and services for all people who experience homelessness should be eliminated or mitigated.

Targeting of Permanent Supportive Housing and HUD-VA Supportive Housing Program

We know from decades of practice and research that, with permanent supportive housing, people with disabling conditions and long or repeated histories of homelessness are successful at attaining and maintaining housing, improving their health, and reintegrating into communities. Primarily, the HUD-VASH program provides interventions for Veterans experiencing chronic homelessness. Without this intervention the Veterans would likely remain in homelessness.

We also know from practice and research that permanent supportive housing saves money by breaking the costly cycle of chronic homelessness. Studies have shown that an average person experiencing chronic homelessness can cost communities between $30,000 to $50,000 per year in emergency room visits, medical bills, law enforcement and other services.[1] For the highest utilizers of these services, the

[1] *See* Culhane, Dennis P., Stephen Metraux, and Trevor Hadley. "Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing." *Housing Policy Debate* 13.1 (2002): 107-163.fle. *See also* Larimer, Mary E., Malone, Daniel K., Garner, Michelle D., et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol

costs can be several times that. In contrast, the cost to provide an individual with permanent housing with connections to the preventative services they need to achieve stability is only about $20,000. This represents a significant return on investment to taxpayers—not only in monies saved but also in visible and felt improvement in quality of life.

To ensure that HUD-VASH and other permanent supportive housing options are deployed for the most vulnerable Veterans, USICH worked closely with HUD and VA to develop a strategy to target resources to Veterans and families who are most in need. This strategy ensures that HUD-VASH and other permanent supportive housing options are deployed for the most vulnerable Veterans and that programs achieve the maximum impact and offset other public costs. HUD-VASH has exceeded its performance goal of ensuring that at least 65 percent of new and turnover vouchers are provided to Veterans experiencing chronic homelessness. Currently, 71 percent of new and turnover vouchers are provided to Veterans experiencing chronic homelessness. HUD-VASH is also an important intervention for families, female Veterans, and returning Veterans with severe disabling conditions.

Developing local service coordination teams is an effective way to strategically collaborate and allocate permanent supportive housing. These teams include program staff from VA homeless programs, the local public housing agency, Continuums of Care (CoCs), and city and other public officials. CoCs are charged with establishing and operating a centralized or coordinated assessment system locally, which increases access to homeless assistance and ensures that appropriate levels of assistance are provided to people based on their needs and strengths, including using permanent supportive housing for people experiencing chronic homelessness. VA's participation in developing local coordinated assessment systems, including a VA-led effort focused on establishing and operating a centralized or coordinated assessment system in 25 communities that represent 40 percent of the nation's Veterans who experience homelessness, has been critical to maximizing the impact of every dollar invested in ending homelessness. Permanent supportive housing provides proven and cost effective solutions that are adjustable to the varying needs of Veterans without fixed and artificial time limits.

Rapid Re-Housing and Supportive Services for Veteran Families

There is a growing body of evaluation and research demonstrating that rapid re-housing is an effective means of solving homelessness among Veterans, families, and others who are not experiencing chronic homelessness. Through rapid re-housing, Veterans and their families receive assistance quickly and are able to regain stable housing in a short amount of time. HUD's Homelessness Prevention and Rapid Re-Housing Program (HPRP) helped to prevent or end homelessness for more than 1.3 million people between 2009 and 2012. As a primary tool in HUD's HPRP, rapid re-housing allowed communities—in partnership with USICH and Council agencies—to retool outdated homelessness response systems to more quickly connect Veterans and their families with supports tailored to meet their needs. These collaborative and coordinated efforts are ongoing, and have paved the way for the success of rapid re-

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Problems." *JAMA.* 2009;301(13):1349-1357; Hall, Gerod; Davidson, Clare; Neighbors, Charles; Hogue, Aaron; and Morgenstern, Jon. "Public Service Use and Costs Associated with NY/NY III's Supportive Housing for Active Substance Users" (CASAColumbia 2014).

housing programs across the country, including VA's Supportive Services for Veteran Families program (SSVF). USICH promotes expansion of rapid re-housing as a part of community coordinated systems that quickly assesses Veterans and their families and links them to the best housing option.

SSVF is VA's rapid re-housing and homelessness-prevention program, which draws upon the strength of community agencies to provide focused, rapid, and flexible services to vulnerable Veterans and their families. The progress we have seen in preventing and ending Veteran homelessness is due in large part to strategic investments in evidence- based, cost-effective programs, such as SSVF. Services provided to these Veteran families have been highly effective. The number of Veterans and persons served by SSVF doubled between FY 2012 and FY 2013—the first and second years of operation—serving more participants than expected as the program grew from 32,676 to 65,303 participants, totaling nearly 100,000 Veterans and their family members (97,979 people in total, including more than 13,800 children) served altogether.

In 2014, VA published the Effectiveness of Permanent Housing Program FY 2013 Report, which reported results for the first year of operation of the SSVF program. The results indicated that 84 percent of households served had successfully exited to permanent housing. The program continues to prove cost-effective at an average cost of only $2,500 per household and median engagement of only 90 days. National SSVF program data reveals that this assistance is being targeted to the Veterans with the greatest housing challenges: three quarters of participants qualified as extremely low income. Growth of this program builds on these proven results and effective coordination with community partners.

As the number of Veterans experiencing homelessness decreases, those who remain homeless or at-risk are increasingly younger, female, and/or part of a family. SSVF's target populations include younger Veterans returning from Afghanistan and/or Iraq, female Veterans, and Veterans with at least one dependent family member. In fact, nearly 17 percent of all Veterans served by the SSVF program in FY 2013 were returning from Afghanistan and/or Iraq. Roughly fifteen percent of Veterans served by SSVF in FY 2013 were female, the highest proportion of women served of any VA homelessness initiative, and a higher proportion than the national rate of female Veterans in the United States. Homelessness among female Veterans increased by eight percent from 2013 to 2014, though female Veterans represent less than 10 percent of all Veterans experiencing homelessness. This increase demonstrates the need for increased resources, like SSVF, designed to serve female Veterans. Moreover, 45 percent of all those served by SSVF in FY 2013 were part of a household with children. In FY 2014, SSVF served approximately 125,000 participants.

The drawdown of troops could lead to a new cohort of Veterans that need homelessness prevention and rapid re-housing assistance. USICH is concerned that the FY 2015 spending cap placed on the SSVF program in the Department of Veterans Affairs Expiring Authorities Act of 2014(P.L. 113-175) could reduce VA's capacity to sustain an end to homelessness among Veterans beyond the 2015 goal.

Increasing Economic Security

Jobs are a key part of preventing and ending homelessness among Veterans. *Opening Doors* focuses on increasing meaningful and sustainable employment opportunities for Veterans and for all sectors of

society by improving access to mainstream workforce and income support programs to reduce financial vulnerability to homelessness.

Programs like DOL's Homeless Veterans Reintegration Program (HVRP), employment programs available through American Job Centers across the nation, and other programs available at the State and local level help Veterans who are experiencing homelessness reintegrate into society and the labor force. Services include job placement, on-the-job training, career counseling, life skills training, money management mentoring, and help in finding housing. For the period July 1, 2012 to June 30, 2013, HVRP successfully connected 11,317 Veterans with meaningful employment. Without the ability to get and keep a job, many Veterans cannot sustain housing stability. Many Veterans have poor credit and major legal histories that present significant challenges. The Council recognizes that to end Veteran homelessness and sustain housing stability, many more Veterans need employment and the supports that help them access and retain employment. The Council is working to increase employment opportunities for Veterans who are experiencing, leaving, or at-risk of entering homelessness.

Ending Homelessness among Veterans who are Ineligible for VA Health Care

Our goal is to end homelessness among all Veterans, regardless of their eligibility to receive VA health care. CoCs are charged with serving all people experiencing homelessness, including those Veterans who are not eligible to participate in VA's homeless programs and services. In the Fiscal Years 2013 and 2014 Continuum of Care Program Competition, HUD included Veterans who are ineligible for VA benefits among its priority populations. The Council helps communities partner local CoCs and VA Medical Centers together in order to identify and connect Veterans to housing and services offered by CoC-funded providers.

A National Network of Partnerships and Collaborations

Opening Doors makes solving homelessness among Veterans the responsibility of the entire Federal government in partnership with state and local community providers. Only by working together, in coordination and partnership, have we achieved such significant progress. Only by continuing this unprecedented collaboration will we achieve an end to homelessness among Veterans. The goal cannot be reached by one Federal department or agency alone, nor can it be reached without intentional and meaningful partnership and coordination with state, community, and private and not-for-profit partners. USICH is driving the collaboration and partnerships necessary to end homelessness among Veterans.

The Mayors Challenge

Launched earlier this year, the Mayors Challenge to End Veteran Homelessness is a way to solidify partnerships and secure commitments to end Veteran homelessness from mayors across the country. First Lady Michelle Obama, HUD Secretary Julián Castro, USICH Council Chair DOL Secretary Thomas E. Perez, Council agencies, and the National League of Cities are calling on mayors to make a commitment to end Veteran homelessness in their cities in 2015. Already, more than 320 mayors, governors, and county executives have made the commitment to partner with VA, HUD, and USICH to end homelessness among Veterans.

Veteran Outreach

Communities are working each and every day to engage every Veteran who experiences homelessness and provide them with the care and connections to housing they need. The reality of no Veteran living unsheltered is something we can and will achieve. There will be Veterans who initially refuse our assistance. Engaging Veterans, particularly those who experience chronic homelessness, requires skillful and repeated outreach to build trust. Council and community partners, which include over 600 VA staff members, perform coordinated Veteran outreach at shelters, encampments, soup kitchens and community events, in courts, local jails, and state and Federal prisons. Council and community partners also collaborate to host Stand Downs—outreach events designed to connect Veterans who are experiencing homelessness with community resources and VA health care and benefits assistance.

Homeless Patient Aligned Care Teams

Building on the foundation of healthcare for the homeless clinics funded through McKinney-Vento, VA's Homeless Patient Aligned Care Teams (H-PACTs) are an innovative treatment model being implemented at VA medical centers across the country and are playing a key role in ending unsheltered homelessness among Veterans.

H-PACT clinics co-locate a partnership of medical staff, social workers, mental health and substance use counselors, nurses, and homeless program staff and are located on VA campuses, community-based outpatient clinics, and Community Resource and Referral Centers. These professionals form a team that provides Veterans with comprehensive, individualized care, including services that lead to permanent housing. H-PACT teams are attuned to how housing insecurity and other social factors like poverty harm Veterans' health overall, worsen sickness, delay care, and exacerbate both temporary and long-term homelessness. VA's H-PACT approach ensures that a fully integrated team is aware of and can treat the issues involved in and contributing to homelessness among Veterans.

Veterans can walk into H-PACT clinics without an appointment and receive medical care, case management, housing placement supports, substance use and mental health treatment, community referrals, triage services, benefits counseling, and even hot showers and clean clothes.

The implementation of *Opening Doors* across the Federal government and in communities across the country is working. Collaboration across Federal agencies and with state and community partners has been unprecedented and continues to expand. Congress and the Administration have worked in a bipartisan manner to fund programs aimed at ending Veteran homelessness, proving that, where strategic resources are meeting the need and where effective partnerships are developed, meaningful results are achieved.

Ending homelessness among Veterans is not an aspirational goal. Homelessness among Veterans is not an intractable problem; it is a problem we, as a nation, are solving. And by doing so, we are proving that ending all forms of homelessness is possible. Thank you for your partnership.

STATEMENT FOR THE RECORD

Submitted by

Sandra A. Miller
Chair
Homeless Veterans Committee

Before the

House Committee on Veterans Affairs

Regarding

Evaluating Federal and Community Efforts to Eliminate Veteran Homelessness

December 11, 2014

Chairman Miller, Ranking Member, Michaud and distinguished members of this committee, good morning and thank you for the opportunity to present our Statement for the Record here today.

My name is Sandra Miller and I am the current Chair of the Homeless Veterans Committee for Vietnam Veterans of America. One of my other hats is that of Director of Coatesville Residential Services for The Veterans Multi-Service Center, located in Philadelphia, PA, where I oversee the operation of 125 VA Homeless Grant and Per Diem beds.

Vietnam Veterans of America has as its' number one legislative priority the issue of accountability; accountability at every level of any agency, federal, state, or local, that impacts Veterans and their families. It is through this accountability that Vietnam Veterans of America hopes to improve the quality of care and life for all of our nation's Veterans. Without accountability countless dollars are lost to programs that are ineffective, inefficient and even potentially unsafe. We all must be the "keepers of the gate" insuring our programs are achieving the goals they were established to attain.

After all these years of effort, energy, and attention given to the Homeless Veteran issue it remains and endures as a disturbing situation for these Veterans. Can we bring an end to Veterans living on the streets or in boxes, cars, shelters, vacant buildings? None of us can answer that question but we continue to work in order to make an impact on this situation. There will always be those who choose this way of life…there always have been…from the beginning of time. We can, however, offer and assist those who seek a different way of existing in the short time we have all been granted, but they can't make it on their own. They just can't make it out of the darkness, so we continue to try to find an effective and efficient way to help those who are helping these Veterans.

US Departments of Housing and Urban Development (HUD) and Veterans Affairs (VA) HUD VASH Program

Oversight of the HUD VASH program and its processes will prove to be an invaluable tool in the continuance and expansion of this program. Oversight of the HUD VASH voucher program is necessary to ensure that these vouchers are administered, distributed and utilized to the fullest extent possible and for the purpose they were intended. By tracking the outcomes of the current HUD VASH voucher program, a full annual evaluation of their effectiveness may well drive the recognition for additional vouchers.

Vietnam Veterans of America strongly supports and has urged the continued funding and expansion of the HUD VASH voucher program. Further, VVA has urged the US Department of Housing and Urban Development and US Department of Veterans Affairs to establish a mechanism whereby oversight of the HUD VASH voucher program can insure that it is being monitored for compliance and fully utilized effectively for the Veterans it was intended to assist.

Are the HUD VASH vouchers being distributed equitably throughout the country? We don't know this. We do know that some areas are saturated with vouchers, while others are screaming for more. We do know that one of the barriers to providing vouchers in some areas of the country is lack of case management. Alaska is one example of the staffing situation which results in the delay in issuing or utilizing the vouchers.

Are ***all*** VA Medical Centers providing the appropriate level of case management to the Veterans in the HUD VASH program? We don't know this. We do know that case management activities vary from VA facility to VA facility. We appreciate that case management is able to be "contracted out" to community service providers and applaud the recognition that no one agency or organization can do it all. The VA and the Veterans need these collaborations, now more than ever, if, in fact, we are to end Veteran Homelessness in just a little over two years.

Here's what we do know. According to the 2013 Annual Homeless Assessment Report (AHAR), a HUD and VA joint effort, there were 57,849 homeless Veterans, down 24% from the 2010 report. There are currently 58,155 vouchers authorized 43,371 have been leased up. There are over 1,500 VA HUD VASH case managers. Approximately 8% of the vouchers have gone to women Veterans.

One challenge that many of our Veterans face in receiving a HUD VASH voucher is the expense of moving in to their new apartments. This has been addressed in some fashion by the awarding of the VA Supported Services for Veterans and Low Income Families (SSVF) grants across the country. SSVF assists with these move-in costs, furniture, etc.

Does HUD VASH work? Vietnam Veterans of America believes it does. It does provide housing opportunities for homeless Veterans to obtain safe and secure housing. However, we are concerned that not enough attention is placed on the income and motivation of the Veteran or continued housing stability.

If a Veteran is placed in housing with a HUD VASH voucher and only has minimal income, though rents are inexpensive and subsidized, that income may not be enough to sustain the Veteran. Recently, Veterans in the HUD VASH program who were receiving Public Assistance at $214 per month were cut off with little notice. They now have zero income. How do they survive? Certainly they qualify for food stamps, but what assistance is there to insure they will be able to maintain their current housing arrangement with no income? Realizing that HUD VASH focuses on "housing", it is VVA's opinion that long-term, realistic, sustainable income must to be part of the intake assessment, as well as the ongoing case management. Demanding anything less is surely setting the Veteran up to fail.

Motivating the employable Veteran to return to the work force or seeking additional income, may prove to be one of the most challenging yet vital component of the case manager's responsibilities. Case Managers are the front line defense for these Veterans and they should be assisting with all avenues for increasing the Veteran's income.

Vietnam Veterans of America believes in the concept of the "housing first" model and that it is ideal for some Veterans. However, VVA also believes that the "housing ready" model may be the best fit for others. In this model a Veteran is given the opportunity to build on a strong foundation and become accustomed to daily living and have the ability to develop daily life skills. To think that "housing first" is the best for every Veteran is not true. It has always been the belief of VVA that our homeless Veterans must be given every opportunity to succeed in independent living to include housing. There are no "cookie cutter" solutions...VVA embraces the Interagency Council on Homeless mantra of "no wrong door" when addressing the housing needs of our Veterans.

VA Homeless Grant and Per Diem Service Centers

One of the most effective front line outreach operations funded by VA HGPD is the Veterans Day Service Center, sometimes referred to as a Drop-In- Center. Agencies stretch themselves and their staff almost beyond its limit in order to keep the programs afloat. Few even remain in the HGPD system due to the limited per diem funding support.

These service centers are unique and indispensable as a resource for VA frontline contact with homeless Veterans. These Service Centers reach deep into the homeless Veteran population that are still on the streets and in the shelters of our cities and towns. They are the portal from the streets and shelters to substance abuse treatment, job placement, job training, VA benefits, VA medical and mental health care and treatment, homeless domiciliary placement, and transitional housing. They are the first step to independent living. For many it is the first step out of homelessness. But this can only happen if they are able to operate in an effective environment.

Under the VA HGPD program non-profits receive per diem at rates based on an hourly calculation per diem ($5.42) for the actual time that the homeless Veteran is actually on site in the center. This amount may cover the cost of the coffee and food that the Veterans receive but it does not come close to paying for the professional staff that must provide the assistance and comprehensive services that continue on the Veteran's behalf, long after they leave the facility. As one can well imagine the needs of these Veterans are great and demands an enormous amount of time, energy, and manpower in order to be effective and successful. Their problems are complicated by years of abuse on many levels of life experience.

It is for this reason, the lack of sufficient operational funding, that many service centers for homeless Veterans have either closed or never opened after being funded by VA HGPD. The VA acknowledges and understands that this problem exists. This is a tremendous loss to the outreach efforts so important in connecting the homeless Veterans with the VA and independent housing opportunities.

The reality is that most city and municipality social services do not have the knowledge or capacity to provide appropriate supportive services that directly involve the treatment, care, and entitlements of Veterans. It is for this reason that these homeless Veteran service centers are so vital and irreplaceable. These service centers desperately need help and attention. They are an integral part of the outreach and first line contact with homeless Veterans that is, in fact, so

essential as part of the Secretary Shinseki's 5 Year Plan. Service Center programs are challenging and staff intensive. But they are one of the raw conduits out of homelessness in many cases.

VVA believes that it is possible to create "Service Center Staffing/Operational" grants, much like the VA "Special Needs" grants. In light of the Special Needs grants, passing legislation to establish this type of funding stream would not be setting a precedent. "Special Needs" grants have been doing it for years. VVA believes that these service centers can't hang on much longer. Agencies have been advocating for years for the VA to recognize a more appropriate funding distribution process of HGPD resources for their true operational activities. Without serious and speedy activation of staffing grants the result could well be the demise of the service centers…centers that have proven to be essential community outreach efforts.

We cannot lose these valuable front line, "on the streets", service center outreach programs. They are the heartthrob of VA homeless Veteran programs; the first hand up offered too many of the homeless Veterans who are on the streets and in the shelter system of our cities.

There are agencies in this country that bring support, services, and housing to homeless Veterans. They often times do this with little financial assistance from the outside. There needs to be some consideration given to providing grant dollars through the HGPD program to these Veteran specific programs. This will enable these agencies to hire appropriate staff for case management. Without this possible assistance and resource, the full opportunity of these homeless Veteran programs will be lost.

VA Homeless Grant and Per Diem Payments

Non-profits have long struggled with the process used to justify the receipt of the per diem payments from VA Homeless Grant and Per Diem (HGPD) program. Although the amount of per diem money received per Veteran per day provided has increased over time, the requirement documentation to meet a 100% cost expense has created a significant burden on non-profits. There are 15,500 VA Homeless Grant and Per Diem beds.

The collateral expenses of a HGPD program often can be incurred by a non-profit agency and even require discretionary dollars to pay for them. This occurs because of certain restrictions on allowable expenses. This is especially true if the HGPD program is not located on the site of the home agency. Without the up keep and solvency of the parent agency the per diem program could not function because, in truth, the program is linked inexplicably to the parent agency. The HGPD program could not exist without the home agency and therefore some of the expenses of the agency must be directly allowable as expenses to the program.

In actuality, HGPD is "fee for service". One difference is that it is not set up as a contract agreement as utilized in the past by the VA where agencies were paid as contractors. Today's methodology works on the approach that grantees are paid based on past accounted and audited expenses, not anticipated expenses.

Though not a popular resolve some non-profit agencies as asking, "Why aren't our programs seen as "fee for service" operations instead of a reimbursement?" This option would, it seems, place the existing and future grant awardees in a per diem program much like that of the past programs which were paid as contractors. But this option is one that is discussed due to the frustration in obtaining the correct amount of per diem based on actual program expenses.

Currently, the per diem amount that non-profits receive is based on the previous year expenses as defined in its annual audit. It is not based on anticipated expenses for the operating year in which the per diem will be paid. This causes the program to fall short in meeting its expenses for the agency's operating year. For this reason, we believe it is a reasonable suggestion that VA consider the distribution of per diem payments in much the same way that other federal agencies operate. One solution to consider would be to set up HGPD disbursements in a "draw down" account similar to the system utilized by the U.S. Department of Housing and Urban Development, whereby agencies submit their projected budgets, are allocated the funds, and draw down on the allocated funds throughout the year. At the end of year reconciliations and adjustments as made.

Payments need to be based on actual anticipated budgetary expenses, not based on past year expenses. We cannot enhance services or hire additional necessary staff before we are able to access the dollars of increased per diem to pay for them. It sets in place a vicious cycle of need. (The agencies have a set per diem; they need more staff; they haven't shown it as an expense on the approved per diem they are receiving, so they can't afford to hire necessary additional staff or establish additional program enhancements because they don't have the money to do so.) This process leaves the program and the agency at a clear disadvantage because they do not have the money to do any advanced or "real time" enhancements to the program.

To do so would place them at high risk and this action could be suicidal for a small non-profit. It places them at risk with creditors or, the agency has to reach into its line of credit at the bank. This credit line utilization results in paying interest on the use of its line of credit until they can be approved for higher per diem. This interest is then an added expense to the program…a cost they cannot recoup.

VVA continues to wait to see the evaluation and study related to HGPD fund distribution as required by Congress in Public Law 112-154, Honoring America's Veterans and Caring for Camp Lejeune Families, signed into law on August 6, 2012 by President Obama. This report was due one year from Public Law 112-154 being signed into law…it is almost two (2) years overdue. Where, again, is the accountability? And most concerning, where is the report?

As with any change, oversight is the key to the success or failure of the programs. There is already a process for defined oversight in regard to annual inspections, services offered, and goals attained in place. With the requirement for intensive annual inspections by the VA on all GPD programs, we do not see any potential diminished ability by the VA in the oversight of the programs. The method by which funds are paid should have no effect on the VA's ability to provide oversight.

In the past, some very successful VA HGPD residential programs identified a need for increased bed capacity due to a clear identification of increased need for program admission. These existing programs requested additional beds under a VA HGPD "Per Diem Only" (PDO) grant process and were awarded the ability to increase the overall number of program beds.

The original HGPD grant and the PDO grant were awarded at different times; hence, they have separate and different VA "project numbers". These two project numbers are attached to the *same program* with the *same expenses* and the *same staff*. The only difference it has brought to the program is an increase in bed capacity. Here's where it gets convoluted and tricky.

VA policy states that everything related to the one program must be divided out by a percentage based on the number of beds attached to the two project numbers. This includes the request for per diem amounts and the entire budgeted expenses of the entire program. Every bed in the one program has been assigned to one of the two project numbers. For the purpose of billing the VA at the end of each month, each Veteran must be tracked on a daily basis, indicating the bed he/she was assigned on that particular day. And this must be done because when the audit was done for the one program to determine the level of per diem the agency can receive, it was identified that the per diem per day for the two project numbers was different. Not only is this a very time consuming process on the reporting side, all expenses for the one program on the bookkeeping side of the agency have to be calculated by percentage. This also makes it extremely difficult to request increased per diem.

We believe that if a single program has two different project numbers based solely on an approved expansion without change to the program, that program should be treated as a whole and the two projects numbers should be merged. This is the only fair way to work with the non-profit. To do so would allow an agency to function in a more efficient manner, have access to an appropriate and true per diem structure, and reduce the paper work for the VA HGPD offices.

VA HGPD Participant Fee Calculation

Most HGPD programs across the country charge their Residents a "program fee" or "participant fee". Previously these "fees" could not be more than 30% of the individuals' income, minus court ordered payments and child support. Many programs placed a maximum cap on these fees at much less than the legal 30% in order to create a vehicle for greater Veteran participant in their savings plan. These fees augmented HGPD payments in providing the non-profit with income to enhance the comprehensive programing and assist with the cost of food and services.

New verbiage in Title 38, reads, "**§ 61.82 Participant fees for supportive housing.**

(a) Each participant of supportive housing may be required to pay a participant fee in an amount determined by the recipient, except that such participant fee may not exceed 30 percent of the participant's monthly income after deducting medical expenses, child care expenses, court ordered child support payments, or other court ordered payments; nor may it exceed the program's set maximum rate or the HUD Fair Market Rent for that type of housing and its location, whichever is less The participant fee determination and

collection process/procedures should be documented in the grant recipient's operating procedures to ensure consistency, fairness, and accuracy of fees collected. The participant's monthly income includes all income earned by or paid to the participant.

In correspondence received from the VA National Grant & Per Diem Program Office in Tampa, Florida, Grant and Per Diem Liaisons were told, "We have been interpreting the Fair Market Rent (FMR) for "that type of housing" to mean that the total rent received would be around the amount of the Fair market rent for that type of housing. To calculate FMR, divide the housing size by total number of beds. So housing with a single bedroom with two beds would be One bedroom FMR divided by 2. Housing with two bedrooms one bed each would be Two bedrooms FMR divided by 2. A two bedroom with two beds in each bedroom would be a Two bedroom FMR divided by 4. Etc. To calculate larger congregate facilities (more than four bedrooms) you would calculate .15 times the number of bedrooms over 4 bedrooms, add 1, multiply this number to the local FMR for a four bedroom apartment, then divide that number by total number of beds to get cost per bed. Example: a 50 bedroom facility that has 100 residents in Hillsborough County Florida would be calculated this way: Start with the FMR for a 4 bedroom house, $1520. Multiply the number of bedrooms above 4 by .15. In this example that would be 46 (50 bedrooms – the four bedrooms we started with) 46 x .15 = 6.9. Add 1 to that number and get 7.9. What this is saying is that there are the equivalents of 7.9 four bedroom units in this facility. So, the rent for 1 four bedroom unit is $1520 and the rent for 7.9 four bedroom units is $12008 (7.9 X $1520). Divide that number by the number of beds in the facility, 100. $12008/100 = $120.08 per Veteran per month, but only for months where the Vet earns income and only if this number is lower than 30% of that income. If the 30% of the monthly income is lower, the provider must use that."

This absurd calculation does not take into consideration the agencies with programs occupying space on the grounds of VA medical center/facilities, nor does it take into consideration other programs located in a "dormitory" style building. These agencies are considered "contractors" by the VA and as such they must sign a lengthy lease agreement that could also include costs not only for space utilization but other fees for services. The space utilization cost is not based on FMR but on a square footage charge. The amount of these signed VA lease agreements is quite costly to the non-profit, some over a quarter of a million dollars per year. One may wonder why some of these programs are paying the VA such large lease payments with VA homeless grant dollars. But under these circumstances, utilizing the FMR, will cause non-profits to lose a tremendous amount of their operating income resulting in the loss of essential case management staff and valuable services. Food budgets will need to be reduced and van transportation to jobs will be limited due to the cost of gas and maintenance. How can non-profit providers be expected to complete our current mission if we don't have the funds to do so?

VVA requests the VA Grant and Per Diem Program Office to reconsider the calculations they have assigned for program/participant fees. First, there is a great difference between the FMR and the VA Lease costs for VA HGPD programs on VA grounds. Second, in putting "Veterans First" it makes no sense to handcuff agencies with reduced incomes which ultimately results in less than adequate services.

VA Supportive Services for Veteran Families

Supportive Services for Veteran Families (SSVF) is a rapid re-housing program for Veterans to move quickly into housing. Rapid re-housing is time-limited assistance to get Veterans housed first and then provided supportive services directly or linked to other programs that may be needed to support stability goals.

Currently, SSVF funds can support HUD-VASH clients by providing financial and specialized support to move their clients into permanent housing. For example, a recent recipient of a HUDVASH voucher received SSVF funds to pay the rent deposit, utility costs, and moving costs. There are clear regulations detailing how SSVF funds can support HUD-VASH clients, but the ability to utilize both programs ensures that Veterans have the additional resources on the path to a successful independent transition. This creative pairing of two programs gives Veterans real hope for a better outcome.

Initially, SSVF funds could be used to support transitional housing clients who stayed under 90 days. In the past year, SSVF regulations have been further restricted in supporting transitional housing clients. Now, SSVF funds can only be used for clients who have stayed under 30 days. While transitional housing programs focus on an exit to permanent housing few programs have subsidy resources to help a Veteran gain a foothold in the market when it is time for them to leave a transitional program.

The tightening of SSVF regulations on transitional housing clients is detrimental for numerous reasons. Transitional housing clients are considered homeless and make up significant portion of the community's homeless Veteran population. Therefore, the impact of the SSVF change is notable. Transitional housing programs provide specific support, many with a focus on the resolve of issues other than homelessness alone. These could include additional support, treatment or therapy related to military sexual trauma (MST), Traumatic Brain Injury, Post Traumatic stress Disorder, surgery, terminal illness, or enormous debt resolution. They are not homeless shelters. Therefore, the restriction of SSVF funds for clients who are in GPD programs under 30 days weakens the value of these programs. This restriction could result in the inappropriate termination of GPD assistance and critical treatment or problem resolution in order to utilize SSVF funds. It is critical to revisit this new restriction because an arbitrary 30 days is no benefit to Veterans.

Ending Veteran homelessness can be done if all resources are used effectively and efficiently. By not permitting successful discharges from transitional housing, no matter the length of stay, does not support the VA commitment to ending Veteran homelessness below the Secretary level.

VVA recommends that all restrictions on SSVF concerning transitional housing be removed. These homeless Veterans need the support from SSVF like HUD-ASH clients to ensure they have the ability to keep a roof over their head. SSVF support to transitional housing Veterans will add a very powerful weapon in the war on Veteran homelessness and should not be withheld.

Closing

I have spent some time highlighting a number of items that Vietnam Veterans of America believes needs attention and/or change. VVA doesn't know the answer but we know we are going to try…and keep on trying to do our best to be a part of any solution that will help. Eventually, this will make a difference. It certainly will for the Veteran who finds her way home. VVA welcomes any opportunity to have further discussions on the content of this testimony and looks forward to working with your offices.

Funding Statement

December 11, 2014

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

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Sandra A. Miller

Sandra Miller currently serves as Chair of Vietnam Veterans of America Homeless Veterans Committee. She has served on the VA Advisory Committee on Homeless Veterans since 2003. Ms. Miller was a volunteer at Philadelphia Stand Down from 1995 until 2001.

Ms. Miller currently works as the Program Director of Coatesville Residential Services for The Veterans Multi-Service. She is responsible for the operation of Residential Services, including LZ II Transitional Residence for homeless male veterans and The Mary E. Walker House for homeless female veterans. She is responsible for insuring the goals and objectives of all homeless veteran residential programs are accomplished within the prescribed time frame and funding parameters.

She served in the U.S. Navy from 1975 until 1981 as a Radioman. During Ms. Miller's military service, she received numerous awards including a Good Conduct Medal, Navy Meritorious Unit Citation w/1 Bronze Device (2 awards), Zaire Airlift Letter of Commendation, U.S. Naval Forces Europe Letter of Appreciation, and numerous Command Petty Officer of the Quarter awards. Ms. Miller was awarded the AT&T Microelectronics National Volunteer of the Year in 1995 and the Lucent Technologies Humanitarian Service Award in 1996. She also received Vietnam Veterans of America, Region II James "Pop" Johnson Memorial Distinguished Service Award in 1998 and the Chapel of Four Chaplains, Legion of Honor Award, in September 2000 for her work with homeless veterans.

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