
Staff Findings and Proposed Recommendations

Veterans' Home at Rocky Hill:
Residential Services

December 19, 2014

Legislative Program Review
and Investigations Committee

Connecticut General Assembly

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Veterans' Home at Rocky Hill: Residential Services

Background

In May 2014, the program review committee authorized a study to evaluate the Connecticut State Veterans' Home's operations and effectiveness.

The Home offers veterans 24-hour nursing care (similar to a nursing home) as well as domiciliary care. Domiciliary care consists of shelter, food, and services intended to prepare residents to successfully rejoin the wider community. The Home charges domiciliary residents \$200 monthly, which can be waived. Nursing care residents must use public insurance (e.g., Medicaid) and self-support to pay for their stays.

Most domiciliary care residents live in the main Residential Facility. Others participate in a residential substance use treatment program with separate housing, live somewhat independently in campus apartments for a short time, or reside in one of several single-family houses across the street from the main Home campus. The nursing care residents live in a separate building, the Health Care Facility.

The Home is the centerpiece of the state Department of Veterans' Affairs (DVA). It accounted for 97 percent of the department's budget in FY 14, with a cost of nearly \$28 million.

To complete this study, program review committee staff: interviewed Home and DVA personnel; obtained residents' views, mainly through surveys and public hearings; observed certain Home staff meetings and a DVA Board of Trustees meeting; reviewed a variety of documents and websites; analyzed data provided by DVA and the federal Department of Veterans Affairs (VA); communicated with several other state agencies' staff, multiple VA personnel, and some managers of other states' homes; toured a few other veteran housing options; and interviewed a number of advocates, researchers, and service providers involved with veteran housing / homelessness issues at the state and national levels.

Main Staff Findings

The Home's major domiciliary care program has the goal of helping residents successfully move to independent housing, but not the features needed to support that goal. For example, currently there is one full-time equivalent social worker for every 96 residents at the Home, when the generally accepted ratio is 1:25. Only about 10 percent of residents are satisfied with how well the Home staff has helped them try to find employment or housing.

Domiciliary care has become permanent housing for many residents, but its rules approach, accommodations, and services are inadequate for permanent supportive housing. Roughly 60 percent of residents have lived at the Home longer than three years; overall about half have been there at least five years. About one-quarter of the residents do not intend to leave. They must live with the same restrictive rules and lack of personal space (12-person rooms) as the short-term residents.

Demand is low for the Home's domiciliary care, for many reasons. The federal VA has boosted resources to prevent homelessness, which combined with its policy shift toward permanent housing, may be translating into fewer referrals from VA staff. Others may not want to live there because of strict rules and/or the campus's institutional feel. The recent upswing in the economy may mean fewer veterans need the Home.

The Home's Health Care Facility's quality is strong. The facility performed well on recent federal and state inspections, which are more thorough than for domiciliary care (due to being a long-term care facility). Residents generally are satisfied. Recent direct care staffing changes, however, could impact quality, and need to be closely monitored.

The Home has been isolated and deficient in oversight, program monitoring, public relations, and vision. The Home's shortcomings have gone largely overlooked due to limited attention to performance by the Board of Trustees and the legislature. Antiquated data systems and other data problems have also contributed.

PRI Staff Recommendations

Many recommendations are proposed to strengthen the Home's services and sustainability, as well as improve residents' lives. The recommendations, centered around five key goals, would:

1. **Transform the Home's domiciliary care into transitional and permanent supportive housing**, in terms of program design, staffing, rules, responsibilities, fees, and accommodations;
2. **Ensure the Home's substance use treatment services are high-quality and possibly accessible to more veterans;**
3. **Maintain quality at the Health Care Facility; and**
4. **Improve collaboration, oversight, program monitoring, and opportunities for residents' views to be heard.**

Acronyms

CMS	Centers for Medicare and Medicaid Services
CY	Calendar year
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DVA	(State) Department of Veterans' Affairs
FFY	Federal fiscal year
FY	(State) fiscal year
GPD	Grant and Per Diem
HCF	Health Care Facility
HPPD	Hours per patient day
HUD-VASH	U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing
PHA	Public housing agency
PRI	Program Review and Investigations Committee
PSH	Permanent supportive housing
RAP	Rental Assistance Program
RBA	Results-Based Accountability
RPP	Residential Plus Program
SSVF	Supportive Services for Veteran Families
VA	(Federal) Department of Veterans Affairs
VIP	Veterans Improvement Program

Proposed Recommendations

Veterans' Home at Rocky Hill: Residential Services

Domiciliary Care Overall

1. The Department of Veterans' Affairs should replace its current general domiciliary program at the State Veterans' Home with two separate programs that resemble transitional housing and permanent supportive housing.
2. The Department of Veterans' Affairs should determine the number of staff needed to fully implement the recommended programs, including case managers / social workers, employment specialists, and behavioral health staff. The department should consider partnering with staff from other state agencies and nonprofits. The DVA should then pursue the necessary resources.
3. All current residents of the Veterans' Home's domiciliary care (except for those in the Patriots' Landing program) should be fully assessed and given the option to move out of the Home via a federal Department of Veterans Affairs program. Those who choose to stay at the Home should decide whether they would like to be in its transitional housing or permanent supportive housing program. Once the programs are active, the residents would need to comply with the applicable program rules.
 - a. Home residents should actively participate in an assessment process, which should be done in-person by a team of contracted case managers who work for the VA and/or nonprofit agencies offering case management services to homeless veterans. Each resident should have an assigned case manager.
 - b. The assessment should be based on a common information gathering tool. The tool should include:
 - i. education, work history, and particular skills, licenses, certifications, or training;
 - ii. financial resources;
 - iii. overall physical and mental health, including any diagnosed disabilities;
 - iv. ability to complete activities of daily living, including the ability to self-administer medication;
 - v. external supports;
 - vi. current length of stay at the Home; and
 - vii. housing preferences, after first receiving: a) an in-person, one-on-one explanation of federal VA transitional and permanent supportive housing options; b) a description of the Home's new programs; and c) the results of the assigned case manager's recommendations.

- c. The assigned case manager should recommend to the resident the type of VA program for which the person is best-suited and which of the Home's new programs is appropriate for the person (transitional housing or permanent supportive housing). Using this information, each resident should choose his or her living arrangement.
4. New applicants to the Veterans' Home should submit a modified version of the assessment for current residents (in addition to an admissions application), including a program preference (for either transitional housing or permanent supportive housing). Based on the assessment, the Home staff should recommend the most appropriate program to the resident. As part of the admissions process, and on the Home's website, the DVA should also give the applicants information on federal VA housing options.
5. The DVA should consider what behavioral health and other staff resources may be necessary in order for the Veterans' Home to accept applicants with more-recent psychiatric problems. The DVA should communicate closely with the federal Department of Veterans Affairs and the Connecticut Department of Mental Health and Addiction Services to develop an analysis. The analysis should be delivered to the Board of Trustees and the legislative committees of cognizance by June 1, 2015.
6. Each Veterans' Home domiciliary resident should have a semi-private or private room, with the room's own door. If semi-private rooms are done, residents should be assessed for compatibility and their personal preference (e.g., if the person would like to have a certain resident as a roommate) and then grouped accordingly.
7. The Department of Veterans' Affairs should eliminate the Veteran Worker and Detail programs. Prior to the elimination, the DVA should assess the overall need of each position currently in the programs. The DVA should consider working with the Department of Administrative Services and/or the Office of Policy and Management, or a contracted firm, to conduct the analysis. The analysis should determine which positions will be:
 - a. Converted to state employee positions through a standard, public recruitment process that gives a hiring preference to current Veteran Workers;
 - b. Converted to time-limited paid state internship or apprenticeship-type positions, for the Home's transitional housing participants, with the expectation of attendance and a limited amount of sick time; or
 - c. Eliminated, possibly through assigning small tasks to all Home residents (e.g., up to one or two hours weekly).
8. Regarding the Veterans' Home's current "program fee" and DVA's Institutional General Welfare Fund, which houses the program fees, the Department of Veterans' Affairs should:

- a. Beginning in the 2015 calendar year, a new resident's first month at the Home should remain free. The fee should be applied for every month thereafter. Veterans who are admitted to the Home before 2015 will continue to have a free first three months.
 - b. For transitional housing residents:
 - i. Specify that the fee is a "resident care fee" and maintain the current level of \$200 for the 2015 calendar year.
 - ii. Effective January 1, 2016, the transitional housing resident fee level should be annually adjusted for inflation. A fee waiver can be requested at any time, based on the Home's current waiver process, and a waiver should be approved if a resident's income falls below three times the fee level. Each waiver is valid for six months.
 - c. For permanent supportive housing residents, replace the program fee with an income-based resident care fee, effective January 1, 2016. The income should be determined after subtracting for taxes and court-ordered payments. The fee should be 30 percent of adjusted income.
 - d. Provide transparency regarding the Institutional General Welfare Fund by formally sharing with all residents a semiannual, plain-language summary of how the Fund is used in accordance with state law (to "directly benefit veterans or the Veterans' Home").
 - e. Provide the opportunity for residents to make suggestions on projects for which they would like to see the Institutional General Welfare Fund used. Residents' input should be requested at least semiannually.
9. The Veterans' Home should frequently and routinely (e.g., weekly) offer classes on life and vocational skills, such as establishing a bank account, budgeting, searching for jobs online and through networking, navigating federal VA services, interviewing for jobs, and cooking. The Home should consider opening these classes to veterans in the general public, and assess its equipment to determine whether additional resources are needed. The Home should also seek out volunteers to conduct the classes.
 10. The Veterans' Home should offer and publicize increased volunteer opportunities for the public on-campus, including at the main Residential Facility, and for veterans in the community.
 11. The Veterans' Home should make the following changes to its security procedures for domiciliary residents:
 - a. Domiciliary residents who intend to leave the campus should sign out using a log in their building each time they leave campus, noting whether they intend to return that day or a following day. No permission should be needed to leave the campus.

- b. The Home should transition to a swipe-card door-locking system for its main Residential Facility and Fellowship House. Upon the transition, a resident should no longer be required to swipe a Home identification card at the campus entrance security building, in order to leave or return to campus, and the identification card should open the vehicle gate.
 - c. The Home should discontinue the mandatory visual package and vehicle inspections done when a resident re-enters campus. An inspection may be done when there is reason to believe a resident is bringing a prohibited item onto campus. Written guidelines should be established by DVA regarding what constitutes “reason to believe” and then distributed to each resident.
 - d. Residents should be allowed to use their personal vehicles from their first day at the Home. Permits should be issued within a resident’s first week at the Home and remain valid until the person moves out of the Home.
12. The pass restriction system for handling rule violations should be replaced with the following system as of January 1, 2015:
- a. The first violation should result in an immediate meeting (within one working day) between the resident and his or her case manager / social worker and employment specialist. The meeting should involve discussion of the incident, the underlying reason(s) the incident occurred, consequences for subsequent violations, and the resident’s plan to avoid or correct the behavior.
 - b. The second violation should result in a similar meeting as the first, but include the domiciliary care administrator and the staff should emphasize that the third offense results in immediate discharge.
 - c. The third violation should result in discharge, appealable to the DVA commissioner. As is current practice, staff should assist the resident in locating a place to live.

Transitional Housing Program

13. The Veterans’ Home’s new transitional housing program should have the following components to ensure a focus on successfully discharging residents to independent living and encouraging personal responsibility:
- a. New residents should have a stay limit of nine months in the transitional program.
 - i. If a resident reaches the seven-month point, there should be a meeting with the person’s case manager / social worker, the employment specialist, and B Clinic personnel to determine what steps need to be taken should the person reach the nine-month stay limit. All options, including entirely independent housing, federal VA programs, and the Home’s programs, should be fully discussed and considered. The resident should select two

preferences and, working with the case manager, aggressively pursue them.

- ii. If, at the nine month point, alternative housing has not been found, a three-month stay extension is possible upon resident request to the program director. The program director should solicit staff opinions from each supportive services area when making the decision.
- b. Current residents in the transitional housing program should have a two-year stay limit.
- i. If, by the twentieth month in the program, a resident is employed and/or enrolled in education or training for at least 30 hours per week, the resident should have the ability to stay in the transitional program for an additional year.
 - ii. If a current resident reaches the 21-month point, there should be a meeting with the person's case manager / social worker, the employment specialist, and B Clinic personnel to determine what steps need to be taken should the person reach the 24-month stay limit. All options, including entirely independent housing, federal VA programs, and the Home's programs, should be fully discussed and considered. The resident should select two preferences and, working with the case manager, aggressively pursue them.
- c. A veteran may participate in the transitional housing program twice, either consecutively or at two separate times. If a veteran is approaching the time limit of a second round in the transitional housing program, and prefers to stay at the Home, the resident should move to the permanent supportive housing program.
- d. Discharge planning should begin on the day of admission, including meetings with the person's case manager / social worker and employment specialist.
- e. There should be clear, unified messages from all staff that the resident will leave the program at the specified time limit and needs to spend the time in the program finding employment, pursuing education and/or training, acquiring benefits (including housing benefits), and locating housing options, as appropriate. Staff should project a positive attitude regarding living independently in the community and not use the time limits in any negative manner against residents.
- f. Each resident should meet at least weekly with the person's social worker / case manager. There should be a maximum ratio of one social worker / case manager for every 25 residents. Each resident should also meet at least weekly with an employment specialist if not enrolled in education or training. Those who are enrolled should meet at least monthly with the employment specialist.
- g. There should be a monthly meeting for each resident that includes the person's social worker / case manager, employment specialist, and B Clinic nurse; the

resident must attend. The first such meeting should occur within the person's first week.

- h. When veterans move to independent living, the social worker / case manager should remain in contact and open to assisting the former resident for up to one year. At minimum, the social worker should collect information every three months (including at 12 months after discharge from the Home) on employment and education status, treatment services, and housing type.
- i. Upon discharge for a violation, or upon voluntarily leaving the Home to avoid a third offense, a resident should be allowed to re-enter the program after three months have passed, if the person has not previously participated in the transitional housing program.

Permanent Supportive Housing Program

- 14. The Veterans' Home's new permanent supportive housing program should have the following components to recognize the long-term nature of some residents' stays and encourage independence:
 - a. Each resident's social worker / case manager should reach out to the veteran at least weekly; participation in supportive services is the resident's personal choice. The social worker / case manager should monitor the person's well-being and assist in improvement. The social worker / case manager should encourage the resident to attend life skills classes and apply for independent housing programs, such as HUD-VASH and other options. There should be a maximum ratio of one social worker / case manager for every 35 residents.
 - b. The Home should work to place these residents in a separate building(s) from transitional housing residents (e.g., one side of the main Residential Facility); at minimum, in the short-term, they should be on separate floors. In the long-term, the Home should place its permanent supportive housing residents in studio or one-bedroom apartments.
 - c. Once the permanent supportive housing residents are in a separate building(s), all rules not involving building and personal safety should be eliminated. There should be a set of rules specifically for residents of the program, mirroring a typical apartment or house lease agreement. A process should be established for eviction if rules are seriously or repeatedly broken. The DVA should develop guidelines for what offenses or accumulation of offenses may result in eviction. Evictions should be appealable to the Board of Trustees. Readmission should be allowed once, no earlier than six months later, for those required to leave.
 - d. There should be a tenants' association, which should meet monthly, to: review program rules and offerings; make suggestions on rules, program offerings, accommodations, and other aspects of the permanent supportive housing program;

and receive complaints from residents. The tenants' association should provide a detailed annual report of its activities to the Board of Trustees.

- e. Residents should be encouraged to attend group recreational activities designed to meet their interests, and may choose to use the Home's on-site medical services (B Clinic) as well as its Dining Hall. Once a permanent supportive housing resident has access to a kitchen with a working stove, the person can choose to use the Dining Hall as a guest, which should include payment.
- f. The Home should consider starting a compensated work therapy program, modeled after the best practices of such programs, for its permanent supportive housing residents.

Substance Use Treatment Services

15. The Department of Veterans' Affairs should develop and implement a plan by January 1, 2016, to improve its substance use treatment services, as currently provided at the Veterans' Home's Fellowship House.

- a. As part of the plan's formulation, DVA should work intensively with the Department of Mental Health and Addiction Services, the Department of Public Health, the federal Department of Veterans Affairs, veteran organizations, and substance use recovery organizations.
- b. The plan should be based on evidence-based and best practices for substance use treatment.
- c. The plan should consider:
 - i. all aspects of the Home's residential substance use treatment program;
 - ii. how the Home can best serve its many residents who are in recovery but do not live in Fellowship House; and
 - iii. whether DVA should offer any substance use treatment to Connecticut veterans in the community who may wish to participate in veteran-specific substance use treatment, and the resources that would be required to take that step.
- d. The plan should also include:
 - i. Clear missions for all substance use treatment programs envisioned;
 - ii. Performance measures, including but not limited to participant satisfaction and outcomes, for all programs; and
 - iii. How the program staff will collect data on the performance measures.

Health Care Facility

16. The Health Care Facility should continue to track its overall performance and work toward continuous improvement regarding resident care and safety. The DVA commissioner and Board of Trustees (and regulators) should carefully monitor direct care staffing levels at the facility to ensure its performance is not compromised in any way as a result of cost reduction measures.
17. The Department of Veterans' Affairs should conduct a full needs assessment of its long-term care program to determine if action is necessary to help alleviate capacity concerns and increase the availability of respite care at the Health Care Facility. At minimum, the assessment should examine whether the use of off-site short-term rehabilitation services for domiciliary care residents offers a pragmatic solution. The department should present its findings to the Board of Trustees by July 1, 2015.

Leadership

18. DVA should fully coordinate and collaborate with key stakeholders who focus on veteran issues, particularly affordable housing for veterans, to identify ways to continually improve the Veterans' Home's services using evidence-based approaches and best practices. As part of this effort, the department should develop a stronger working relationship with the federal VA in Connecticut to better understand the VA's housing programs for veterans, while providing the VA an opportunity to more fully understand the Home's programs.

Residents Aging in Place

19. The Department of Veterans' Affairs should work with its Board of Trustees on devising a strategy and program to address the issue of residents who are aging in place. A well-designed plan should be developed by October 1, 2015. A summary of the plan should be forwarded to the department's legislative committees of cognizance, and included in the board's 2015 annual report. If needed, additional resources should be requested of the legislature.

Performance Oversight and Monitoring

19. The Board of Trustees should be strengthened in the following ways:
 - a. All current and new board members should fully understand and work toward their role to advise and assist the commissioner on the Home's programs, services, and administration. Members should request the necessary information from the department to appropriately monitor the Home's overall progress towards meeting its missions and the department should provide the information in a timely manner.

- b. The board should develop (and submit to the legislature and governor) an annual report by February 15 of its previous calendar year's activities. At minimum, the report should include the Home's progress in fulfilling its mission based on programmatic outcomes.
 - c. A full complement of members should be appointed to the board by March 1, 2015. The appointing authorities should continue to ensure members are appointed in a timely way when vacancies occur.
 - d. The governor should appoint a chairperson, other than the DVA commissioner, from among the members of the board. The chairperson should have the authority to call meetings of the board, as should a majority of the board membership.
 - e. Beginning January 1, 2015, any board member who fails to attend three consecutive meetings or who fails to attend 50 percent of all meetings held during any calendar year should be deemed to have resigned from the board.
 - f. Board membership should include one veteran from each of the Home's permanent and transitional housing programs, and long-term care facility. The members should be elected yearly, or upon a member's resignation, by fellow residents, and serve in a non-voting capacity on the board.
 - g. All meeting notices, minutes, and reports of the board should be prominently posted on the department's website (and provided in accordance with all current statutory requirements). The information should be kept current, with meeting minutes posted to the website within seven days after each board meeting (with an indication that they are considered "draft" until approved by the board). Any historical information pertaining to the board – dating back to at least January 1, 2012 – also should be posted.
21. The Department of Veterans' Affairs should establish an internal workgroup to examine the overall capacity of the department's management information system. The workgroup should include agency leadership, program managers, and the Department of Administrative Services. The group should review the program data currently collected by program managers and the system(s) used to collect the data. The group should develop appropriate measures to gauge programmatic implementation and outcomes and ensure the data necessary to support such examination is collected and maintained. Once the workgroup's review is completed, it should report its findings to the department's Board of Trustees.
22. Beginning January 1, 2016, and annually thereafter, the department should develop an annual Results-Based Accountability-style report card to fully capture its performance based on RBA principles. The report card should be promptly distributed to the Board of Trustees and the legislature's committees of cognizance, and posted on the department's website.

Veterans' Home at Rocky Hill: Residential Services

The Connecticut State Veterans' Home provides domiciliary and 24-hour nursing care to eligible veterans, on its 90-acre Rocky Hill campus.¹ Domiciliary care generally consists of housing, food, day and evening outpatient nursing care when needed, and some social services. Within domiciliary care, the Home has three distinct programs, including a residential substance use treatment program.² Long-term nursing care is delivered by the Home's Sgt. John L. Levitow Health Care Center, also known as the Health Care Facility (HCF). It is a state-licensed Chronic Disease Hospital, and similar to a skilled nursing facility in many ways. The Home's federally-authorized domiciliary capacity (488 residents) is more than three times the HCF's (125).³

The Veterans' Home is operated by the state Department of Veterans' Affairs (DVA). It is, by far, the agency's largest expenditure, costing \$27.9 million (97 percent of DVA's \$28.8 million budget) in FY 2014. The DVA's other major programs are the State Veterans' Cemeteries and the Office of Advocacy and Assistance, which were not reviewed in this study. The department's main administrative office is located on the Home's grounds. The Home is funded by the state and federal governments, its residents, and private donors.

The Rocky Hill home was the first state veterans' home in the country. Currently, each state has a home, and there are 149 nationally.⁴ Among them, 140 offer nursing home-like care, 54 provide domiciliary care, and two have adult day programs.^{5,6}

Study Scope

In May 2014, the Legislative Program Review and Investigations Committee (PRI) voted to evaluate the Veterans' Home's operations and effectiveness. The original intent of the study

¹ The statutory eligibility criteria are: 1) serving actively in the Armed Forces; and 2) exiting service honorably or "under honorable conditions." Active service means full-time duty in the U.S. Army, Navy, Marine Corps, Coast Guard, Air Force, and/or the Connecticut National Guard. Reserves are included, as is service with wartime allies. Types of full-time duty that do not qualify are training, cadet service, or training service during which the person was injured, according to U.S. Code. Due to the wording of the state statutes, Connecticut residency does not seem to be required. See C.G.S. Sec. 27-108(a), with reference to C.G.S. Sec. 27-103(a). Connecticut residency is addressed in C.G.S. Sec. 27-108(b), which involves veterans who are entitled to Armed Forces retirement pay, but not the admissions criteria for the Home.

² One of the programs, Patriots' Landing, does not offer food and nursing care to inhabitants. This program is new and very small, limited to residents of five single-family houses located across from the main campus (the West Street Houses).

³ Although the authorized domiciliary capacity is 488, the actual capacity based on the facilities currently used is slightly smaller, at 456.

⁴ Including the District of Columbia and Puerto Rico.

⁵ Delanko, JoAnne, and Valerie Parker. "2014 State Veterans Homes – VA Survey Deficiency Overview." Presentation, 2014 National Association of State Veterans Homes Summer Conference (July 27-August 1), Charleston, SC, July 27-August 1, 2014. VA Office of GEC Operations. <http://www.nasvh.org/Conferences/conferenceLinks.cfm> (accessed August 26, 2014).

⁶ Adult day programs offer group care for people who need some assistance but not full-time nursing care.

was to assess many aspects of the Home, including its admissions, complaint, and discipline processes, overall performance, and occupancy.

As the study progressed, important, pressing issues became clear to the program review committee staff, particularly on the domiciliary side of the Home. Committee staff chose to focus its time on fully identifying and addressing those issues. Areas not thoroughly covered in this staff findings and recommendations report generally were explored in the committee staff's October update, which explained several aspects of the Home, such as admissions and budget. The October update is available on the committee staff's website and will be incorporated into the committee's final report.

Research Methods

This study relied on many sources. To learn about operations and conditions at the Home, committee staff had numerous conversations with the Home's staff, requested and reviewed data, and examined various documents. Committee staff spoke with more than 30 DVA and Veterans' Home managers, staff, and union leaders. Home personnel also provided data, policies and procedures manuals, federal and state inspection results, and program-related documents. Committee staff observed Home admissions decision meetings and talked with personnel from Chrysalis Center, Inc., which is the nonprofit agency contracted by the Home to provide services to residents in a small domiciliary program.

Committee staff conversed with numerous Home residents, mainly at a meeting to explain a domiciliary care survey the residents would soon receive, during resident council meetings, and at survey collection times. Home resident views were also elicited through two public hearings held by the committee (including one at the Veterans' Home) and original surveys, including in-person, on-site discussions with HCF residents.

Additional information was collected on operations and related topics through conversations with the Connecticut Departments of Consumer Protection, Labor, Mental Health and Addiction Services, and Public Health. Committee staff also toured the Home's buildings (including those unoccupied), observed a DVA Board of Trustees meeting, and spoke with some board members.

To understand the Veterans' Home's outreach, perception among Connecticut providers of services related to veterans and/or housing, and how the Home fits within the context of those other services, committee staff interviewed personnel from:

- Four veteran service organizations (American Legion, Vietnam Veterans of America, Disabled American Veterans, and Veterans of Foreign Wars);
- Three housing and homelessness organizations, Connecticut Coalition to End Homelessness, Connecticut Housing Coalition, and Partnership for Strong Communities;
- CT Heroes Project;
- Homes for the Brave/ABRI, which provides transitional and permanent supportive housing for veterans through federal programs;

- Community Renewal Team, which provides transitional housing for veterans via a federal program, among many other social services; and
- Errera Community Care Center (part of the federal Department of Veterans Affairs, or VA, behavioral health services in Connecticut), including VA homeless services.

Committee staff also:

- had discussions with the point-person of the recently-formed Governor’s Working Group charged with examining the Veterans’ Home;
- toured permanent supportive housing at Victory Gardens, an affordable housing development on the campus of the Newington VA Medical Center;
- toured two buildings offering transitional housing for veterans, Homes for the Brave in Bridgeport and Veterans’ Crossing in East Hartford; and
- surveyed Connecticut municipal veteran contacts via an online survey method.

To understand national programs related to housing veterans and the state veterans’ homes, committee staff spoke with people from:

- two advocacy organizations, the National Alliance to End Homelessness and the National Coalition for Homeless Veterans;
- the National Center on Homelessness Among Veterans, which is a federal VA organization that researches veteran homelessness and federal veteran homelessness programs, and also disseminates best practices;
- the federal VA’s state homes inspection management unit and government liaison office; and
- multiple previously mentioned organizations.

The federal VA government liaison office and the federal VA in Connecticut shared some data regarding the state veterans’ homes and federal veteran housing programs.

To learn about other states’ veterans’ homes, committee staff selected the ten largest-capacity domiciles (as well as another, due to proximity to Connecticut) and researched them. For several states, sufficient information was located on the Internet. For others – certain homes in Massachusetts, Minnesota, and Pennsylvania, as well as Rhode Island’s sole home – committee staff had telephone conversations with high-level personnel.

Report Organization

This report has five chapters and seven appendices. Chapter I explains the federal programs for housing veterans and discusses approaches to housing homeless people to help provide context for how Connecticut operates its Veterans’ Home’s residential services. Chapter II assesses the Veterans’ Home’s domiciliary care, including comparisons to relevant federal programs and other states. Chapter III presents proposed recommendations to overhaul domiciliary care at the Home. Chapter IV gives findings and proposed recommendations for the Home’s nursing care facility, which intend to ensure quality care continues to be provided.

Chapter V describes some problems that impact both domiciliary and nursing care at the Home, and proposes recommendation to solve them.

The appendices provide additional information on: Housing First, an approach to housing homeless people (Appendix A); Connecticut-specific data for two federally-funded programs for homeless veterans (B and C); methods and results of the program review committee staff surveys of domiciliary residents and town veterans' issues liaisons (D and F); domiciliary resident rules (E); and other states' domiciliary care (G).

Veteran Housing: Federal Approach

A description of the federal VA's three major housing programs for veterans – HUD-VA Supportive Housing, Supportive Services for Veteran Families, and Grant and Per Diem – is provided in this chapter. As discussed below, the VA's programs – and the broader federal approach to homelessness – use either the Housing First or a “housing readiness” model. Understanding the federal programs, and the models used to implement them, is important context for committee staff's domiciliary care assessment and recommendations in Chapters II and III.

The federal approach for housing homeless veterans – and homeless people, generally – is moving away from the traditional time-limited “housing readiness” strategy. That model focuses on treating the underlying cause(s) of a person's homelessness, such as mental illness, substance use, unemployment, or physical disability, while the person is in “transitional housing.”¹ Once the issues have been addressed, the goal is for the veteran to move to permanent housing, either with or without supportive services.

The new federal approach, based on the Housing First model, offers quick placement in permanent housing – or support to maintain such housing – without any preconditions.² It is generally paired with the short- or long-term services necessary to maintain independent living. This policy shift was signaled by the passage of two federal acts in 2009.³ The two laws placed greater emphasis on homelessness prevention and rapid re-housing of people into permanent housing. The laws also underscore that homelessness services should view independent housing as the first goal, not as something that needs to be earned.

The goal for most people is to live independently. For individuals who want to live on their own but still need long-term social services, permanent supportive housing (PSH) is an alternative. This option combines permanent housing with permanent supportive services to help enable independent living. Permanent supportive housing is offered in single-site housing, whereby residents live and receive services in a particular building(s), and individual scattered-site apartments in the broader community.⁴ Single-site PSH can involve either private rooms with shared kitchens or personal apartments.

¹ The length of time someone can stay in transitional housing varies; there is 24-month maximum stay for veterans in transitional housing under VA requirements.

http://www.va.gov/HOMELESS/docs/GPD/GPD_Final_Rule_38CFR61_02-25-2013.pdf (accessed November 16, 2014).

² A more detailed description of the Housing First approach is provided in Appendix A.

³ Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH), and the stimulus law, which included the Homeless Prevention and Rapid Rehousing Program (HPRP).

⁴ While basic tenant rights are afforded participants, personal accountability is expected, such as paying rent on time and abiding by landlord rules. If a tenant does not fulfill those responsibilities, sanctions may be imposed, including eviction.

Permanent supportive housing, based on the Housing First model, became a national strategy 2010, when *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* was put forth.⁵ The plan, which includes the federal VA's plan for ending homelessness among veterans by 2015, specified "the research is clear that permanent supportive housing based on a Housing First approach is the primary solution for helping people experiencing chronic homelessness."⁶ Permanent supportive housing and Housing First are considered evidence-based practices for eliminating homelessness.^{7,8} Despite this new approach, not all service providers agree the strategy can, by itself, eradicate homelessness. Some contend the "housing readiness" approach is a necessary supplement to Housing First, and is more appropriate for certain people.

As noted above, the federal Department of Veterans Affairs administers three key programs to help homeless veterans find and maintain housing. Two – HUD-VASH and Supportive Services for Veteran Families – follow the Housing First model to quickly house veterans, which is the VA's policy,⁹ while the third program – Grant and Per Diem – is a long-standing VA program operating on the "housing readiness" model. Each program is discussed below.

HUD-VASH

The VA and the federal Department of Housing and Urban Development (HUD) have combined efforts to create a program for homeless veterans – including those with severe psychiatric issues, substance use disorders, and/or physical disability – and their families to move them from homelessness to permanent supportive housing.¹⁰ The program's overall purpose is to help the most vulnerable and chronically homeless veterans, including those in shelters, emergency rooms, and inpatient mental health treatment programs, obtain and retain permanent supportive housing.

⁵ Connecticut has adopted the federal goal of ending homelessness among veterans. See:

<http://www.governor.ct.gov/malloy/cwp/view.asp?A=4010&Q=539758> (accessed November 4, 2014).

⁶U.S. Interagency Council on Homelessness, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, Washington, D.C., 2010. http://usich.gov/PDF/OpeningDoors_2010_FSPPPreventEndHomeless.pdf (accessed October 22, 2014).

⁷Evidence-based programs have strong research demonstrating repeated success at reaching specific outcomes across a variety of settings or locations (See: Hannah G, McCarthy S, Chinman M. (2011). *Getting To Outcomes in Services for Homeless Veterans: 10 Steps for Achieving Accountability*; and National Center on Homelessness Among Veterans. http://www.va.gov/homeless/nationalcenter_additional_information.asp, accessed November 4, 2014).

⁸Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Permanent Supportive Housing: The Evidence*, 2010. <http://www.samhsa.gov> (accessed November 2, 2104); and United States Interagency Council on Homelessness, *Housing First*. http://usich.gov/usich_resources/solutions/explore/housing_first (accessed November 4, 2014).

⁹Montgomery, AE., Hill, L., Kane, V., Culhane, D., *Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH*. The National Center on Homelessness Among Veterans, March 2013. http://works.bepress.com/cgi/viewcontent.cgi?article=1153&context=dennis_culhane (accessed November 14, 2014).

¹⁰ The program officially began in 1992, releasing just under 1,800 vouchers. It remained relatively stagnant until 2008, when it began distributing thousands more vouchers (and using a Housing First approach instead of the previous "housing readiness" model); over 60,000 vouchers currently exist nationwide.

What is it? The HUD-VA Supportive Housing program (HUD-VASH) gives veterans HUD's Housing Choice Vouchers (i.e., "Section 8") for rental assistance, as well as case management and clinical services through a local VA medical center. Rental vouchers are distributed by HUD to individual public housing agencies (PHAs). The number of vouchers a PHA receives is determined through a collaborative effort between HUD and VA that relies on specific data to calculate geographic need.¹¹

HUD-VASH uses a somewhat modified Housing First approach. The program does not require a set period of sobriety or engagement in any sort of treatment prior to receiving a voucher, but it does require participants to agree to case management provided by the VA medical centers.¹² The other eligibility criteria are that the veteran must:¹³

1. meet the federal definition of homelessness;¹⁴
2. not be on the state's lifetime sex offender registry;
3. be able to perform activities of daily living and live independently; and
4. be eligible for VA healthcare.

Eligibility determination is a joint effort between the VA medical center and public housing agency serving the veteran applying for the voucher.¹⁵ Once in the program, veterans are expected to participate in case management and use the support services, treatment recommendations, and assistance needed to successfully maintain recovery and sustain housing in the community. For veterans receiving case management services, the program attempts to maintain a 1:25 ratio of case managers to veteran households.¹⁶

The voucher, and any accompanying supportive services, is considered permanent unless the veteran voluntarily relinquishes it, dies, or otherwise is forced to surrender it due to not following the program's requirements, including refusing case management services without good cause.¹⁷ Families may be offered a "regular" Housing Choice Voucher, if one is available,

¹¹ The data used are: HUD point-in-time data on homeless veterans needing services in the area, VA medical center data on the number of contacts with homeless veterans, and performance data from the housing agencies and medical centers. See: U.S. General Accountability Office, *Veteran Homelessness: VA and HUD Working Are Working to Improve Data on Supportive Housing Program*, June 2012. <http://www.gao.gov/assets/600/591906.pdf> (accessed November 10, 2014).

¹² Veterans Healthcare Administration Handbook, HUD-VASH Program, September 14, 2011. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2446 (accessed November 14, 2014).

¹³ U.S. Department of Veterans Affairs: HUD-VASH Eligibility Criteria. http://www.va.gov/homeless/hud-vash_eligibility.asp (accessed November 18, 2014).

¹⁴ Generally, federal law defines chronic homelessness as someone homeless for a full year or at four different times over a three-year period. For the full definition: <https://www.hudexchange.info/resources/documents/HomelessAssistanceActAmendedbyHEARTH.pdf> (accessed November 18, 2014).

¹⁵ The VA first evaluates a veteran's homelessness status, VA healthcare eligibility, and whether the veteran agrees to receiving case management services. Public housing authorities then assess a person's income and sex offender registry status prior to voucher approval.

¹⁶ U.S. Interagency Council on Homelessness, *Case Management*. http://usich.gov/usich_resources/toolkits_for_local_action/using_hud_vash_to_end_veterans_homelessness/case_management/ (accessed November 25, 2014).

¹⁷ VHA HUD-VASH Handbook, Department of Veterans Affairs. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2446 (accessed November 20, 2014).

instead of the HUD-VASH voucher, as a way to free-up the HUD-VASH voucher for another veteran. The supportive housing vouchers for veterans are portable, within certain guidelines. Veterans receiving HUD-VASH can live in various types of housing, including private-market, housing owned by non-profit agencies, or public housing.

How effective is it? HUD-VASH was administered on a very small scale until 2008, and specific research on the program’s effectiveness since then is limited but promising. One study released in 2013 showed veterans who participated in HUD-VASH under the Housing First framework had less time to housing placement, were more likely to stay housed, and used the emergency room less, compared to veterans in a “housing readiness” model.¹⁸ The study, however, indicated more rigorous research is needed to further evaluate the effectiveness of the using the Housing First model to end homelessness among veterans. To that end, VA and HUD have joined efforts to further study the program to more fully determine ways to improve its effectiveness. That study’s release is anticipated in early 2015.¹⁹

Use in Connecticut. Table I-1 shows 63 HUD-VASH vouchers are currently available to Connecticut veterans, or nine percent of the 679 vouchers allocated to the state since FFY 08.²⁰ Currently 11 general vouchers and two project-based vouchers remain.²¹ Of the 54 new vouchers allotted to Connecticut in FFY 14, only four are being used. According to stakeholders interviewed by committee staff, the number of new HUD-VASH vouchers is anticipated to remain relatively steady in the coming years.

Table I-1. HUD-VASH Voucher Activity in Connecticut: FFY 08-14*			
<i>Fiscal Year Allocated</i>	<i>Total Vouchers</i>	<i>Vouchers In Use</i>	<i>Available Vouchers</i>
2008-2013	610	599 (98%)	11 (2%)
2011 (Project-based only)**	15	13 (87%)	2 (13%)
2014	54	4 (7%)	50 (93%)
Total	679	616 (91%)	63 (9%)
*As of November 21, 2014. **Vouchers are intended to be tenant-based, meaning they can be used to lease a private-market rental unit. Some vouchers are project-based, meaning they are tied to a specific development and do not move with the veteran. Although PHAs receive both types of vouchers, most are tenant-based because project-based vouchers are capped at 20 percent of the PHA’s tenant-based voucher budget. Source: PRI staff analysis of Department of Veterans Affairs-Connecticut data.			

¹⁸ The National Center on Homelessness among Veterans, *Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH*. Montgomery, A.E., Hill, L., Kane, V., Culhane, D. March 2013. http://works.bepress.com/cgi/viewcontent.cgi?article=1153&context=dennis_culhane (accessed November 10, 2014).

¹⁹ Department of Veterans Affairs, National Center on Homelessness Among Veterans: 2013 Annual Report. <http://endveteranhomelessness.org/sites/default/files/VA%20National%20Center%20Homelessness%20Among%20Veterans%202013%20Annual%20Report.pdf> (accessed November 22, 2014).

²⁰ See Appendix B of this report for a listing of vouchers by VA medical center.

²¹ Vouchers are intended to be tenant-based, meaning they can be used to lease a private-market rental unit. Some vouchers are project-based, meaning they are tied to a specific development (i.e., single-site) and do not move with the veteran. Although PHAs receive both types of vouchers, most are tenant-based, not project-based, since project-based are capped at 20 percent of the PHA’s tenant-based voucher budget.

Although the state may see limited new HUD-VASH vouchers, there are other efforts to continue to make permanent supportive housing available to veterans. There is attention in the state on helping voucher holders achieve permanent housing independent of the rental assistance voucher. This would potentially allow more voucher turnover, increasing the number homeless veterans served. In addition, the state recently announced the immediate release of 50 state-funded Rental Assistance Program (RAP) vouchers for veterans, with the potential for 50 additional RAP vouchers in early 2015. The initiative is to assist veterans who want to move from permanent supportive housing to housing without supports but still need assistance with rent payments. As a result of the RAP vouchers, 50 more homeless veterans could be provided access to permanent supportive housing through federally-subsidized HUD-VASH vouchers, when those vouchers are turned over.

Supportive Services for Veteran Families

What is it? The federal VA's Supportive Services for Veteran Families (SSVF) program provides grants to selected non-profit organizations to prevent and end homelessness among very low income veterans.²² The program helps veterans who are in danger of becoming homeless to remain housed, and rapidly rehouses veterans who become homeless. It was not originally intended for people experiencing chronic homelessness, but has begun providing assistance to a cross-section of homeless veterans. The program became fully operational in 2012 and uses a Housing First approach. It is offered both to families and individuals.

The program provides financial help (generally for three to six months) and case management services to assist with financial, employment, legal, and benefits issues. Recently, the VA has begun encouraging SSVF providers to work with veterans who are living in domiciliary care at the veterans' homes.

Individual grantees determine whether a veteran family is eligible for SSVF assistance, using a screening tool approved by VA. The form requests information to determine whether a veteran meets the program eligibility requirements:

1. Member of a "veteran family," meaning the individual is a veteran or a member of a family whose head of household, or the spouse of the head of household, is a veteran;
2. Very low income; and
3. Literally homeless (according to the federal definition) or imminently at risk of becoming homelessness.²³

²² Very low-income is defined as household income not exceeding 50% of area median income. See: U.S. Department of Veterans Affairs - Supportive Services for Veteran Families (SSVF) Program: Program Guide, Last updated March 31, 2014). http://www.va.gov/HOMELESS/ssvf/docs/SSVFUniversity/SSVF_Program_Guide_March31_2014.pdf (accessed November 18, 2014).

²³ Meets the federal definition of homeless, and: 1) is scheduled to become a resident of permanent housing within 90 days pending the location or development of housing suitable for permanent housing; or 2) has exited permanent housing within the previous 90 days to seek other housing that is responsive to the very low-income Veteran family's needs and preferences. (Veterans may live in permanent housing and still receive SSVF services.)

Grantees collect other information to help assess the veteran's overall level of need, including the number of times the person has moved in the past 60 days, reason(s) for recent housing loss, number of dependents and their ages, and whether rent payment is in arrears. Each assessment item is associated with a number; the larger the final number, the more the person is considered in need of SSVS services. In areas where there is more demand than funding, higher-need veterans are prioritized.

How effective is it? Studies specific to the overall effectiveness SSVF are short-term, given the program only recently began, but the research is promising. Strong majorities of program participants are avoiding homelessness or getting housed.

For example, in a nationwide follow-up of SSVF participants after their exit from the program over a two-year period, only a small minority of veterans experienced an episode of homelessness over an extended period of time.²⁴ The study showed just over nine percent of all veteran families exiting the program after receiving rapid rehousing assistance experienced homelessness within one year, and 16 percent over two years. For single veterans, the rates were 16 and 27 percent respectively. Of veteran families participating in SSVF prevention assistance, seven percent experienced homelessness one year following SSVF exit and 11 percent after two years; the rates for single adults were 10 percent after one year and 18 percent after two years.

Another study limited to veterans who exited the SSVF program in FFY 12, showed most (86 percent) has a successful outcome (i.e., left to permanent housing).²⁵ Specifically, 90 percent of veterans with children and 81 percent of individual veterans exited to permanent housing. Among veteran households at risk of homelessness, 90 percent avoided homelessness.

The concept of “rapid rehousing” as a method to address homelessness – which is a primary component of SSVF – has been used effectively since the late 1980s to end homelessness for individuals and families.²⁶ Although large-scale rigorous evaluations have not been completed, findings of program-specific evaluations are fairly consistent. These have often reported that 90 percent or more of heads of households served remained housed after one or more years, and that very few returned to shelters.²⁷ In fact, one study specific to Connecticut showed 95 percent of families had not returned to shelters, three years after being rapidly rehoused through a federal initiative.²⁸

²⁴ Byrne, Thomas; Culhane, Dennis; Kane, Vincent; Kuhn, John; and Treglia, Dan, *Predictors of Homelessness Following Exit from the Supportive Services for Veteran Families Program*. VA National Center on Homelessness Among Veterans, U.S. Department of Veterans Affairs, Research Brief, October 2014.

<http://www.endveteranhomelessness.org/content/predictors-homelessness-following-exit-supportive-services-veteran-families-program> (accessed December 11, 2014).

²⁵ “Effectiveness of Permanent Housing Program FY 12” http://www.va.gov/HOMELESS/docs/SSVF/Effectiveness_of_SSVF_Program_Report_FY2012.pdf (accessed November 18, 2014).

²⁶ U.S. Interagency Council on Homelessness, *Rapid Rehousing*. http://usich.gov/usich_resources/solutions/explore/rapid_re_housing (accessed November 22, 2014).

²⁷ *Ibid*

²⁸ Connecticut Coalition to End Homelessness. “Where Are They Now? Three years later, did Rapid Re-housing work in Connecticut?” http://www.cceh.org/files/publications/NEW_RRH_works_in_CT_FINAL_2013.10.10_CCEH.pdf (accessed November 18, 2014).

Use in Connecticut. Three community-based non-profit agencies throughout the state were awarded SSVF program grants in FFY 14 totaling almost \$3.3 million, or roughly 1 percent of that year's nationwide SSVF funding.²⁹ As a part of their awards, grantees estimate they would serve 715 households statewide at the completion of the grant year. Comparing award amounts with the estimated number of people the grantees anticipate serving, the cost per participant ranges from just under \$3,000 to \$5,235; the estimated average per-participant cost among the three grantees is \$4,563.

Federal funding for SSVF has increased significantly in the program's short existence, signaling commitment to the program. During the program's first year of operation (FFY 12), funding totaled \$60 million to 85 nonprofit grantees.³⁰ Over the next two years, funding grew five-fold, to \$300 million distributed to 319 grantees.³¹

It is unclear if the current funding level will be sustained. During its interviews with key stakeholders nationwide and in Connecticut, committee staff was told that SSVF funding is expected to continue in the near future, but the program's long-term financial outlook is less certain.

Grant and Per Diem

The federal VA's Homeless Providers Grant and Per Diem (GPD) program is a long-established transitional housing program for veterans. This is the only major VA program that continues to operate using a "housing readiness" approach to prepare veterans to live on their own.

What is it? The GPD program provides per diem payments³² and construction-related grants to selected community-based providers of transitional housing for veterans.³³ Providers receiving GPD funding are expected to serve mostly veterans.³⁴ Community-based transitional housing programs are selected by VA through an application process.

²⁹ See Appendix C for a listing of the grantees and their award amounts.

³⁰ Department of Veterans Affairs - Supportive Services for Veteran Families (SSVF) Program: Program Guide, Last updated March 31, 2014. http://www.va.gov/HOMELESS/ssvf/docs/SSVFUniversity/SSVF_Program_Guide_March31_2014.pdf (accessed November 12, 2014).

³¹ In January 2014, the VA released a Notice of Funding Availability for the SSVF program. Program funding was designated in two ways: 1) up to \$300 million to renew existing grants; and 2) up to \$300 million in one-time grant funding over the next three years to 78 communities with the highest need based on factors including current level of unmet service needs, level of veteran homelessness, levels of Veteran poverty, and the overall size of the veteran population. (See: Federal Register, Vol. 79, No. 9, Tuesday, January 14, 2014, Notices, and subsequent corrections to original notice.)

³² The per diem rate is federally-determined, and the current maximum rate is \$43.32. The rate is paid for each day an eligible veteran occupies an authorized bed.

³³ The grant portion of the GPD program provides funding for up to 65 percent of projects involving the construction, acquisition, or renovation of facilities offering transitional housing to homeless veterans. It can also be used to purchase vans to provide outreach and services to homeless veterans.

³⁴ Up to 25 percent of bed capacity in a transitional housing arrangement may be used for non-veterans, without payment.

To meet GPD eligibility requirements, veterans must be:³⁵

1. homeless (according to the federal definition) or in imminent risk of losing housing;
2. referred by the veteran's primary clinician; and
3. be in treatment for mental health, medical, and/or substance abuse issues (including compliance with toxicology screens); and
4. actively working towards a plan of independent living.³⁶

Individual GPD programs may have their own requirements for residents. Based on committee staff's discussions with providers in Connecticut, some programs require a period of sobriety before admission. If a veteran has income, programs may charge rent, and some do. Programs may choose to provide meals to residents.

GPD programs provide supportive services, with a focus on case management. Services are geared toward helping the veteran become ready for independent living (with or without supports), and generally include assistance with VA benefits, connection to mental health and substance use treatment services, financial guidance, education counseling, employment-related assistance, and assistance with finding permanent housing.

Veterans are limited to a 24-month stay in a GPD program, with a maximum of three separate stays in any combination of programs. Once in GPD housing, in Connecticut, the VA has been urging programs to focus on successful exits (i.e., into permanent housing) by six to nine months. In fact, the average length of stay in Connecticut GPD programs is around five months, with about two-thirds moving to permanent supportive housing.

Extensions may be granted beyond two years on an individual basis if permanent housing for the veteran has not been located or if the veteran requires additional time to prepare for independent living. The VA's GPD liaisons make those decisions.³⁷ GPD liaisons are also responsible for monitoring programs' operations and results, as well as conducting annual facility inspections.

How effective is it? There is debate at the national level and in Connecticut as to the overall necessity and effectiveness of transitional housing. A known limitation of the approach is that a majority of those who are chronically homeless, even those who have participated in treatment or transitional programs intended to prepare the person for permanent housing, may not be able to meet the housing preconditions.³⁸ Others are not in favor of transitional housing

³⁵ VA Connecticut Healthcare System: Errera Community Care Center, "Transitional Housing: The Homeless Grant and Per Diem Program," March 2014.

³⁶ Although veterans in transitional housing for longer than 90 days are no longer considered "chronically homeless" under the HEARTH Act, they are still eligible for HUD-VASH vouchers if they have high vulnerability and need the case management services to successfully sustain permanent housing. <http://100khomes.org/blog/mythbusters-using-hud-vash-to-house-homeless-veterans#sthash.NyREx25h.dpuf>

³⁷ No more than half of a provider's residents may exceed the 24-month limit at any time.

³⁸ Caton, Carol, Wilkens, Carol, Anderson, Jacquelyn, *People Who Experience Long-Term Homelessness: Characteristics and Interventions*. 2007. <http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/> (accessed on November 23, 2014).

due to its time-limited nature, which means it is, by definition, temporary, and there is a lack of independence for residents. Advocates of transitional housing, however, say it provides a better place for those experiencing homelessness to live than emergency shelters, while allowing them to work on the issues contributing to their homelessness and toward permanent housing.

Research on transitional housing and the GPD program results is scant. The VA's National Center on Homelessness Among Veterans' website references one study from 2007 (making it relatively dated) that determined 79 percent of those leaving GPD facilities were permanently housed one year after discharge.³⁹

As noted above, the VA's approach to homelessness is shifting from transitional housing to a Housing First model. GPD providers in Connecticut told committee staff the federal VA is placing increased emphasis on provider accountability and quicker placement in permanent housing. Multiple national associations on homelessness also told committee staff that while funding for the federal GPD program has not declined, the approach of early prevention and rapid rehousing of homeless veterans is getting more attention at the federal level (as discussed earlier). In addition, modifications to the traditional GPD program are being tried, including Transition in Place, a program whereby beds in transitional housing programs become permanent for the veterans living there.

Use in Connecticut. Table I-2 highlights GPD program activity in Connecticut for FFYs 12-14. In FFY 14, there were 16 GPD providers throughout the state, offering 167 beds to veterans, generally the same as the previous two fiscal years. The average time veterans remained in GPD transitional housing was the same for FFYs 12 and 13 (149 days), and decreased somewhat in FFY 14, to 145 days (possibly as a result of VA's emphasis on shorter stays in GPD programs). The average occupancy rate dropped between FFYs 13 and 14, from 79 percent to 76 percent. The percent of veterans discharged to permanent supportive housing increased from FFYs 13-14 – from 61 to 66 percent.⁴⁰ At the same time, information about the length of time veterans remain permanently housed before becoming homeless again is not formally tracked. Annual federal GPD funding to Connecticut averaged almost \$1.8 million.

³⁹ Department of Veterans Affairs, http://www.va.gov/homeless/nationalcenter_additional_information.asp (accessed November 20, 2014).

⁴⁰ The VA noted its data was collected differently for FFY 12; it was not included in PRI staff's analysis.

Table I-2. Federal VA Grant and Per Diem Program Activity in Connecticut: FFYs 12-14			
	<i>FFY 2012</i>	<i>FFY 2013</i>	<i>FFY 2014</i>
Number of providers	16	15	16
Number of total beds	(not available)	160	167
Average occupancy rate	(not available)	79%	76%
Average length of stay (days)	149	149	145
Percent discharged to Permanent Supportive Housing (PSH)	58% (data collected differently)	61%	66%
Total federal funding in Connecticut*	\$1,650,917	\$1,853,083	\$1,873,938
<p>Note: The data provided by VA-CT led to additional questions. Due to time constraints, committee staff was unable to follow up.</p> <p>*May not have all been spent; could have been returned to VA (but would likely have been a small amount, if any).</p> <p>Source: PRI staff analysis of Department of Veterans Affairs-Connecticut data.</p>			

Domiciliary Care Assessment

The Connecticut State Veterans' Home's domiciliary care, which is based on the "housing readiness" approach, needs improvement. General domiciliary care in the main Residential Facility has a "rehabilitation" mission that implies both a transitional housing program and permanent supportive housing, but it does not adequately provide either, based on committee staff's analysis. It lacks the necessary case management intensity, employment services, and day-one emphasis on successfully moving on to independent living to qualify as transitional housing. General domiciliary care also has a population of medium- and long-term residents, some of whom do not intend to ever move out from the Home. However, the Home does not offer those residents the services, accommodations, rules, and responsibilities of permanent supportive housing.

The Home's other main types of domiciliary care – transitional housing in free-standing houses, and residential substance use treatment – are challenging to assess. The first type is a new and very small program, so this study chose to focus most resources elsewhere. The second type, residential substance use treatment, has unclear goals and poor data. It was not possible within the study's time constraints and scope to thoroughly explore how the program compares to others. There are some indications that the Home's residential substance use treatment program could be strengthened.

This chapter assesses all three settings for performance on the program goals, occupancy (as an imperfect proxy for quality, outreach, and/or need in the community for the service), and participant satisfaction. Evaluating any of the domiciliary settings using data is difficult. The Home does not have the data to monitor and assess some of its key services and outcomes; in some cases, it is hindered by an antiquated data system. The program review committee staff surveyed domiciliary residents (except those in the new, small program) and found that, overall, about half are satisfied with the Home, and the vast majority generally felt safe. Some respondents were dissatisfied with staff services, especially those geared toward helping residents move on to independent living, and with the available avenues for registering complaints. Survey methods and full survey results are found in Appendix D.

Overview of the Home's Domiciliary Care

The mission of the Veterans' Home's domiciliary care is: "...to facilitate rehabilitation in all its residents to the greatest extent possible and at the fastest rate possible. The ultimate goal is to return as many residents as possible to society as productive citizens, capable of independent living."¹ Domiciliary care is provided by the Connecticut Department of Veterans' Affairs (DVA) in multiple settings on the Home's campus, outlined below in Figure II-1. The largest setting is the main Residential Facility. It is made up of multiple connected buildings and often

¹ Connecticut State Department of Veterans' Affairs. *Residential Facility Programs and Services Policy & Procedures Manual*. 2013.

Figure II-1.

Veterans' Home Domiciliary Care

Main Residential Facility



- General population
- 362 capacity
- Multi-person rooms

Fellowship House



- Residential substance use treatment
- 75 capacity
- Single-person rooms

STAR Apartments



- Working full-time off-campus and seeking to move into the community
- 12 capacity*
- 5 apartments with 3 private bedrooms each

West Street Houses



- Families and single women**
- 7 veteran capacity, plus family members
- 5 single-family three-bedroom houses

Notes

*Full capacity is 15 but one of the apartments is being used as American Legion offices.

**Single women may also live in the other residential options, except for Fellowship House.

Sources: Department of Veterans' Affairs for West Street Houses picture; Friar Associates Inc. 2005 Master Plan for the department's grounds, for the Fellowship House picture; PRI staff.

called “the Domicile” or “the Dom.” The STAR apartments are considered an extension of the main Residential Facility, for the purposes of this report. As of December 8, 188 veterans were living in the main Residential Facility and STAR, and another 35 in the Home’s residential substance use treatment program, located in Fellowship House.

Nearly all domiciliary care residents have access to a range of on-campus social, rehabilitative, and health care services. They may eat three meals every day in the common dining hall at no cost beyond the program fee. The exception is the West Street houses’ residents, who are in unique accommodations for a special program, as described below. The Home’s domiciliary care is reviewed annually by the federal Department of Veterans Affairs (VA), as a condition of the Home’s federal funding.

There is no fee for the first three months of domiciliary care. Thereafter, the fee of \$200 may be waived upon application and approval by DVA.

West Street Houses (Patriots’ Landing)

Since early 2014, the five fully-furnished houses across West Street from the bulk of the Home campus have hosted mainly families as transitional housing, in line with the Home’s housing readiness approach. The families receive case management services from a contracted nonprofit, Chrysalis Center, Inc., and are limited to two years in the houses.² The nonprofit is expected to meet specific performance measures and expected outcomes, such as no clients exiting to homelessness.

How effective is it? Because the Patriots’ Landing program is new and small, it is difficult to assess effectiveness.

- **Program goal:** *Success in reaching the program goal cannot be determined at this early stage.* Because the program has been running for less than a year, with a “successful exit” (to permanent housing) deadline of two years, it is unfair to judge the program based on this goal.
- **Occupancy:** *Demand seems high, relative to the Home’s other domiciliary settings.* The houses largely have been full. One family left a few months ago and the program administrators from both DVA and Chrysalis Center, Inc. have been interviewing prospective tenants.
- **Resident satisfaction:** *Participant satisfaction is unknown.* This aspect of the program was not assessed by program review committee staff, due to the small number of program participants. However, some level of satisfaction may be implied from the low turnover rate to date.

How does it compare? The Patriots’ Landing program is similar to a standard transitional housing program, with a few exceptions. The table below shows how the program’s

² Chrysalis Center, Inc. is contracted by the Connecticut Department of Mental Health and Addiction Services (DMHAS), which in turn has a Memorandum of Understanding with DVA for reimbursement. The agreement covers a 28-month period ending June 30, 2016.

rules, discharge timeframe, and level of case management services match transitional housing. The program differs in its single-family house setting and population. Most transitional housing is for single people and gives private or semi-private rooms in a large house or building. Due to the setting and population, some of the Patriots’ Landing rules are more relaxed than standard transitional housing. For example, there is no curfew, and overnight guests are allowed with permission requested in advance. None of the twelve veterans’ homes in other states researched by program review committee staff offers transitional housing for families with children.

Table II-1. Comparison of Home’s Patriots’ Landing to Standard Transitional Housing		
	<i>Patriots’ Landing</i>	<i>Standard Transitional Housing</i>
Exit deadline (goal)	2 years	2 years
Case manager staff: client ratio	1:10-20	1:25
Alcohol prohibited	Yes	Yes
Accommodations	Single family house	Private or semi-private room in large building or house
Curfew	No	Yes
Monthly cost	\$200* Meals not included	\$0-200 Meals usually included
*Free for the first three months. Source: PRI staff analysis. “Standard Transitional Housing” based a few Connecticut nonprofit providers of transitional housing for veterans funded by the U.S. Department of Veterans Affairs’ Grant and Per Diem Program.		

Fellowship House: Residential Substance Use Treatment

Fellowship House, also known as the Veterans Recovery Center, hosts residential treatment for people with substance use disorders. It contains 75 single-occupant rooms (with shared bathrooms), group meeting rooms, and a few recreational areas. To be eligible for admission, someone must have been substance-free (“clean”) for at least 21 days and meet the other Home requirements. (The federal Department of Veterans Affairs has a 21-day detoxification program in West Haven.)

The main treatment program – the Recovery Support Program – consists of group and individual therapy, as well as 12-step group meetings. Group therapy is more intensive during the first four to six months (Phase I). In the second six months (Phase II), participants are to address employment and legal issues, as well as take a leadership role in a 12-step group. Those who complete a year in Fellowship House may choose to apply for up to two additional years living there, called Alumni Year (second year) and Recovery In Motion (third year). The House also offers outpatient relapse education to any domiciliary care resident (except those in Patriots’ Landing) through its Recovery Education Programs. In addition, the House’s Alcoholics Anonymous/Narcotics Anonymous meetings are open to anyone living at the Veterans’ Home and the public.

How effective is it? For multiple reasons, assessing the effectiveness of Fellowship House's main residential treatment program is difficult. However, residents of Fellowship House seem satisfied with the substance use treatment services they are receiving.

- **Program goal:** *Success in reaching the residential treatment program goal cannot be determined with certainty due to a lack of a clear goal, as well as data shortcomings.* Until 2014, program staff considered someone to have successfully completed the residential treatment program when the person reached 12 months there. Starting this year, staff changed the definition of "completion" to mean completing the "core" group therapy courses featured in Phase I. The change was made because the staff considers the core group therapy courses the most intensive component of the program. Completion of these groups can take four to six months.

However, new entrants into the program are not told there is a specific treatment or program completion point. Instead, they are told about the different stages of the program, and the ability to stay at the Fellowship House for two years. As such, it is possible some residents may not be wholly focused on their treatment or working toward life after Fellowship House, knowing they could stay there for multiple years.

While Fellowship House staff were responsive in compiling data requested by program review committee staff, there were multiple data inconsistencies that could not be adequately resolved. Consequently, committee staff limited their analysis to the first twelve months of Fellowship House residence, the portion of the data for which there were fewer problems. In addition, critical information – what happened to people once they left Fellowship House – could not be determined within the timeframe of the study. This is true even for those Fellowship House residents who completed residential treatment and then moved to the main Residential Facility.

Keeping in mind data limitations, it appears that over five recent fiscal years (FYs 2009-13), 71 percent of the 204 people who began the residential treatment program completed at least Phase I. A very small share (three percent) of those who had completed Phase I had chosen to leave within six months. By the twelve-month mark, 57 percent had successfully lived at Fellowship House for that long or left after completing one or both phases of the program. The table below shows there is some variation in completion rates, from year to year, due in part to the small number of veterans beginning the program.

Table II-2. Residential Treatment Program Completion at Six and Twelve Months, FYs 09-13*					
<i>FY Cohort</i>	<i># Began Program</i>	<i>% Completed At Least Phase I (4-6 Mos.)**</i>	<i>% Completed Phase I <u>and</u> Had Left House Between</i>		<i>% Completed Phases I and II, or Had Left the Home After Completing At Least Phase I, By 12 Months***</i>
			<i>4-6 Months</i>	<i>4-12 Months</i>	
2009	58	69%	5%	22%	59%
2010	31	71%	0%	16%	65%
2011	34	65%	0%	24%	53%
2012	44	75%	2%	25%	59%
2013	37	73%	5%	14%	49%
Total, FYs 09-13	204	71%	3%	21%	57%
<p>*FY 14 data was unavailable because persons in that cohort could have entered the program anytime from July 2013 to June 2014. Consequently, the six- and twelve-month points would not have been reached for some portion of the cohort, by the time of data request (July 2014).</p> <p>**The data indicate the share of the cohort that was either still living at Fellowship House six months after admission or had chosen to leave the House after completing Phase I.</p> <p>***Excludes those who had left against Fellowship House staff advice.</p> <p>Source: PRI staff analysis of Department of Veterans' Affairs data.</p>					

Reasons for leaving. There are multiple reasons why people left the residential treatment program, other than successful program completion. Most of those who left for other reasons (29 percent who entered the program in Fiscal Years 2009-13) departed due to relapse, as displayed by Table II-3.³ Some (9 percent) exited because they required medical care, while smaller shares left for other program violations – including being absent without leave, which may indicate relapse – or choosing to leave against the advice of treatment staff.

Table II-3. Shares of Residential Treatment Program Participants Who Left in the First 12 Months, For Reasons Other Than Successful Completion, FYs 09-13				
<i>FY Cohort</i>	<i>% Significant Relapse*</i>	<i>% Other Violations**</i>	<i>% Chose to Leave Against Treatment Advice</i>	<i>% Needed Medical Care (Non-Relapse)</i>
2009	36%	2%	2%	2%
2010	19%	0%	10%	6%
2011	32%	3%	0%	12%
2012	18%	7%	2%	14%
2013	35%	3%	0%	14%
Total, FYs 09-13	29%	3%	2%	9%
*Includes only those living in Fellowship House. First and second relapses generally result in the person participating in the Home’s Recovery Education Program, while the third results in discharge from Fellowship House. The program staff have some discretion in handling relapses.				
**Examples of “Other Violations” are non-compliance with the program/treatment plan and violations of the Home’s general rules for domiciliary residents (e.g., someone Absent Without Leave).				
Source: PRI staff analysis of Department of Veterans’ Affairs data.				

Relapse rates. It is difficult to assess any substance use treatment program’s effectiveness based on relapse rates. Limited data are available overall, and particularly for residential programs. Furthermore, it is generally accepted by researchers, treatment professionals, medical personnel, and persons in recovery that substance use disorders are a chronic condition; many people with any chronic condition – from 30 to 70 percent – experience relapse(s).⁴

Keeping these caveats in mind, information on relapse rates for Fellowship House residents is provided below, for relapses resulting in treatment program discharge

³ First and second relapses generally result in the person participating in the Home’s Recovery Education Programs, while the third results in discharge from Fellowship House and, once alternative accommodations (preferably a treatment program) have been found, from the Veterans’ Home. The program staff have some discretion in handling relapses.

⁴ National Institute on Drug Abuse. *Principles of Drug Addiction Treatment; A Research-Based Guide, 3rd Ed.* U.S. Department of Health and Human Services, 2012. http://www.drugabuse.gov/sites/default/files/podat_1.pdf (accessed November 12, 2014).

– which generally means the person has relapsed three times. Among Fellowship House residents, the 12-month significant relapse rates ranged from 18 to 36 percent, averaging 29 percent. Former participants who had left Fellowship House before a year for reasons other than relapse are excluded from these rates.

Table II-4. Residential Treatment Program Participant Significant Relapse* Rates, FYs 09-12				
<i>FY Cohort</i>	<i>0-6 Months</i>	<i>6-12 months</i>		<i>0-12 Months</i>
		<i>% of Cohort</i>	<i>% of Those Who Were Still in Program, at 6 Months</i>	
2009	26%	10%	16%	36%
2010	13%	6%	9%	19%
2011	21%	12%	18%	32%
2012	9%	9%	13%	18%
2013	14%	22%	32%	35%
Total, FYs 09-13	17%	12%	17%	29%

*Includes only those living in Fellowship House. First and second relapses generally result in the person participating in the Home’s Recovery Education Program, while the third results in discharge from Fellowship House. The program staff have some discretion in handling relapses. Source: PRI staff analysis of Department of Veterans’ Affairs data.

Data not analyzed. Information on participation, completions, and discharges for the Alumni Year (year two) and Recovery in Motion (year three) programs was provided by the Home but not analyzed, due to data quality issues. In addition, the Home does not collect data on what happens to residents once they leave Fellowship House. Therefore, longer-term outcomes regarding substance use, housing, and other areas of interest are unavailable.

- **Occupancy:** *Fellowship House has not been full in several years, if it ever was.* The average annual occupancy rate has fluctuated since FY 10, rising from 60 percent to 76 percent in FY 12, before falling to 57 percent in FY 14. The number of new House residents has also varied. Although 58 veterans were admitted in FY 09, in the next four fiscal years, between 31 and 44 began the program annually.

If residents could not extend their stays (upon application) by an additional one to two years, it is likely the House would regularly be less than half full. In early November 2014, 25 of the 75 rooms (33 percent) were occupied by first-year residents (seven in Phase I, and 18 in Phase II). Another 10 rooms (13 percent of rooms, and 29 percent of the occupied rooms) housed residents in their second and third years (two and eight residents, respectively).

- **Resident satisfaction:** *Residents appear satisfied with the program.* All 13 Fellowship House residents who submitted a program review committee staff survey indicated they were either very satisfied (62 percent) or satisfied (38 percent) with how well the Veterans’ Home staff helps them “deal with substance use issues.” Satisfaction surveys administered by Fellowship House staff several years ago (2005 and 2007) also gave favorable feedback; no such surveys have been done recently.

How does it compare? Fellowship House’s residential treatment program is quite different from the vast majority of residential substance use treatment programs in Connecticut. It is longer, has an option for maintaining housing in the same location post-completion, and is considerably less costly than standard private residential programs, as the table below shows. It also uniquely serves veterans. There are some residential treatment programs funded by the Department of Mental Health and Addiction Services (DMHAS) that are relatively lengthy, like the Home’s, but those programs are also different in key ways.

Table II-5. Comparison of Home’s Fellowship House to Other Residential Treatment Programs			
	<i>Fellowship House</i>	<i>Standard Private Residential Program</i>	<i>DMHAS-Funded Program Slots</i>
Number of days of abstinence required before admission	21	Varies; as little as a few days	5 to 7
Program length	Not clearly defined. Most intensive phase is 4-6 months; but see below	28 days	Varies by program; from 3-4 weeks to 6-9 months
Post-program housing in same location	Yes	No	No
Accommodations	Private rooms	Private rooms	Mainly shared rooms
Mix of group and individual counseling	Yes	Yes	Yes
Integrated substance use and mental health treatment	No	Varies	Yes
Monthly cost (all include meals)	\$200*	Health insurance might cover, in part, if insured; if not, likely several thousand dollars	Free**
*Free for the first three months. After three months, fee may be waived if income is below a certain threshold. **DMHAS funds some programs that accept non-DMHAS clients, who may be charged. Source: PRI staff analysis.			

Other states. Just one of the twelve other state veterans' homes' websites examined by program review committee staff (Minnesota's Hastings home) specifically mentioned assisting residents with substance use treatment. That home has two psychologists, a lower-level mental health professional, and a weekly consulting psychiatrist, for about 160 residents. The psychologists' caseloads are about 20 clients apiece. It does not offer residential-level substance use treatment, but does have some group counseling sessions around substance use issues.

Federal VA. The federal VA has some residential substance use treatment programs in other states. The closest ones are in Providence, Rhode Island, and Northport (Long Island), New York. These programs mainly have general staffing and programming requirements, with the federal VA requiring at least two licensed (not certified) practitioners and adherence to evidence-based practices for treating substance use disorders.⁵

Overall. The quality of the Veterans' Home's residential substance use treatment program is unclear, but a few circumstances suggest there may be room for improvement:

- *The program is not currently licensed by the Connecticut Department of Public Health, which sets and maintains standards for private and some state residential substance use treatment facilities. The Department of Veterans' Affairs explored licensing the program, in the past, but decided against it. However, the agency seems to be reconsidering. The program is not accredited by an outside agency (e.g., The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities).*
- *Program staff have not communicated with the Connecticut Department of Mental Health and Addiction Services or the federal Department of Veterans Affairs regarding what makes a high-quality residential treatment program, based on program review committee staff interviews.*
- *Because residents receive mental health care off-campus from the federal VA, substance use and mental health treatment is not optimally integrated. Although Fellowship House staff can communicate with the federal VA providers (with permission from the patient), treatment is not integrated in terms of substance use treatment staff or the treatment program content.*
- *The program review committee staff is unsure whether it is wise to extend the option of living in Fellowship House past 12 months (for a possible total of 36 months), as is currently done. There is a general recognition in the field of substance use treatment that establishing recovery supports in a person's home community is critical. What is effectively up to a three-year residential program (with "light" program services in the second and third years) at Fellowship House may inhibit someone from achieving full recovery potential over the rest of the person's life.*

⁵ Department of Veterans Affairs. *VHA Handbook 1162.02: Mental Health Residential Rehabilitation Treatment Program*. 2010. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2354 (accessed November 20, 2014).

General Domiciliary Care: Main Residential Facility

The vast majority of Veterans' Home residents live in the main Residential Facility. They reside in the East and West Domiciles, sharing large rooms (divided into three sections, or "bays") that can host up to 12 people each. Services offered are an on-site medical clinic (B Clinic), social work, vocational rehabilitation, and recreational activities. The main Residential Facility also contains a dining hall and kitchen, which prepares and serves food to the Home's residents, including transporting it to the Health Care Facility, which gives long-term care. The main Residential Facility services are also available to STAR apartment and Fellowship House residents.

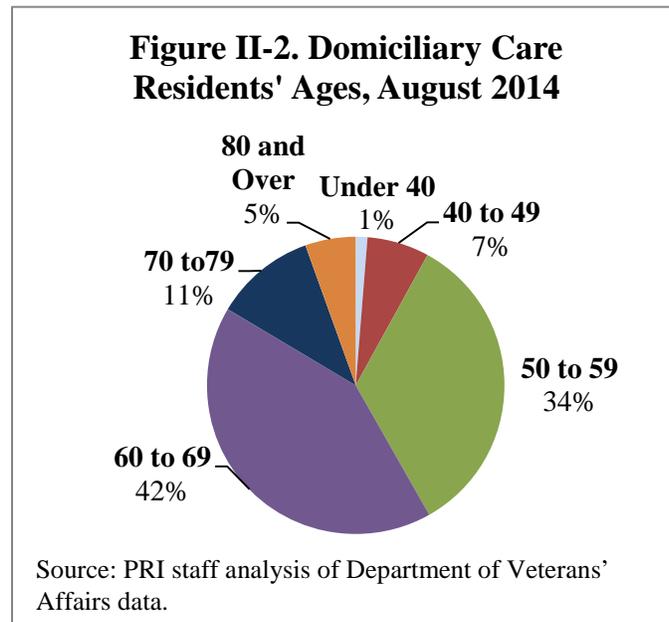
The STAR apartments are designated for domiciliary residents who have obtained employment and plan to leave the Home within six months, with a possible six-month extension. STAR residents have more relaxed rules. During the latter part of their stay in STAR, residents are required to purchase and prepare their own food, and cannot use B Clinic. Due to the low number of participants (two as of early December), they are included in this discussion of regular domiciliary care.

An entering resident is expected to meet separately with an assigned social worker (one of the Home's four) and the vocational rehabilitation coordinator within the first five days. Both meetings involve discussion of the resident's goals and how the staff can assist the resident in reaching them.

Three months after a new resident has arrived, the social worker, vocational rehabilitation coordinator, and substance use treatment director meet with the resident to develop a discharge plan. The Home's goal is for the resident to successfully leave to independent housing within two years, but some residents have a three-year goal while others are working toward leaving sooner.⁶ Some choose not to participate in discharge planning, initially or at a later point. The team then is supposed to work with the resident to make the plan happen, and adjust the plan when necessary; this is called the Veterans Improvement Program (VIP). The resident and service team are to meet every three months. In between, as-needed meetings and communication can occur among the service staff and resident. There is an expectation of monthly written, phone, or in-person contact with a social worker for those actively working toward successful discharge and, for every resident, a meeting every three months with the person's social worker.

⁶ The domiciliary care policies and procedures manual states the program goal is two years, but data produced by the Home at its staff's own initiative (before a data request had been received), set the short-term length of stay at three years. In addition, domiciliary staff conveyed in multiple ways throughout the study that the goal is flexible and can extend to three years.

Resident characteristics. Domiciliary residents (including those in Fellowship House) generally are older and dealing with a range of health issues. Most residents are in their 50s or 60s (76 percent combined), with small shares under 50 (8 percent) and 70 or beyond (16 percent), as shown in Figure II-2.⁷



Both mental and physical health challenges are common.⁸ More than half of residents have a psychiatric and/or substance use diagnosis. The most common psychiatric diagnoses among residents are depression (estimated at 55 percent), post-traumatic stress disorder (about 19 percent) and anxiety (approximately 17 percent).⁹ Roughly three-quarters have heart disease or a precursor, about half have diabetes, and almost one-third have cognitive impairments.¹⁰

Most (70 percent) domiciliary residents are White. Just over one-quarter (27 percent) are Black, and a very small share (3 percent) identify primarily as Spanish, Hispanic, or Latino.¹¹

How effective is it? Unclear goals, a wide range in residents' lengths of stay, and limited data availability hampered the program review committee staff's attempt to fully assess the effectiveness of the Veterans' Home's regular domiciliary care.

- **Program goal – Length of stay:** *If the goal is for new residents to successfully leave within two to three years, the Home is falling short.* Nearly half (47 percent) of domiciliary care residents in a recent month had lived at the Home for more

⁷ August 2014 residents.

⁸ The program review committee staff is not fully confident in the preciseness of the psychiatric and medical condition data in this paragraph. The June 2014 data gathered by the Home that provided information in these areas, which was presented in the committee staff's October update report, conflicted somewhat regarding age with more reliable age data given by the Home for August 2014 residents. Upon committee staff's request, the Home produced more specific psychiatric diagnosis data in October 2014, but there was a considerable swing from June 2014 in the percent of residents with a psychiatric diagnosis. All health condition data provided by the Home – March 2013 data analyzed in the update report, June 2014 data, and October 2014 data – were produced using the same methods. Consequently, committee staff chose to give estimated data, based on as many of the three data points as possible. Committee staff also no longer believes that the Home's data is sufficiently strong to show that the domiciliary population has growing medical needs and is aging rapidly, conclusions that were provided in the October update report.

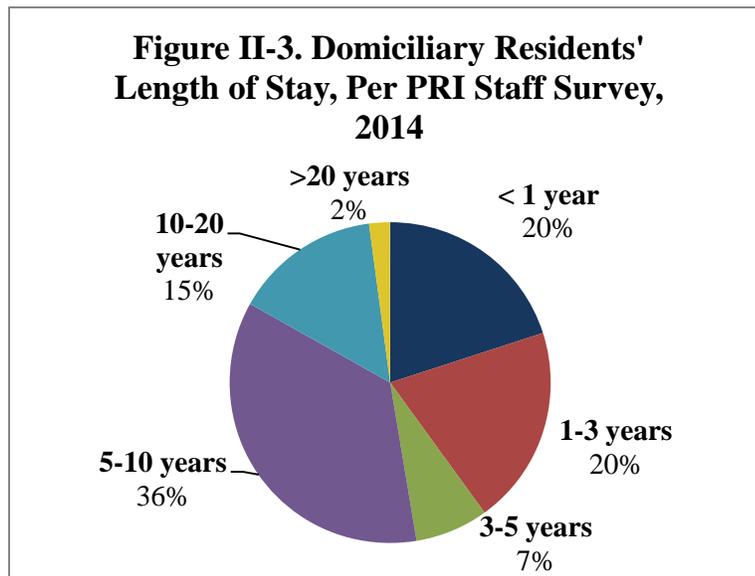
⁹ October 2014 residents.

¹⁰ Rough estimates based on Home data for March 2013 and June 2014 residents.

¹¹ August 2014 residents.

than five years. Another 11 percent had resided there for between three and five years.¹²

DVA was unable to provide detailed information on length of stay (due to data system limitations), but the program review committee staff survey provides a glimpse. Although not all domiciliary residents completed the survey – 96 of 223 residents (43 percent) did so – the respondents’ median age (61 years) nearly matched that generated by the Home (62 years), so it may be somewhat representative. Figure II-3 shows that one-fifth of survey respondents had lived at the Home for less than one year, and another fifth had been there for one to three years.



If, however, the goal is to be available to house veterans for an extended period of time, the Home is accomplishing it. The figure to the left indicates that many veterans are long-term residents of the Home. One-third (36 percent) of survey respondents had lived at the Home five to ten years, and another one-sixth (17

percent) had been there at least ten years. Overall, 60 percent of residents responding to PRI staff’s survey had lived at the Home beyond the outlying goal of three years. Nearly one-quarter (24 percent) of respondents indicated they want to stay at the Home permanently.

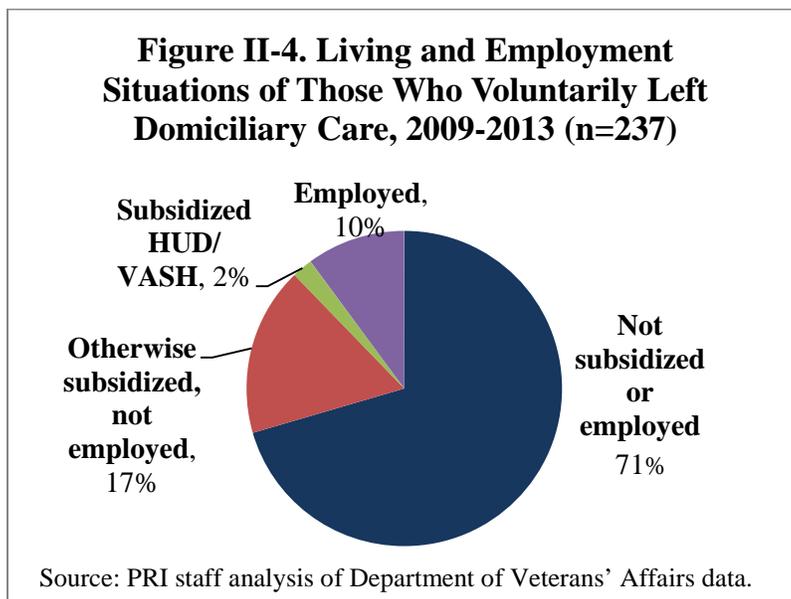
Limited program data from the Home supports the idea that a large share of residents lives there long-term. Eight out of every 13 residents (62 percent, or 141 residents) has either chosen to withdraw from discharge planning (via the Veterans Improvement Program) or has been designated as needing some extra assistance with daily living activities.¹³ Nearly half (47 percent) of the committee

¹² As of June 2014, according to data provided by the Department of Veterans’ Affairs.

¹³ As of October 24, 2014, according to data provided by the Department of Veterans’ Affairs. The resident counts per program level were: 82 (36 percent) in Standard (expected stay of six to 24 months); 128 (57 percent) have withdrawn from discharge planning and therefore have a program status of Extended; 13 (6 percent) in the Residential Plus Program, the Home’s version of an assisted living program; and three (one percent) in the STAR accommodations, which means a current expectation of departing within one year. It appears no residents were in the Accelerated level of the program, which is for new residents with community employment who intend to leave within six months.

staff's survey respondents did not know what level of the VIP program they were in, or if they had withdrawn from the program.

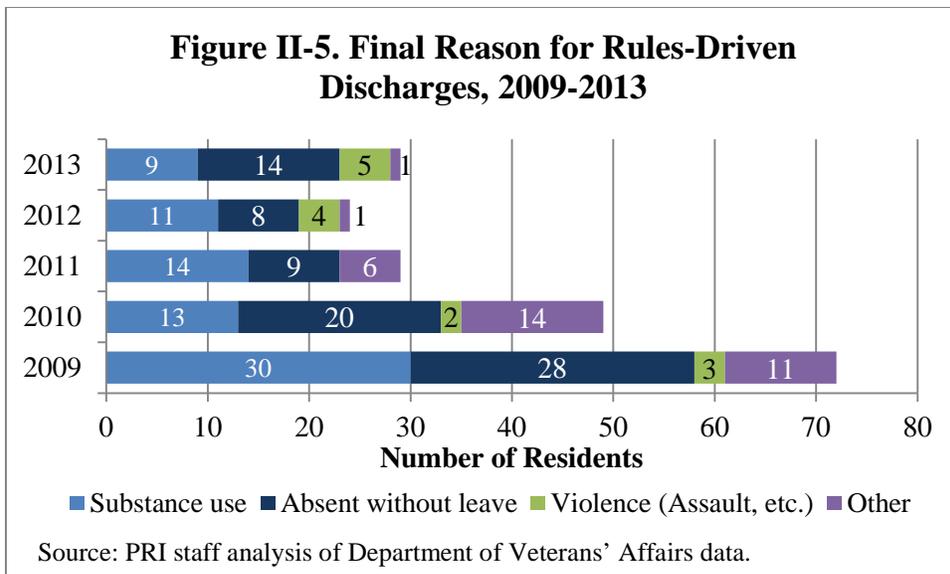
- **Program goal – Independent housing:** *Some residents leave the Home for independent housing.* For calendar years 2009 through 2013, 237 veterans exited the Home (including Fellowship House and regular domiciliary care) to independent housing in the community. Most (70 percent) left for unsubsidized housing without employment, as conveyed by the chart below.¹⁴ Home staff indicated that many of those residents pay for housing via Social Security Disability, VA benefits, and/or private pensions.



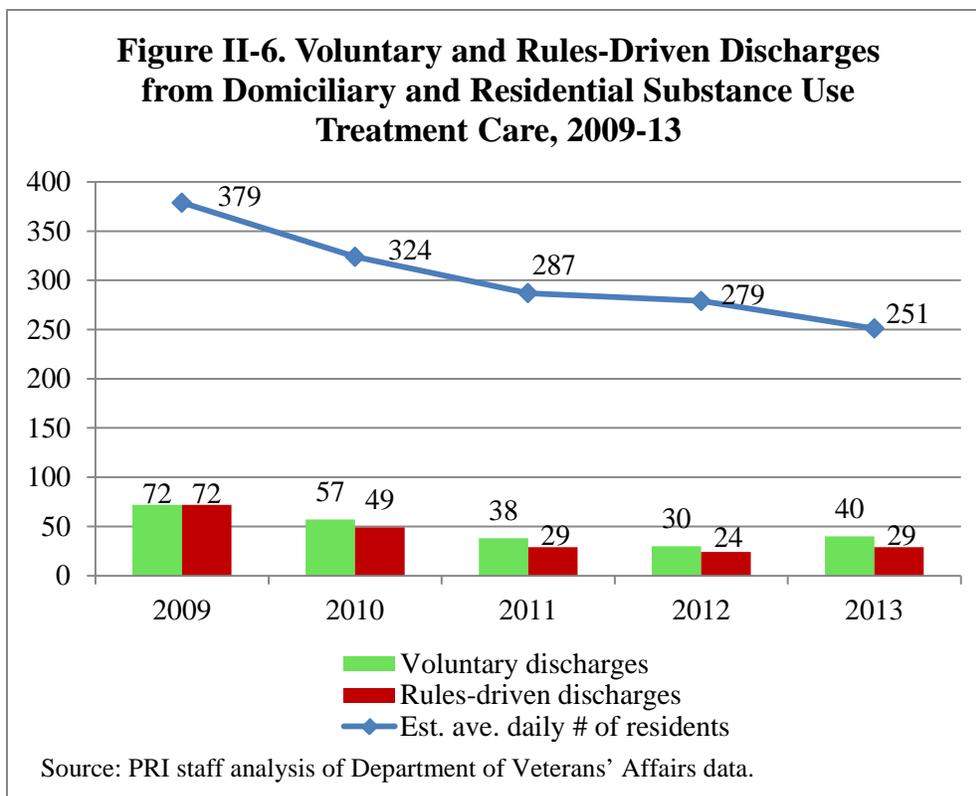
Some (19 percent) moved into subsidized housing. A small share (10 percent, or 24 residents) left for their own housing with employment.

Rules-driven exits. Other residents are involuntarily discharged for breaking the Home's rules (listed in Appendix E), while some choose to leave to avoid a rule violation penalty (i.e., voluntary discharge for rules-related reasons). Most (77 percent, or 156) of rules-related discharges from 2009 through 2013 ultimately were due to being off-campus without permission (absent without leave, at 39 percent) or substance use (38 percent), as Figure II-5 conveys. A small portion (7 percent of involuntary discharges) were due to violence, while some (16 percent) were due to other reasons, such as theft, being arrested and held, or the person choosing to leave to avoid a penalty. Those who leave the Home for penalty-related reasons are offered assistance in finding somewhere to live or take shelter.

¹⁴ The number of unduplicated residents for each of several recent years was requested but unable to be provided by Department of Veterans' Affairs staff.



Since 2009, the share of discharges that are rules-driven has declined. Figure II-6 indicates there was an equal number of rules-driven and voluntary discharges in 2009, but since then, the ratio has fallen from 4:4 to about 3:4. Between 2009 and 2013, rules-driven discharges fell from 19 percent of the estimated average daily number of residents to 12 percent.



- **Program goal – Employment progress:** *Some residents engage in education or training, or obtain employment, while living at the Home.* Since 2010, on average 17 residents per semester (about 6 percent of the average daily census) have been enrolled in postsecondary education or training. Fourteen residents earned a certificate or degree while there, and another three obtained a Commercial Driver’s License. Four to fifteen people per year acquired a job, with a median wage of \$12 per hour. It is unclear to what extent Veterans’ Home staff assisted these particular residents in making vocational progress.

Coordination. *There is no coordination between the state Department of Labor’s Office for Veterans’ Workforce Development and the Veterans’ Home’s vocational rehabilitation coordinator.* The state labor department has representatives in six offices who do similar tasks as the Home’s vocational staff person, and they generally do not work with Home residents. The Home’s vocational staff person does not work with that office on job developing, but does collaborate at times with job developers at the federal VA to assist specific residents in finding jobs.

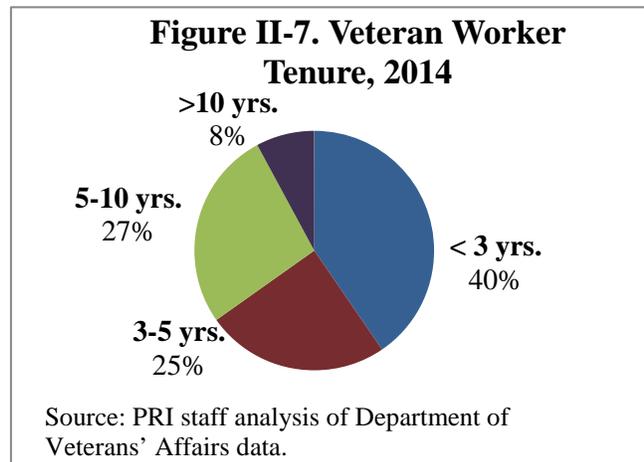
Veteran Worker program. *Thirty-eight percent of residents (93) participates in the on-campus Veteran Worker program, which is intended to be therapeutic for residents.*¹⁵ It involves working at the Home for minimum wage, with no possibility of advancement or a raise. Common positions include maintainer/janitor, food service worker, and wing monitor (roughly similar to a resident assistant at a college), but Veteran Workers support nearly every department on campus.

Another 45 percent of residents receive \$3 an hour for up to ten hours weekly of less-intensive work, like sweeping, through the Detail program. All domiciliary care residents must have either a Veteran Worker or Detail position, or an uncompensated, minimal chore, to live at the Home.

The overarching goal of the Veteran Worker program is to “assess an individual’s ability to return to gainful employment within the community,” according to the program manual, which continues that the work is to be “of a therapeutic nature.” In more practical language, the intent is to deliver multiple benefits to participants: self-esteem; recent work experience; increased work skills; an employment reference; and income in return for work. These are all attributes that could assist residents in living and working independently. The DVA staff reported that in recent years, a majority of residents who became employed off-campus first participated in the Veteran Worker program.

¹⁵ As of June 27, 2014.

Yet, the program's key goal of helping the resident become employed in the community is not being met in a timely way. The majority of participants (60 percent) have been Veteran Workers for more than three years, as shown in Figure II-7, and about one-third of them for longer than five years.



Employment of more than three years for such a large share of participants does not seem to indicate the program is effectively moving people toward employment in the community. Instead, the program may be encouraging at least some people to remain Home residents because they feel tied (practically or emotionally) to their work there. The program may be encouraging

complacency with living at the Home instead of motivation to seek work outside it.

If Veteran Worker participants are remaining in their same positions for many years, there are limited opportunities for new Home residents to engage in the program. Although data were unavailable, Home staff acknowledged there has been relatively little turnover in positions recently. This problem has worsened, according to Home staff, due to complicated logistics involving reclassifying (by the Department of Administrative Services)¹⁶ long-held positions when they become vacant, which is a lengthy process.

While the program's goals may be sound, the Veteran Worker program has dampened morale and created tension between the resident participants and state employees. Many residents with whom committee staff spoke complained bitterly of working alongside state employees who do similar work for better pay, sometimes for many years. Many state employees at the Home with whom committee staff spoke about the program acknowledged the resentment and tension it has created.

The Veteran Worker program critically supplements the Home's contingent of state employees. All staff and residents with whom program review committee staff spoke about the program noted that the Home relies on the Veteran Workers to run. A few managers discussed problems with some participants' work ethic and attendance, but most spoke favorably about their experiences with the Veteran Workers.

¹⁶ Veteran Workers are non-classified workers but the State's pay system requires each worker to have a classification in order to get compensated.

- **Program goal – Safe environment:** *Half of resident survey respondents indicated they always felt safe at the Home; over one-third (38 percent) reported feeling safe most of the time.*

Assault. As noted in Figure II-5, annually there were five or fewer violence related incidents by domiciliary residents resulting in discharge at the Home from 2009 through 2013. More assault-related incidents – 15 on annual average – were reported to Safety and Security (for 2012 and 2013) than incidents resulting in discharge, although only three reports of assault have been made so far for 2014. The discrepancy between reported incidents and violence-related discharges may be due to resulting investigations determining the reports were false.

Property. The trend in missing property / theft is down recently, as Table II-6 shows. At the same time, prohibited items like weapons and illegal substances have been more frequently discovered in 2014 than in the two previous years. Both types of property-related infractions are relatively rare.

Table II-6. Domiciliary Care Property-Related Incidents: Number of Incidents and Rough Estimate of the Share of Residents Experiencing Them, 2012-2014*			
	2012	2013	2014
	#		
	(per-resident basis)		
Theft / missing property	7 (2.5%)	4 (1.6%)	3 (1.3%)
Weapon possession	3 (1.1%)	2 (0.8%)	5 (2.1%)
Illegal substance possession	2 (0.7%)	1 (0.4%)	4 (1.7%)
*2014 data are through mid-November. Number of incidents includes those reported by staff and residents. Some incidents may have been experienced by staff, not residents. Includes all domiciliary care: main Residential Facility, Fellowship House, STAR, and Patriots' Landing. Per-resident basis was calculated using the average daily census for the year. Source of data: PRI staff analysis of Department of Veterans' Affairs data.			

Rules. There are numerous rules intended to maintain personal and community safety on campus. The rules address a variety of subjects, from behavior to personal possessions and living space. Residents who break the rules may be required to leave (involuntarily discharged, as described above) if the offense is severe, or have their ability to leave campus be restricted (i.e., pass restriction). The residential director judges the evidence and determines whether a violation occurred and if a penalty is issued. She may choose to give a warning instead of a penalty, if the resident acknowledges the error and agrees to corrective action.

The annual number of rule violation incidents on an approximate per-resident basis has fluctuated between one for every two residents and one for every 1.6 residents, since 2009. In 2013, there were 150 incidents that could have resulted

in a violation; of these, 69 percent did. In the past several years, fewer incidents have resulted in violations (versus warnings).

Some residents are dissatisfied with the process for determining whether there has been a violation and how it should be treated. Although a slim majority of respondents (52 percent) reported they felt fairly treated during rule violation situations, only 13 percent thought they were *always* treated fairly then – and 33 percent indicated feeling they were only sometimes or never treated fairly. Fifty percent of survey respondents thought violations are issued about the right amount of time, given the rules; 42 percent think they are given too frequently.

Regarding the rules themselves, the survey respondents are about evenly split between thinking the rules are too strict (47 percent) and about right (50 percent). They did not consistently write in any particular rule as their top three they think should be changed or eliminated. The three rule changes most frequently listed by the survey respondents were:

- relaxing substance use (not possession) screening or threshold policies (26 percent);
- relaxing or eliminating pass restrictions (20 percent); and
- stopping the relatively new visual inspections the campus's Safety and Security personnel perform of all resident packages and vehicles, upon re-entry to campus (16 percent).

Assistance with living tasks. The Home's Residential Plus Program assists about one dozen domiciliary residents who need some help with activities of daily living (e.g., dressing). One to two nurse aides staff the program between 6:45 a.m. and 11:15 p.m. The program began in January 2014, in response to growing needs of several long-term residents. Admissions to it, though, have been frozen since June 2014. The DVA reported it is attempting to figure out how to match the program to Department of Public Health regulations.

The establishment of this program is indicative of a larger problem facing the Home, discussed in Chapters IV and V: how to properly serve domiciliary care residents who are aging in place. These residents, who are growing in number according to Home staff, need assistance beyond what is generally provided for the Home's domiciliary veterans, but do not need the level of care offered at the Health Care Facility.

- **Program goal – Substance-free environment:** The Home takes multiple steps to ensure certain residents abstain from alcohol and illegal substances entirely, and to keep others from returning to campus intoxicated. (Residents may not have alcohol or other substances on the Home's campus.) Veterans in the residential treatment program have weekly zero-tolerance screens for their (first) two years at the Home.

Screening. Residents of the main Residential Facility and STAR apartments may be Breathalyzed upon re-entering campus, if Safety and Security or other staff observe signs of possible intoxication. All Fellowship House residents are required to have a Breathalyzer upon return to campus, as are all residents who are considered to be absent without leave.

Between 2012 and 2014 (as of mid-November), roughly 18 percent of residents were screened (with 108 screens across the years).¹⁷ The screens indicated intoxication at the state-defined level 43 percent of the time, meaning that roughly 7 percent of residents had a positive screen – about 15 residents per year.

Those who test positive receive at least a violation and need staff permission to leave campus for a certain amount of time (which lengthens depending on the number of violations recently received); they are also subjected to random screening and may lose a Veteran Worker position. Twelve percent of main Residential Facility residents in October 2014 were required to comply with random screening due to not having two “clean” years at the Home.¹⁸ The results of the residents’ random screens were unavailable due to time constraints.

Medication assistance. The Home assists some residents in taking medication. More than one-third (37 percent) of domiciliary residents received this help, in October 2014. Of particular interest, thirty-three residents (15 percent) were on injectable medication, which must be stored at the Home’s domiciliary clinic, and 42 (19 percent) were receiving assistance in taking psychiatric medication.¹⁹

- **Program goal – Other outcomes:** *Major data shortcomings impede a more complete assessment of the Home’s challenges and successes.* For example, DVA staff was unable to develop cohort data to help program review committee staff understand what happened to all residents who entered in a particular year. On a programmatic level, DVA staff could not produce some requested data, like the number of residents in a year a Home social worker had helped reconnect or improve relationships with family members.

Neither was any information available on how former residents fared after departing the Veterans’ Home. Recently, however, the Department of Veterans’ Affairs agreed to become part of the Homeless Management Information System (HMIS), which tracks persons who use homelessness services in Connecticut. That step should enable the Home to understand whether its former residents return to homelessness, as discussed in Chapter V.

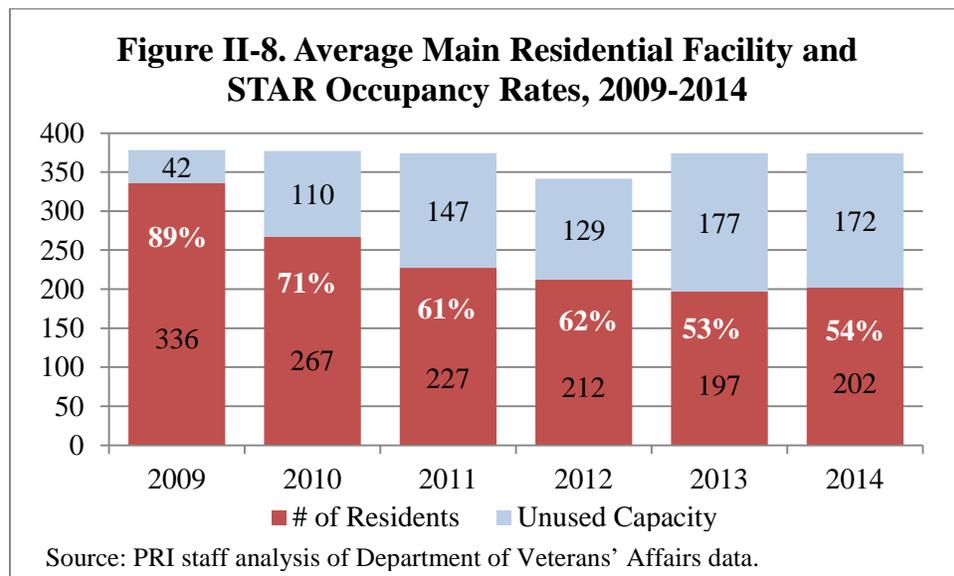
¹⁷ The estimate is rough because it is based on the average daily census divided by the total number of screens, not on the actual, unduplicated number of residents who were screened.

¹⁸ Includes those who had a rules violation and those who moved from Fellowship House to the main Residential Facility before two clean years there.

¹⁹ A resident may receive assistance with both injectable and psychiatric medication, and such a person would be included once in each figure here. No resident was receiving assistance only with psychiatric medication, at the time this data was produced (October 2014).

Home staff similarly could not provide information on the number or share of residents that had repeatedly been admitted to the Home, but nearly one-quarter (24 percent) of respondents to the committee staff survey had lived at the Home at least once before. Of these, three percent had previously resided there two or more times.

- **Occupancy:** *The main Residential Facility and the STAR apartments collectively are just over half full (54 percent occupancy).* The average number of residents has dropped by 40 percent since 2009, to 202 residents in 2014 – the lowest level over the last six years. The decline was sharp from 2009 to 2011; the number of residents dropped once more in 2013, as displayed in Figure II-8 below.



On average in 2014, there has been room for another 172 veterans in regular domiciliary care. It is unclear why the Home's occupancy rate has fallen so precipitously. Possible reasons include:

- the expansion of federal Department of Veterans Affairs programs to help homeless veterans;
- perhaps fewer referrals from the VA as it shifted to a Housing First philosophy for most of its major veteran housing programs;
- maybe lower need among people generally for housing as the recent recession eased; and
- less interest among veterans in the accommodations, rules, and services that come with living at the Veterans' Home.

Admissions criteria naturally affect occupancy, and it is possible the Home's criteria could be reconsidered. Home staff and those outside the Home believe that many, if not most, application denials are due to mental health disorder

severity. The Home staff appears to be especially wary of admitting persons who might be at risk of suicide.

The Home may be overly restrictive in this respect and there could be steps to make the DVA more comfortable with admitting veterans with psychiatric illnesses. The steps could include on-site behavioral health staff (aside from Fellowship House personnel) and suicide risk assessments. The Home is considering requesting permission (and funding) to hire a psychiatrist, which potentially could help address the issue.

The Home does not formally collect from its potential and actual applicants that could provide valuable information on how people learn about it and why some people choose not to apply. Home staff believe most successful applicants originally learned about the Home through federal VA personnel in Connecticut and Massachusetts.

The Veterans' Home does not actively publicize or promote domiciliary care availability to veterans who may be in need of housing. No staff at the Home or the DVA are tasked with reaching out to nonprofit homeless services providers and their staff who directly work with homeless people. Nonprofit case managers and personnel at veterans service organizations told program review committee staff that they rarely refer veterans to the Home, in large part because of the restrictive admissions and living rules.

Similarly, it seems that town veteran service contacts – with whom the DVA's Office of Advocacy and Assistance is in touch – seldom point veterans toward the Home's domiciliary (or nursing) care. Only five of the 33 respondents to program review committee staff's web-based survey of the contacts indicated they had referred people there in the last two years. Just over half of the respondents (53 percent) indicated they did not know enough about domiciliary care at the Home to have an opinion about it. Roughly one-quarter (27 percent) had a favorable opinion, and only a few (9 percent) held a negative opinion.²⁰ Few (6 percent) marked that DVA or the Home had encouraged them to refer people to the Home or given them basic information on the Home (12 percent). The survey's methods and results are provided in Appendix F.

- **Resident satisfaction:** *About half (49 percent) of program review committee staff survey respondents were very satisfied or satisfied with living at the Veterans' Home. One-third (33 percent) were neutral, while just over one-sixth (18 percent) were either dissatisfied or very dissatisfied.*

About one-quarter (26 percent) of survey respondents reported dissatisfaction with how well the Veterans' Home staff helps them achieve [their] goals to move off-campus. Seventeen percent were very dissatisfied, 9 percent were dissatisfied, and only 21 percent were some level of satisfied. Most (61 percent) of survey respondents reported wanting to live outside the Home "within a year or two."

²⁰ The remainder of respondents (12 percent) was neutral toward the Home's domiciliary care.

The lowest levels of satisfaction with staff services were for the specific services that would directly aid in accomplishing that goal: finding off-campus employment (10 percent satisfaction) and locating off-campus housing (11 percent satisfaction). The highest satisfaction level was for on-site medical care, at 49 percent.

Most survey respondents were overall satisfied or neutral toward the condition of the Home, with the Dining Hall receiving the worst marks (24 percent dissatisfied). At the same time, about four out of five residents (81 percent) indicated they would like their own private living quarters.

The Home does not regularly survey its residents to understand residents' satisfaction or learn how they think the services and facilities could be improved. The only routine effort involves collecting minimal, non-specific feedback from veterans who are leaving the facility and choose to complete a discharge form. The questions on the form ask about overall staff helpfulness and the share of the departing residents' goals met. There has not been a survey of residents in recent years. The Home gets some feedback from its veterans through a residents' council, but it has several deficiencies, as discussed below.

Staff fairness. *A substantial share of residents feels they are not treated fairly by the Home's staff.* Several residents shared this sentiment with the program review committee and its staff, publicly and privately, throughout the study. The survey results show that about one-quarter of respondents (26 percent) believed they are treated fairly all the time, and another one-third (33 percent) thought treatment is fair most of the time. Two of every five respondents (40 percent) believed they are treated fairly half the time or less.

Complaints. *A large share of residents does not feel there is a safe, effective way to voice complaints.* There are two main ways to complain: to staff, or to the residents' council. More than two in five (43 percent) indicated they are uncomfortable with bringing complaints to the staff, and about one in four (27 percent) felt they had been treated worse by staff after complaining. Among those who have not complained to staff in the last two years, one in four wrote they had not done so because they were afraid of staff retaliation, and an approximately equal number stated the reason was because they did not think anything would change.

The residents' council, however, is not viewed as effective. Just one in six (17 percent) marked they were satisfied with the council's ability to get results for residents. Of those who had not complained to the council recently, about one in three wrote the reason for their silence was their belief that no change would result (35 percent). The same share stated they had not complained because the council seemed too close to the staff or administration (32 percent).

A majority of respondents who had complained to staff and/or the residents' council within the last two years did not feel attention was paid to the complaint (58 and 59 percent, respectively).

How does it compare? *Regular domiciliary care at the State Veterans' Home does not resemble either standard transitional housing programs or permanent supportive housing.* The Home has a stated goal of helping veterans move out to independent housing within two to three years, which is similar to transitional housing, as previously discussed. Veterans can choose, however, to remain at the Home permanently, which is not allowed in transitional housing.²¹ The Home does offer some supportive services to veterans who are long-term residents. Yet, the Veterans' Home's case management services, accommodations, some rules, and other features do not look like either transitional housing or permanent supportive housing.

If the Veterans' Home is attempting to provide transitional housing, as it appears, the Home falls quite short of the federal VA's standards for its transitional housing program providers. The Veterans' Home's services to help residents successfully navigate life are much less intensive and the Home's exit goal is up to four times longer. Table II-7 notably shows:

- The Home's case management staffing level is less than one-third what transitional housing providers are expected to maintain, and its case management expectations are minimal in comparison; and
- Discharge planning at the Home begins three months after a veteran enters, compared to the first day in transitional housing funded by the VA.

During the committee staff's research, transitional housing provider personnel and people who work for housing-related organizations were asked to comment on the Home's case management staffing levels and timeframe for beginning discharge planning. Each person had the same response: *To most effectively give every veteran a chance at a successful, independent life, the Home must dramatically intensify case management and begin discharge planning on the day of admission.*

²¹ The federal VA is working toward converting some of its contracted transitional housing capacity to permanent housing, when the unit resembles an apartment setting, through the Transition in Place program. The idea is that persons who may be suitable for transitional housing enter the unit, receive services for up to 24 months, and then assume the lease for the unit. Services do not continue past the leasing point; it is not permanent supportive housing. See: http://www.va.gov/HOMELESS/docs/GPD/PDO_Transition_in_Place_Guide_09192012.pdf, accessed December 2, 2014).

Table II-7. Comparison of Home's Regular Domiciliary Care Services and Goals to Federal VA's Transitional and Permanent Supportive Housing Services

	<i>Home's Regular Domiciliary Care</i>	<i>Transitional Housing: Federal VA's Program (GPD) in CT</i>	<i>Permanent Supportive Housing: Federal VA's Program (HUD-VASH)</i>
Exit goal	2-3 years	6-9 months	Not applicable
Exit deadline	None	2 years; small percentage of provider's clients may get extension	None
When discharge planning begins	3 months into the stay	First day	Not applicable
Case manager staff: client ratio	1:96*	Varies; generally not above 1:25 and may be as low as 1:10	1:25
Case manager contact required	Monthly for those looking to move out; every three months otherwise	Weekly, typically	Monthly
Monthly cost	\$200**	\$0-300; one requires 20% of income and 60% of income to savings. May charge up to 30% of adjusted income***	30% of adjusted income

*From June through mid-September (3.5 months), the number of social workers serving nearly all residents at the Veterans' Home, including the Health Care Facility but not Patriots' Landing, was two instead of the normal four. One social worker had left employment at the Home and another was temporarily on leave. During those months, the ratio was about 1:177. The worker who was on leave has returned at half-time; the person will switch back to full-time in April 2015. At that point, the Home will again have four full-time social workers, lowering the ratio to roughly 1:77, depending on the number of residents.

**Free for the first three months. After three months, the fee may be waived if income is less than three times the fee and the resident's monthly waiver request is approved by DVA.

***Can charge up to 30 percent of income after deducting medical expenses, child care expenses, and any court-ordered payments; must not exceed federal Department of Housing and Urban Development's Fair Market Rent. Sources: PRI staff research, including: interviews with DVA personnel, GPD providers, providers of case management at a single-site project that includes HUD-VASH veterans, and federal VA staff; review of the federal VA handbook for the GPD program; and review of the VA-CT brochures for the GPD and HUD-VASH programs.

There are a few similarities, and a few key differences, between the Veterans' Home's rules and transitional housing, illustrated in Table II-8. The Veterans' Home's rules related to alcohol and other substances, as well as curfew, align with transitional housing program rules. However, the Home's rule forbidding vehicle use in a resident's first three months is dissimilar and may be overly restrictive, particularly given the somewhat isolated setting of the Home. The Home sits on a large campus with extremely limited public bus service. There is transportation provided by the Home but it, too, is limited.

Another contrast with transitional housing (and permanent supportive housing) is that the Home’s approach to rules violations mainly seems punitive – to restrict the person from easily traveling off-campus. The Home is a much larger operation than Connecticut transitional housing, which generally is contained to a single building, so a pass restriction is less harsh. At the same time, the philosophy underlying the penalties might not be helpful to residents, or respectful of them. *Transitional housing providers view non-violent violations as a signal to immediately figure out how to better help the person, which is likely to be a more productive response than the Home’s current method.*

Table II-8. Comparison of Home’s Regular Domiciliary Care Rules to Federal VA’s Transitional and Permanent Supportive Housing Rules

	<i>Home’s Regular Domiciliary Care</i>	<i>Transitional Housing: Federal VA’s Program (GPD) in CT</i>	<i>Permanent Supportive Housing: Federal VA’s Program (HUD-VASH)</i>
Alcohol prohibited on grounds	Yes	Yes	No
Alcohol screening if appear intoxicated	Yes	Allowed	No
Random screening for alcohol	For some	Allowed	No
Length of sobriety required	About six months*	0-90 days Average: 30 days Median: 17.5 days	None
Vehicle allowed	After first 3 months, if have complied with rules and campus permit staff approve	Yes	Yes
Curfew	Yes	Yes	No
Result of rules violation (non-violent)	Limited ability to leave campus	Meeting with case manager	Meeting with case manager or a tenants’ council
Accommodations	Large rooms of 12 people, arranged in “bays” of four people	Range; can be private bedroom in a large house, semi-private, or not private	Own apartment
<p>*Determined on an individual basis. Someone with less recovery time, or with more sober time who would like to have recovery support, would likely be admitted to the Home’s residential substance use treatment program. Sources: PRI staff research, including: interviews with DVA personnel, GPD providers, providers of case management at a single-site project that includes HUD-VASH veterans, and federal VA staff; review of the federal VA handbook for the GPD program; and review of the federal VA Connecticut brochures for the GPD and HUD-VASH programs.</p>			

There are some additional key differences not shown in the tables. First, transitional housing providers contracted with the federal VA are expected to do outreach to actively find more residents. Second, those providers must deliver quarterly performance reports that include occupancy and, critically, outcome data. The outcome data include residents' employment progress and other goals the providers promised to meet in their federal VA funding applications. Program review committee staff believes the Veterans' Home could benefit from these activities.

If the Veterans' Home is attempting to provide permanent supportive housing for those residents who choose to remain there long-term, as it appears, the Home falls tremendously short of the federal VA-provided permanent supportive housing standards. The Veterans' Home's services to help residents successfully navigate life are less intensive, while the accommodations and rules offer little to no independence and privacy. Tables II-7 and II-8 notably show:

- The Home's case management staffing level is less than one-third the federal VA's, which is a critical difference because the VA's programs rely on case management as the backbone to assisting veterans in living as productively and independently as possible;
- The Home has rules governing resident behavior and possessions, while permanent supportive housing does not (aside from complying with a lease and laws); and
- The Home does not provide residents with their own apartments, while the VA's permanent supportive housing voucher does.

Roughly half the Home's domiciliary residents have lived there more than five years, abiding by the rules, receiving some comparatively limited case management services, and living without privacy, autonomy, or much self-sufficiency. Again, many people outside the Home with whom committee staff spoke were surprised that dozens of veterans have remained in the Home's living situation for several years. *Home residents who need long-term case management should live in permanent supportive housing, which entails receiving those services more intensively while enjoying much higher levels of privacy, independence, and personal freedom.*

Finally, private rooms for residents are required by federal VA standards for the matching state veterans' home construction grants, when new facilities are being constructed.²² The standards, issued in 2011, apply to both nursing home (or similar) and domiciliary care. *The federal VA has recognized, through these standards, that institutional-like personal space is not appropriate for veterans under government care.*

Other states. Only three of the other nine large state veterans' home domiciles take a "transitional" or "housing readiness" approach, as shown in Appendix G – and one of the three

²² See: "Design Guide: Community Living Centers," U.S. Department of Veterans Affairs, 2011. Accessed November 20, 2014, at: <http://www.cfm.va.gov/til/dGuide/dgCLC.pdf>. Program review committee staff confirmed with federal VA personnel that these standards apply to both domiciliary and nursing care construction.

may be changing soon.²³ The others mainly serve either older adults (e.g., those who are 55 or older) and/or those who are disabled.

Of the three large domiciles with a “housing readiness” approach, one offers a much higher level of behavioral health services, and another could potentially change soon. A home in Minnesota that averages 160 residents has four social workers and is pursuing hiring more, for a caseload average of 40 (possibly soon 27). It also has two psychologists, a lower-level mental health professional, and a weekly consulting psychiatrist, as noted earlier. Massachusetts’s Chelsea home is under review by a state-mandated commission. The commission is charged with examining veterans’ long-term health care and housing needs, including those of the state’s veterans’ homes, to ensure the state’s efforts are complementary to others’ services and in line with best practices.²⁴

A “housing readiness” approach effectively is not found in veterans’ homes in the other states bordering Connecticut. New York has no domiciliary care, and Rhode Island’s “housing readiness” domiciliary care is being phased out. Rhode Island’s domicile has an authorized capacity of 79 but only one occupant. The state’s previous, recent domiciliary residents have received HUD-VASH vouchers from the VA, which has been providing case management and other services to assist domiciliary residents in moving to independent living.

Federal VA. The federal VA offers some domiciliary care at various locations throughout the country. The VA’s domiciliary care comes under the Mental Health Residential Rehabilitation Treatment Program. Some of the locations are for particular populations, such as homeless veterans or those with Post-Traumatic Stress Disorder. Federal VA domiciliary care can include treatment services as part of the program or not (with intensive outpatient services provided by the VA). It is intended for veterans with “multiple and severe” medical, behavioral health, and social needs.

While Connecticut’s Veterans’ Home does not currently resemble transitional or permanent supportive housing, neither does it look like federal VA-provided domiciliary care. Quite a few of the federal VA’s requirements for its domiciliary care programs differ from the Veterans’ Home’s. Specifically:

- discharge planning begins on the day of admission;
- time-limited for domiciliary care for homeless vets;²⁵
- “treatment or therapeutic activities” must be planned for each person for four hours daily, including during evenings and on weekends;

²³ Excluding Connecticut, which has the second-highest capacity.

²⁴ Massachusetts Session Law, Acts of 2014, Chapter 62, Section 32.
<https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter62> (accessed October 23, 2014).

²⁵ Committee staff requested some additional information from the federal VA regarding its Mental Health Residential Rehabilitation Treatment Programs, including the time limit on this particular type of program, but the information was not received in time for inclusion in this report.

- for homeless veterans, there is evidence-based behavioral health treatment, as well as life and vocational skills groups;
- suicide risk assessment is done during admissions screening and upon admission, and an “at risk” determination does not necessarily mean the person will not be admitted;
- there is a much higher on-site supportive staffing level, with at least eight social workers (versus four), four psychologists (versus none, aside from the Home’s residential substance use treatment program), two psychiatrists (versus none), and multiple vocational specialists (compared to one) when the facility is the size of the Connecticut Home’s general domiciliary; and
- each program is accredited by The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.²⁶

The Veterans’ Home does not meet the federal VA’s standards for its own domiciliary care in multiple ways. First, the Home places less emphasis on discharge planning, which is meant to help veterans use their time in care to prepare to live successful independent lives. Second, there is less attention and fewer resources devoted to treatment and therapeutic activities. Third, the Home has chosen not to accept persons with somewhat recent suicidality, which limits its possible pool of applicants.

²⁶ Department of Veterans Affairs. *VHA Handbook 1162.02: Mental Health Residential Rehabilitation Treatment Program*. 2010. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2354 (accessed November 20, 2014).

Domiciliary Care Recommendations

Program review committee staff recommends overhauling the Home's general domiciliary care. The recommendations call for recognizing the dual domiciliary populations, short-term and long-term, by creating two separate programs. These programs would more closely mirror the transitional housing and permanent supportive housing that is offered by Connecticut nonprofits, other state agencies, and the federal VA. The recommendations also call for an examination of how the Home can best provide substance use treatment services, including through its residential treatment program.

The recommended transitional housing and permanent supportive housing programs should be located in separate buildings, or at a minimum, on separate floors. It is necessary to clearly separate the Home's populations and programs for two reasons. First, the rules and accommodations should be vastly different, offering more space and independence to permanent supportive housing residents. Second, the staff and resident expectations, as well as the atmosphere, should be different for those who are working toward achieving their short-term goals and leaving the Home, and those who have decided to stay within the Home's (currently) institutionalized setting.

The specific recommendations provided in this chapter are centered on five goals the committee staff believes the Veterans' Home should continually strive to achieve for every resident, including those in the Health Care Facility:

1. Sensible housing based on current evidence-based and best practices;
2. Appropriate mental and physical care;
3. Personal freedom, dignity, and choice, balanced with individual responsibility;
4. Personal growth and fulfillment, leading to a veteran's highest possible level of independence; and
5. Resident representation in governance and decision-making.

Department of Veterans' Affairs (DVA) personnel may feel they are already living by these goals. Program review committee staff, however, believes there is substantial room for improvement in each of them, for the vast majority of domiciliary residents.

The committee staff's recommendations try to balance the concerns of many with moving the Home in a direction that better achieves the five goals. The ultimate purpose is to improve the overall quality of life of the veterans for whom the state is entrusted to care. The recommendations are presented first for domiciliary care overall, and then separately for the transitional and permanent supportive housing programs, as well as the Home's substance use treatment services. The transitional and permanent supportive housing recommendations are quite specific because those proposed programs differ so dramatically from the Home's current practices. The detail is intended to ensure the new programs reflect prevailing standards of care for homeless veterans.

Domiciliary Care Overall

Two distinct programs. The Home has substantial populations of short-, medium-, and long-term residents. While the Home's domiciliary care program has a goal of transitioning new residents out of the Home after a few years, it is not programmatically set up or sufficiently resourced to meet that goal. The Home's services do not match common standards for either short-term (transitional) or longer-term (permanent supportive) housing programs for veterans, as documented in Chapter II. The DVA also is not implementing any of the evidence-based and best practices discussed in Chapter I. Therefore, the program review committee staff recommends:

- 1. The Department of Veterans' Affairs should replace its current general domiciliary program at the State Veterans' Home with two separate programs that resemble transitional housing and permanent supportive housing.**
- 2. The Department of Veterans' Affairs should determine the number of staff needed to fully implement the recommended programs, including case managers / social workers, employment specialists, and behavioral health staff. The department should consider partnering with staff from other state agencies and nonprofits. The DVA should then pursue the necessary resources.**

The transitional and permanent supportive housing program details recommended later in this chapter are intended to align the Home's programs with the established standards for both types of care. Because the Home's current supportive services staffing is inadequate to meet those standards, DVA will need to assess what resources would be necessary and then request them. The programmatic recommendations should be implemented once sufficient resources are in place.

Resident assessment. It is unclear to what extent current residents have been fully informed about the range of housing options that may be available to them. It is also unknown to what extent the Home's domiciliary care veterans are well-positioned for independent living or alternatives to the Home. The residents who stay as the Home adopts strong transitional and permanent supportive housing programs will need to be in either program to be best-served.

- 3. All current residents of the Veterans' Home's domiciliary care (except for those in the Patriots' Landing program) should be fully assessed and given the option to move out of the Home via a federal Department of Veterans Affairs program. Those who choose to stay at the Home should decide whether they would like to be in its transitional housing or permanent supportive housing program. Once the programs are active, the residents would need to comply with the applicable program rules.**
 - a. Home residents should actively participate in an assessment process, which should be done in-person by a team of contracted case managers who work for the VA and/or nonprofit agencies offering case management services to homeless veterans. Each resident should have an assigned case manager.**

- b. **The assessment should be based on a common information gathering tool. The tool should include:**
- i. **education, work history, and particular skills, licenses, certifications, or training;**
 - ii. **financial resources;**
 - iii. **overall physical and mental health, including any diagnosed disabilities;**
 - iv. **ability to complete activities of daily living, including the ability to self-administer medication;**
 - v. **external supports;**
 - vi. **current length of stay at the Home; and**
 - vii. **housing preferences, after first receiving: a) an in-person, one-on-one explanation of federal VA transitional and permanent supportive housing options; b) a description of the Home's new programs; and c) the results of the assigned case manager's recommendations.**
- c. **The assigned case manager should recommend to the resident the type of VA program for which the person is best-suited and which of the Home's new programs is appropriate for the person (transitional housing or permanent supportive housing). Using this information, each resident should choose his or her living arrangement.**

The recommended assessment would ensure each Home resident has a chance to fully understand available housing choices and then make an informed personal decision, based on a case manager's recommendation. It also would provide needed data to help the Home and legislature to understand residents' service needs and preferences. The assessment of current residents should not be done by Home staff because they could be too vested in the outcome.

New applicants and behavioral health. New applicants to the Home should be encouraged to live in the housing most appropriate to their situation. This includes being informed of the federal VA's programs so they may opt for a different setting, closer to their home communities. Allowing veterans to choose their housing arrangement with full information increases personal freedom.

- 4. New applicants to the Veterans' Home should submit a modified version of the assessment for current residents (in addition to an admissions application), including a program preference (for either transitional housing or permanent supportive housing). Based on the assessment, the Home staff should recommend the most appropriate program to the resident. As part of the admissions process, and on the Home's website, the DVA should also give the applicants information on federal VA housing options.**

The Veterans' Home staff acknowledged that although the vast majority of its residents have at least one psychiatric diagnosis, many applicants are denied admission due to past or current psychiatric problems. The staff cited the Home's lack of behavioral health services as a reason. During the study, committee staff heard from many people outside the Home that

admissions seem unnecessarily restricted, especially since a large share of the neediest veterans do have psychiatric problems. The department should consider what it may require to reach a larger number of homeless veterans.

- 5. The DVA should consider what behavioral health and other staff resources may be necessary in order for the Veterans' Home to accept applicants with more-recent psychiatric problems. The DVA should communicate closely with the federal Department of Veterans Affairs and the Connecticut Department of Mental Health and Addiction Services to develop an analysis. The analysis should be delivered to the Board of Trustees and the legislative committees of cognizance by June 1, 2015.**

The following changes are recommended for all Veterans' Home domiciliary care residents, except those in Patriots' Landing (due to that program's different population, setting, and requirements).

Personal living space. The current living arrangements in the main Residential Facility are unacceptable, based on current evidence-based and best practices for transitional or permanent housing. Residents have no privacy and many complained to program review staff that the habits of their roommates were frequent annoyances that detracted from their quality of life.

- 6. Each Veterans' Home domiciliary resident should have a semi-private or private room, with the room's own door. If semi-private rooms are done, residents should be assessed for compatibility and their personal preference (e.g., if the person would like to have a certain resident as a roommate) and then grouped accordingly.**

The Veterans' Home needs to think creatively about how to better use its living quarters, despite the heating and cooling system constraints. For example, the Home could consider constructing walls out of cubicle materials, in combination with dropped ceilings; donations could be sought. Though not perfect, that method would give residents a greater sense of privacy and dignity than currently exists.

On-campus work. The Veteran Worker and Detail programs were intended to benefit residents but have strayed from that goal and become unsustainable. In some cases, Veteran Workers have held their positions for years, and many have participated in the program for several years, as shown in Chapter II. Therefore, the program has lost its original intent of preparing veterans for employment in the broader community. Neither is it providing temporary income or a boost to residents' job searches. Furthermore, many residents resent working alongside state employees under what they view as worse conditions. The Department of Veterans' Affairs has used the Veteran Worker program to supplement its state employee labor force, which gives credence to residents' resentment.

- 7. The Department of Veterans' Affairs should eliminate the Veteran Worker and Detail programs. Prior to the elimination, the DVA should assess the overall need of each position currently in the programs. The DVA should consider**

working with the Department of Administrative Services and/or the Office of Policy and Management, or a contracted firm, to conduct the analysis. The analysis should determine which positions will be:

- a. Converted to state employee positions through a standard, public recruitment process that gives a hiring preference to current Veteran Workers;**
- b. Converted to time-limited paid state internship or apprenticeship-type positions, for the Home’s transitional housing participants, with the expectation of attendance and a limited amount of sick time; or**
- c. Eliminated, possibly through assigning small tasks to all Home residents (e.g., up to one or two hours weekly).**

The reforms in this recommendation would give Veteran Workers a chance at state employment and require the state to more fully recognize what it takes to run the campus. The recommendation would also provide a way for residents to gain temporary income and employment – including training in potentially marketable skills – which could assist with or even encourage job searching off-campus. At the same time, it is possible not all current Veteran Worker or Detail positions should be converted to other types of positions. Committee staff heard during the study that some managers have trouble with Veteran Worker attendance and therefore have more workers than would be necessary, if people reliably showed up to work.

Fee. The current program fee is a source of consternation for a portion of residents. Some complained to committee staff that they pay a fee for a program they perceive as nonexistent. A few are concerned that the fee expenditures are not transparent. Still others said the current flat fee is inherently unfair because all residents pay the same amount, regardless of income (once the fee waiver threshold of \$600 income is reached).

In addition to these resident concerns, the fee has not changed since 2008. If the stagnant rate were to continue, DVA could be facing additional financial pressure.

8. Regarding the Veterans’ Home’s current “program fee” and DVA’s Institutional General Welfare Fund, which houses the program fees, the Department of Veterans’ Affairs should:

- a. Beginning in the 2015 calendar year, a new resident’s first month at the Home should remain free. The fee should be applied for every month thereafter. Veterans who are admitted to the Home before 2015 will continue to have a free first three months.**
- b. For transitional housing residents:**
 - i. Specify that the fee is a “resident care fee” and maintain the current level of \$200 for the 2015 calendar year.**

- ii. **Effective January 1, 2016, the transitional housing resident fee level should be annually adjusted for inflation. A fee waiver can be requested at any time, based on the Home’s current waiver process, and a waiver should be approved if a resident’s income falls below three times the fee level. Each waiver is valid for six months.**
- c. **For permanent supportive housing residents, replace the program fee with an income-based resident care fee, effective January 1, 2016. The income should be determined after subtracting for taxes and court-ordered payments. The fee should be 30 percent of adjusted income.**
- d. **Provide transparency regarding the Institutional General Welfare Fund by formally sharing with all residents a semiannual, plain-language summary of how the Fund is used in accordance with state law (to “directly benefit veterans or the Veterans’ Home”).**
- e. **Provide the opportunity for residents to make suggestions on projects for which they would like to see the Institutional General Welfare Fund used. Residents’ input should be requested at least semiannually.**

While program review committee staff recommendations below should boost program strength, changing the fee’s terminology may help quell some resentment. In addition, the above recommendations would give residents a voice in determining the fees’ use – and clarity on that use.

Moving from a flat fee to an income-based fee for permanent supportive housing residents would bring the charge in line with general permanent supportive housing practices. This step may also dissuade residents with financial means from choosing to remain at the Home, rather than pursue community-based options, primarily because it is so affordable (\$200 monthly for rent, utilities, and food).

Committee staff considered recommending an income-based fee for transitional housing residents but did not because nearly all federal VA-contracted transitional housing providers charge a flat fee.

Work and life skills. The Home currently does not hold any life or vocational skills classes. Social workers and the vocational coordinator may do some of these tasks with individual residents.

- 9. **The Veterans’ Home should frequently and routinely (e.g., weekly) offer classes on life and vocational skills, such establishing a bank account, budgeting, searching for jobs online and through networking, navigating federal VA services, interviewing for jobs, and cooking. The Home should consider opening these classes to veterans in the general public, and assess its equipment to determine whether additional resources are needed. The Home should also seek out volunteers to conduct the classes.**

The Home's social workers and vocational coordinator can continue to offer assistance with these tasks on an individual basis, but making this assistance clearly available and important could help build more residents' independence.

Volunteering. The Home could more actively solicit volunteers from the community and arrange more opportunities for its residents to volunteer elsewhere.

10. The Veterans' Home should offer and publicize increased volunteer opportunities for the public on-campus, including at the main Residential Facility, and for veterans in the community.

A greater emphasis on recruiting and welcoming volunteers, paired with encouraging residents to volunteer off-campus, would help reduce the isolation of the Home, especially within domiciliary care. The Home could use volunteers to lead or assist with some life and vocational skills classes, as helpers with basic grounds maintenance, and in many other ways. There are volunteer links on DVA's website, but they are not prominent and the volunteer interest form is from 2009. More active outreach, such as to school districts and churches throughout the region, could help the Home gain volunteer visitors.

Security. The security procedures that have been implemented over the last several years are burdensome for many residents, as well as for the Home's Safety and Security staff. The procedures have conveyed to residents that they are not trusted, independent adults. Furthermore, the re-entry inspections reportedly have uncovered few instances of prohibited items. (The inspections observed by committee staff on several occasions were extremely limited in how they were carried out.) Program review committee staff understands that DVA may be worried about incidents on-campus. At the same time, some of the security procedures are unnecessary for residents, based on how other veteran housing in the state operates.

11. The Veterans' Home should make the following changes to its security procedures for domiciliary residents:

- a. **Domiciliary residents who intend to leave the campus should sign out using a log in their building each time they leave campus, noting whether they intend to return that day or a following day. No permission should be needed to leave the campus.**
- b. **The Home should transition to a swipe-card door-locking system for its main Residential Facility and Fellowship House. Upon the transition, a resident should no longer be required to swipe a Home identification card at the campus entrance security building, in order to leave or return to campus, and the identification card should open the vehicle gate.**
- c. **The Home should discontinue the mandatory visual package and vehicle inspections done when a resident re-enters campus. An inspection may be done when there is reason to believe a resident is bringing a prohibited item onto campus. Written guidelines should be established by DVA regarding what constitutes "reason to believe" and then distributed to each resident.**

- d. Residents should be allowed to use their personal vehicles from their first day at the Home. Permits should be issued within a resident's first week at the Home and remain valid until the person moves out of the Home.**

Removing some of the security procedures will help the Home better balance several of the five goals presented at the beginning of this chapter.

Penalties. Domiciliary residents who break the Home's rules may be charged with a "violation" and required for a time to request permission, via a pass, in order to leave the campus. The pass restriction may remain in place for between 15 days (for the first violation within a 24-month period) and 60 days (for a fourth violation in the time period). State regulations allow the fourth violation restriction to reach 180 days. Many residents are dissatisfied with the pass restriction system and what they view as unfairness in how violations and penalties are issued.

12. The pass restriction system for handling rule violations should be replaced with the following system as of January 1, 2015:

- a. The first violation should result in an immediate meeting (within one working day) between the resident and his or her case manager / social worker and employment specialist. The meeting should involve discussion of the incident, the underlying reason(s) the incident occurred, consequences for subsequent violations, and the resident's plan to avoid or correct the behavior.**
- b. The second violation should result in a similar meeting as the first, but include the domiciliary care administrator and the staff should emphasize that the third offense results in immediate discharge.**
- c. The third violation should result in discharge, appealable to the DVA commissioner. As is current practice, staff should assist the resident in locating a place to live.**

Removing the punitive nature of the pass system is intended to support the Home's rehabilitative goal and give the residents more independence – but also more responsibility. The new system would treat violations as a call for intervention. This system is similar to how transitional housing providers handle violations.

Transitional Housing Program

The program review committee staff recommends:

13. The Veterans' Home's new transitional housing program should have the following components to ensure a focus on successfully discharging residents to independent living and encouraging personal responsibility:

- a. New residents should have a stay limit of nine months in the transitional program.**

- f. **Each resident should meet at least weekly with the person’s social worker / case manager. There should be a maximum ratio of one social worker / case manager for every 25 residents. Each resident should also meet at least weekly with an employment specialist if not enrolled in education or training. Those who are enrolled should meet at least monthly with the employment specialist.**
- g. **There should be a monthly meeting for each resident that includes the person’s social worker / case manager, employment specialist, and B Clinic nurse; the resident must attend. The first such meeting should occur within the person’s first week.**
- h. **When veterans move to independent living, the social worker / case manager should remain in contact and open to assisting the former resident for up to one year. At minimum, the social worker should collect information every three months (including at 12 months after discharge from the Home) on employment and education status, treatment services, and housing type.**
- i. **Upon discharge for a violation, or upon voluntarily leaving the Home to avoid a third offense, a resident should be allowed to re-enter the program after three months have passed, if the person has not previously participated in the transitional housing program.**

These recommendations collectively would transform the Home’s supportive services from low intensity to high, from allowing service disengagement to (for this program) requiring participation. With these changes, the Home will have a true transitional program that nearly mirrors transitional programs offered by other homeless services providers.

The rationale behind limiting the time in the program and re-admissions is to give residents and staff a sense of urgency around the importance of making the best possible use of veterans’ time at the Home. Currently that sense is absent. Furthermore, if a program has not worked for a resident twice, it is highly unlikely that a third time will result in success; the resident should pursue other options (which could include permanent supportive housing at the Home).

Permanent Supportive Housing Program

The program review committee staff recommends:

- 14. The Veterans’ Home’s new permanent supportive housing program should have the following components to recognize the long-term nature of some residents’ stays and encourage independence:**
 - a. **Each resident’s social worker / case manager should reach out to the veteran at least weekly; participation in supportive services is the resident’s personal choice. The social worker / case manager should monitor the person’s well-being and assist in improvement. The social worker / case manager should encourage the resident to attend life skills classes and apply for independent**

housing programs, such as HUD-VASH and other options. There should be a maximum ratio of one social worker / case manager for every 35 residents.

- b. The Home should work to place these residents in a separate building(s) from transitional housing residents (e.g., one side of the main Residential Facility); at minimum, in the short-term, they should be on separate floors. In the long-term, the Home should place its permanent supportive housing residents in studio or one-bedroom apartments.**
- c. Once the permanent supportive housing residents are in a separate building(s), all rules not involving building and personal safety should be eliminated. There should be a set of rules specifically for residents of the program, mirroring a typical apartment or house lease agreement. A process should be established for eviction if rules are seriously or repeatedly broken. The DVA should develop guidelines for what offenses or accumulation of offenses may result in eviction. Evictions should be appealable to the Board of Trustees. Readmission should be allowed once, no earlier than six months later, for those required to leave.**
- d. There should be a tenants' association, which should meet monthly, to: review program rules and offerings; make suggestions on rules, program offerings, accommodations, and other aspects of the permanent supportive housing program; and receive complaints from residents. The tenants' association should provide a detailed annual report of its activities to the Board of Trustees.**
- e. Residents should be encouraged to attend group recreational activities designed to meet their interests, and may choose to use the Home's on-site medical services (B Clinic) as well as its Dining Hall. Once a permanent supportive housing resident has access to a kitchen with a working stove, the person can choose to use the Dining Hall as a guest, which should include payment.**
- f. The Home should consider starting a compensated work therapy program, modeled after the best practices of such programs, for its permanent supportive housing residents.**

These recommendations acknowledge that many veterans have chosen to live at the Home more or less permanently, and treat them accordingly, based on federally-endorsed evidence-based and best practices. It is the program review committee staff's strong opinion that persons living in a place for several years should be given the rights and responsibilities of tenants. They should be encouraged to maintain a level of independence in their personal choices, as in any permanent housing arrangement. They also should have their own apartment, including kitchen facilities (though some may choose to eat at the Home's dining hall). The residents should have more frequent contact with a social worker / case manager than is currently done at the Home, in line with current best practices for permanent supportive housing, but

should not be required to engage in services. They also should be encouraged to consider moving to permanent supportive housing in the community via other government agency programs.

Substance Use Treatment Services

The Home's residential substance use treatment program is unique, offering a six- to twelve-month program with the possibility of two additional years in the treatment building. It is unclear if any of the program's stages match evidence-based and best practices. There has been no meaningful communication between the program's staff and the relevant state and federal departments regarding program design.

The Home does not offer substance use treatment or recovery services to the other domiciliary residents, other than the 12-step meetings held by the treatment program. There could be a need to provide services, however, because about half of those veterans have a substance use disorder diagnosis.

Therefore, the program review staff committee recommends:

15. The Department of Veterans' Affairs should develop and implement a plan by January 1, 2016, to improve its substance use treatment services, as currently provided at the Veterans' Home's Fellowship House.

- a. As part of the plan's formulation, DVA should work intensively with the Department of Mental Health and Addiction Services, the Department of Public Health, the federal Department of Veterans Affairs, veteran organizations, and substance use recovery organizations.**
- b. The plan should be based on evidence-based and best practices for substance use treatment.**
- c. The plan should consider:**
 - i. all aspects of the Home's residential substance use treatment program;**
 - ii. how the Home can best serve its many residents who are in recovery but do not live in Fellowship House; and**
 - iii. whether DVA should offer any substance use treatment to Connecticut veterans in the community who may wish to participate in veteran-specific substance use treatment, and the resources that would be required to take that step.**
- d. The plan should also include:**
 - i. Clear missions for all substance use treatment programs envisioned;**

ii. Performance measures, including but not limited to participant satisfaction and outcomes, for all programs; and

iii. How the program staff will collect data on the performance measures.

The Veterans' Home's residential substance use treatment participants are satisfied with the program, but there is potential for improvement. The DVA should learn how other government agencies who deliver or oversee substance use treatment believe the Home's program could be improved, and adjust the Home's residential program accordingly. In addition, the Home should consider what type of recovery support services could be helpful to its general domiciliary residents. There may also be a role for the Home to play in giving substance use treatment to a wider range of veterans, such as those who are not homeless but could benefit from residential or other treatment.

Health Care Facility: Assessment and Recommendations

Overall, the Home is providing quality 24-hour nursing care at its Sgt. John L. Levitow Veterans Healthcare Center. The center, more commonly known as the Health Care Facility (HCF), performed well against the standards in its most recent state and federal inspections, including having proper direct care staffing levels and satisfactory facility conditions.¹ The inspections, however, identified two deficiencies regarding resident safety: a serious patient fall due to inadequate precautions in a section of the facility, and the water temperature being too hot in residents' rooms. The facility has either made or is in the process of making specific corrections to rectify its deficient performance.

A key area needing attention by the facility, and the Department of Veterans' Affairs (DVA), is the level of nursing staff available for residents' care. Recent cost saving measures require fewer nursing staff on each shift, thus lowering the amount of time direct care staff are available for residents. This follows a 22 percent reduction in nursing positions dedicated to directly to residents' care (since FY 09). Although the new staffing standard is well within the facility's state licensing requirements, the overall effect on residents' care needs to be closely monitored.

As best committee staff could determine, residents are satisfied with the living at the Health Care Facility and the overall level of care they receive from the facility. Several areas residents indicated as needing improvement include more timely response by nurse aides to residents' immediate needs, a higher level of dignity and respect for residents by some staff, and the overall quality of food served. The facility also does not formally solicit residents' feedback.

The HCF, like the rest of DVA, is beset by certain management information system issues, including data collection and maintenance in some areas. For example, committee staff asked the facility for various admissions-related data for the last five fiscal years. Although the facility provided information in many of the areas requested, it could not provide key admissions data prior to 2013 – including the number of applications received and reviewed by the facility, and the number of veterans admitted to the facility. Committee staff believes this example, along with other data management problems of the Home identified throughout the report, points to a broader data management issue within the department, as addressed in Chapter V.

Overview of the Health Care Facility

The Home's 125-bed HCF provides mainly long-term nursing care. The facility has physical and occupational therapy staff, a pharmacy, and a small clinic. It also provides nursing staff to run the domiciliary care medical clinic. The facility accounts for half of the Department

¹ The Department of Consumer Protection inspects the facility's pharmacy every seven years for registration purposes, and the Department of Public Health inspects the Home's laboratory every two years for state licensure and federal certification that allows CMS reimbursement. (Committee staff did not examine those inspection results, but focused its review on the three primary state and federal inspections of the Health Care Facility operations).

of Veterans' Affairs' budget, and serves roughly a third of the Home's residents, making it an important part of the Home.

The Health Care Facility is heavily regulated by the state and two federal agencies, unlike the Home's domiciliary care, which only undergoes VA inspections.² As a recipient of the VA's per diem payments for nursing care, the facility undergoes annual inspections by the VA. The inspections cover over 150 standards against which the facility's performance is measured, for a more comprehensive inspection than conducted of the Home's domiciliary care. The state Department of Public Health (DPH) also inspects the HCF as part of the facility's state Chronic Disease Hospital licensure, with inspections every two years.³ Further, as a recipient of Medicare and Medicaid payments, the HCF is inspected every four years against the federal Centers for Medicare and Medicaid (CMS) standards.⁴

Assessment and Recommendations

How effective is it? *The Health Care Facility largely meets its primary goal of offering residents a high level of care to ensure their health, safety, comfort, and overall satisfaction.* Committee staff examined several measures to determine the Health Care Facility's overall effectiveness. Direct care staffing resources, resident safety, occupancy, and residents' satisfaction were reviewed.⁵

- **Program goal – Provide high-quality care:** *The Health Care Facility provides an overall level of care that meets or exceeds most regulatory and resident standards.* The facility offers care to veterans with a range of physical and mental issues. As part of its Chronic Disease Hospital license, the HCF is required to have a certain level of medical staff present at the facility, including medical doctors and a licensed pharmacist. This requirement adds a level of on-site professional care staff not required of long-term care facilities licensed under other categories.⁶ At the same time, the HCF's current staffing levels are not sufficient to avoid overtime costs or the use of outside nursing services when there is not enough facility staff to cover shifts, under the facility's current staffing level goal.

² The state Department of Public Health, as part of its inspection of the Health Care Facility, inspects the food services operation located in the main dining hall, including the kitchen facility, since it is responsible for providing meals to residents in the Health Care Facility as well as most domiciliary care residents.

³ Additional state regulatory requirements applicable to all long-term care facilities apply to the HCF. For example, there are internal oversight requirements (i.e., certain committees to oversee service quality) for events such as falls and medication errors, and infection control, along with requirements to submit specific reports to DPH, including "adverse events" (e.g., untimely deaths).

⁴ CMS inspections are conducted by the state Department of Public Health in conjunction with its biennial licensing inspections of the Health Care Facility.

⁵ Due to this study's time constraints, a comparison of the Health Care Facility's performance with other facilities licensed as Chronic Disease Hospitals could not be conducted.

⁶ When medical doctors are not at the facility, it uses an on-call service at the University of Connecticut Health Center.

Direct care staffing. *The direct nursing care staffing level exceeds state licensure requirements, but has recently been reduced as a cost savings measure. Although a few issues with the Health Care Facility became apparent during the study, none was as prevalent as the level of direct care staffing. Direct care staff are registered nurses, licensed practical nurses, and certified nurse aides who provide care for residents.*

Direct care staff have the most daily interaction with residents of all staff at the facility, and provide a range of professional and personal care services to ensure the residents' needs are met. As with any long-term care facility, direct care staff are vital to daily operations. The DPH requirements for nurse staffing at facilities licensed as Chronic Disease Hospitals are provided in Table IV-I.

Table IV-1. Required Nurse Staffing Levels of Chronic Disease Hospitals in Connecticut		
<i>Shift</i>	<i>Maximum Ratio of Patients to Registered Nurses on Duty</i>	<i>Maximum Ratio of All Nursing Staff (RN, LPN, CNA) on Duty</i>
First (7:00 a.m. to 3:00 p.m.)	30:1	10:1
Second (3:00 p.m. to 11:00 p.m.)	35:1	12:1
Third (11:00 p.m. to 7:00 a.m.)	45:1	15:1
Source: Conn. State Regs. Sec. 19-13-D(e).		

The VA's requirements for veterans home nursing staff as a skilled nursing facility primarily include:⁷ 1) providing an organized nursing service with a sufficient number of qualified nursing personnel, including RNs, to meet total nursing care needs of residents 24 hours a day, 7 days a week; and 2) sufficient nursing services to ensure there is a minimum direct care nurse staffing per patient per 24 hours, 7 days a week of no less than 2.5 hours (also known as hours per patient day, or HPPD).

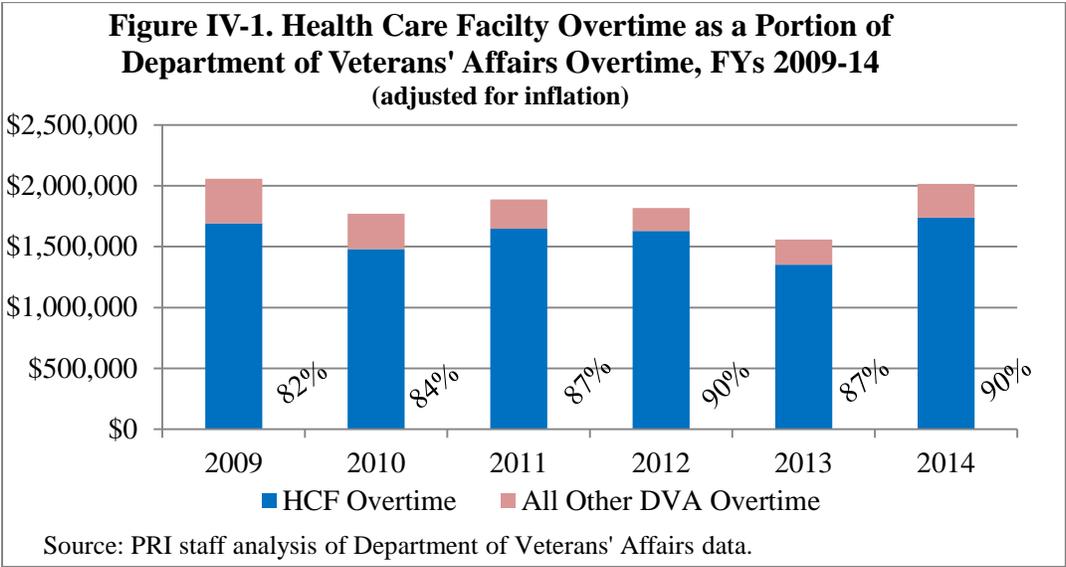
*A review of the facility's most recent DPH inspection report showed no regulatory violations for direct care staffing levels, thus the minimum staffing ratios were met. In addition, the most recent federal VA inspection showed the facility's rating for nursing services met the necessary requirements.*⁸ The federal inspection also showed the HCF met the requirements for nurse aide training; the training is approved by the State.

⁷ The VA recognizes the Health Care Facility as a skilled nursing facility for its regulatory purposes.

⁸ Both the federal VA and state DPH inspections occurred in fall 2014 (October and September, respectively).

The facility has used overtime and private nursing services contractors (i.e., pool staff) to help fill the void between the number of nursing staff at the HCF and the number of staff necessary to meet the facility’s hours per patient day standard. The Health Care Facility has generally used an HPPD level of 3.7 to 4.0, which the current administrator considers low in comparison with private nursing homes in the state.⁹

Figure IV-1 shows fluctuation in overtime costs (adjusted for inflation) for the Health Care Facility as a portion of the department’s total overtime expenditures since FY 09.¹⁰ HCF overtime remained relatively level for FYs 11 and 12, at just over \$1.6 million. Overtime costs dropped 17 percent in FY 13 to \$1.35 million, before increasing again in FY 14 to \$1.74 million, the highest total for the six-year period.



The department’s fiscal office told committee staff the primary reason for the significant decrease in FY 13 was a concerted effort to increase the number of hours part-time nurse aides were permitted to work per week, which reduced the amount of overtime for that year. The office said despite the change continuing in FY 14, the HCF used additional overtime that year to maintain its staffing standard.

In any given year, HCF overtime expenditures averaged \$1.6 million (86 percent) of the department’s total for the last six fiscal years, and ranged from 82 to 90 percent of the department’s total overtime costs. It should be noted, the number of

⁹ The history behind why the Home uses its particular HPPD standard is based on a report produced by the DVA’s planning director in 2012 examining staffing at the Health Care Facility, which stated the average HPPD in Connecticut was 3.7 at that time.

¹⁰ Overtime for the Health Care Facility is for all staff, not just direct care staff. However, committee staff was told that direct care staff account for most of the facility’s overtime expenditures.

full- and part-time direct nursing staff (including head nurses) assigned to the various resident floors of the facility decreased 22 percent between FYs 09-14, from 119 to 93. The total staffing for the facility dropped 15 percent, from 189 to 161, for the same period.

The facility has been instructed by DVA leadership to lower its total expenditure, namely by limiting overtime. To do that, the department has required the facility to start using an HPPD standard of 3.5 for direct care staff, instead of 3.7. The department leadership initially wanted to lower the HPPD level to 3.0, which would still allow the facility to meet state licensing standards. At the request of the facility administrator, who is strongly opposed to any reduction in direct care staffing due to potential safety issues, the new standard was established at 3.5 for now. As discussed more below, the department must give this issue specific attention.

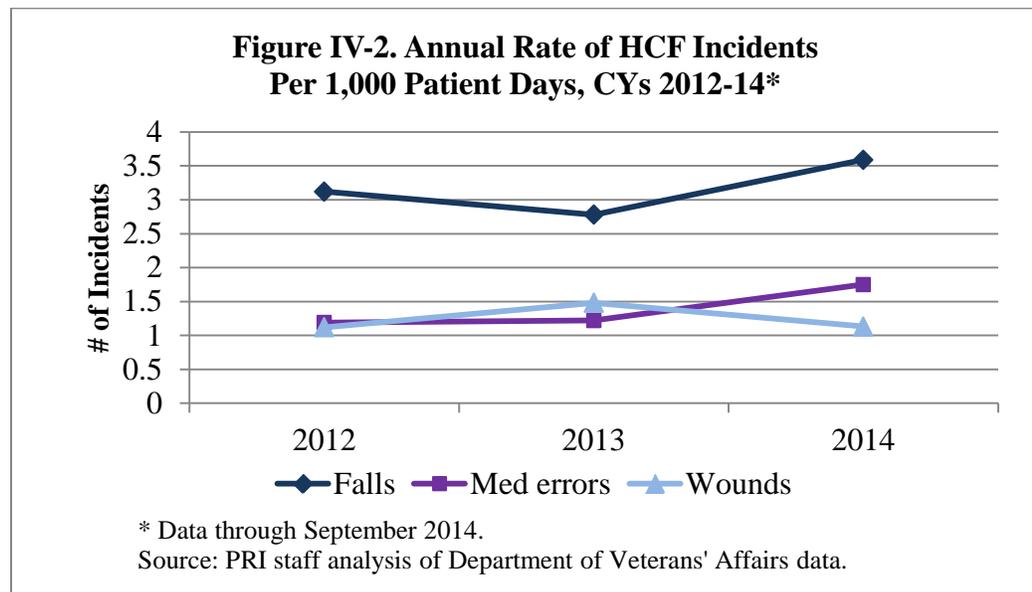
Safety. *The Health Care Facility performs well on several levels regarding residents' safety, although medication errors and falls rose in 2014 from the previous year.* As discussed below, results of federal and state inspections show positive outcomes for most of the resident safety standards they examine. Committee staff's analysis of annual incident rates, as a proxy for overall safety performance, shows a recent increase in falls and medication errors (but not wounds), and the Health Care Facility has taken steps to address those issues.

Inspection results. On the whole, the most recent federal VA and DPH inspections of the Health Care Facility revealed relatively few deficiencies where residents' safety was directly affected. In addition, none of the inspection reports cited the facility for any continued violations found in previous inspections.

The facility received one negative rating on its federal 158-point inspection: water temperature too hot in residents' rooms, which was addressed the same day it was found by inspectors. A new testing procedure was also put into place as part of the facility's required plan of correction.

The DPH inspection revealed two safety-related issues: an unlocked door leading to the loading dock, which allowed a veteran to leave the facility and wander out to the dock and fall off resulting in injury and hospitalization, and a tripping hazard in one of the facility's common areas. (The latter issue was also documented in the federal CMS inspection, which is conducted by DPH inspectors.) The issues were promptly taken care of by the HCF. The facility's plan of correction, submitted to DPH, stated proper procedures would be re-emphasized to facility staff and a new key pad on the door leading out to the loading dock of the facility would be installed.

Incidents. Committee staff examined three key measures related to resident safety: the numbers of falls, medication errors, and severe wounds.¹¹ Figure IV-2 shows the annual rates (per 1,000 patient days) for each of these incidents at the Health Care Facility for 2012-14. *After a decline in 2013, the rate of falls increased 29 percent in 2014. After remaining relatively steady from 2012 to 2013, the medication error rate jumped 43 percent in 2014. The rate of wounds decreased 24 percent in 2014, to the same level it was in 2012.* The increases in falls and medication errors in 2014 correspond with an increase in overtime, which may or may not be associated.



The Health Care Facility staff is aware its rates for falls and medication errors have steeply risen. To address the issues, the the facility created a special task force in August to examine reasons for the increased incidents of falls and medication errors and has begun implementing solutions to help lower incident rates, including increased staff education on policies and procedures. The task force meets monthly.

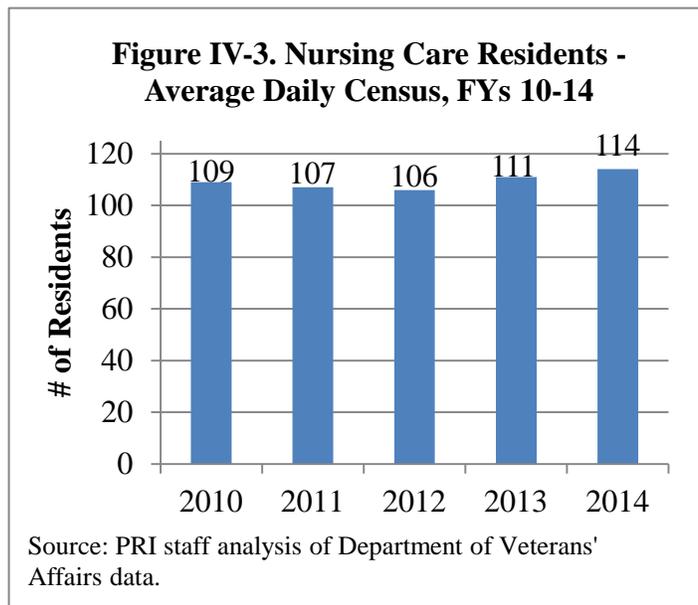
Although the home fared well on its most recent federal and state inspections in most areas, including resident safety, the uptick in falls and medication errors in FY 14 to their highest levels in three years, could signal potential issues. Combined with the new direct nurse staffing standard discussed above, program review committee staff believes *close attention needs to be paid to resident quality care in the Health Care Facility given the recent cutbacks in direct care staffing*, and recommends:

¹¹ Other indicators of the facility's performance include the use restraints, adverse events (e.g., assaults), and the facility is meeting the physical, mental, and emotional needs of residents identified in each resident's care plan. Due to time constraints, committee staff only focused on the three performance indicators provided above in the text.

16. The Health Care Facility should continue to track its overall performance and work toward continuous improvement regarding resident care and safety. The DVA commissioner and Board of Trustees (and regulators) should carefully monitor direct care staffing levels at the facility to ensure its performance is not compromised in any way as a result of cost reduction measures.

- **Occupancy:** *The Health Care Facility is experiencing backlog in admissions; a short waitlist exists for the first time since the facility opened in 2008. The Health Care Facility has a maximum occupancy of 125 residents.¹² As reported in the committee staff’s recent update report, a formal waitlist for prospective residents was not necessary prior to this year. The HCF currently has a waitlist of four veterans who have been approved for admission but are awaiting beds. The facility does not estimate how long any applicant will be on the waitlist.*

Figure IV-3 shows after three years of decline in the average daily number of residents in the Health Care Facility (during FYs 10-12), to a low of 106 residents, there has been an increase since, to a five-year high in FY 14 of 114 residents.



Under current practices, it is not possible for the Health Care Facility to reach 100 percent occupancy. HCF staff tries to keep about 10 beds open for domiciliary care residents needing short-term rehabilitation at any given time. They also reserve beds (generally for ten days) for current residents who need to go to an acute care hospital for treatment.

The Health Care Facility has been operating very close to its maximum capacity, which creates multiple issues. First, additional staffing is needed to ensure the facility’s HPPD standard is met. Since there is a finite number of facility staff, an increase in residents typically results in more overtime or increased use of outside nursing services. Second, a strain may be put on the Veterans’ Home for domiciliary care residents who are aging in place and need long-term care, but may not be able to move to the HCF due to capacity issues. Third, operating near or at maximum capacity means the facility cannot offer veterans in the broader

¹² At the time of the update, the HCF used one room for a sensory area for dementia residents.

community and their primary caregivers respite care services, an issue identified in committee staff's October update. The number of respite days provided by the Health Care Facility fell from 245 days in FY 10 to zero days in FY 14, due to a lack of bed capacity. Committee staff recommends:

17. The Department of Veterans' Affairs should conduct a full needs assessment of its long-term care program to determine if action is necessary to help alleviate capacity concerns and increase the availability of respite care at the Health Care Facility. At minimum, the assessment should examine whether the use of off-site short-term rehabilitation services for domiciliary care residents offers a pragmatic solution. The department should present its findings to the Board of Trustees by July 1, 2015.

- **Resident satisfaction:** *Residents are generally satisfied with the care they receive, although the Health Care Facility has no formal mechanism to collect feedback from residents (or family members).*

Committee staff spent a day at the Health Care Facility surveying residents about their experience and satisfaction levels.¹³ A set list of questions was asked of each resident, but many of the discussions expanded beyond the interview protocol. The residents who committee staff spoke with had lived at the facility for an average of just under three years. Key results of the survey were:

- 85% were satisfied with living at the facility;
- 100% felt safe there;
- 69% felt like they have been treated with respect and dignity by facility staff, with most complaints centered around a lack of respect/concern by nurse aides;
- 23% said they have been verbally mistreated by facility staff; one resident said he was physically mistreated, but that the situation had been rectified;
- 92% were satisfied with the care at the facility;
 - 92% with *medical* care
 - 92% with *therapy* care
 - 77% with *nursing* care, with dissatisfaction coming from residents who said the aides used from private nursing services either had been unfamiliar with residents or slow to respond to residents' needs;
- 69% were dissatisfied with the facility's food, with most concerns about meals not being hot or lacking taste;
- 77% were satisfied with the facility's recreation activities, although several residents said they have not participated at their own choosing, not because they have not liked the activities;

¹³ The Health Care Facility provided committee staff with a list of all residents who did not have conservators, as a method to determine which residents to survey, in person, at the facility. On the day of the survey, the original list contained 35 residents, but one resident had returned to domiciliary care and one resident was in the hospital, for a final total of 33 residents. PRI staff sorted the list in random order prior to going to the facility to conduct the survey. While there, committee staff attempted to contact 30 residents, and had discussions with 13 residents; residents were not available for various reasons (e.g., at medical appointments, not in room, sleeping, or eating).

- 85% were comfortable with bringing any complaint to the facility's staff; and
- Every resident knew there was a residents' council at the facility to listen to residents and help address their concerns.

The survey results presented above show mostly positive results about the Health Care Facility's performance and that residents are satisfied with living at the facility. Although a limited number of residents was surveyed, committee staff believes the HCF should use the results to make changes where necessary, including a sharp focus on ensuring staff treats residents with dignity and respect at all times. Committee staff also believes the facility could benefit from a formal mechanism to collect residents' feedback about the facility's performance. While the HCF residents' council partly serves this purpose, an additional method is needed. (Chapter V addresses this area for the Health Care Facility and domiciliary care.)

How does it compare? The Health Care Facility is highly regulated, meets established standards for long-term care, and serves only veterans. Comparisons with other nursing facilities, although interesting, would not be wholly applicable here. In addition, the VA does not publish data from its inspections in a way that would enable a quality comparison across facilities.

Overarching Issues

The preceding chapters focus on domiciliary and nursing care provided at the Veterans' Home. In addition to the specific findings and recommendations presented earlier, several broad-based issues pertaining to the Home's overall operations became apparent during the study. These issues, when combined, point to systemic deficiencies at the Home that should be addressed to improve operational efficiency and effectiveness. The information and recommendations provided below are intended to strengthen the Home's leadership, oversight and performance monitoring, external perception.

Leadership

As discussed earlier, the Department of Veterans' Affairs (DVA) has not adjusted its general domiciliary program to either prevailing standards of homelessness programs or for major shifts in housing/homelessness policy. Implementation of the changes recommended in this report will need strong, effective leadership by the department and a coordinated and collaborative effort with stakeholders throughout the state. Without these, committee staff believes the Home cannot fully serve veterans who seek the state's assistance.

Over the last decade or more, DVA leadership intermittently has been in contact with various housing- and veteran-related organizations but has not implemented most of the advice provided on how to transform its programs and/or buildings. The department generally has not coordinated with or been a part of the housing/homelessness nonprofit sector. Neither has it developed a strong relationship with the federal Department of Veterans Affairs (VA). The DVA is seen as "isolated" – the word numerous people used to describe the Home during conversations with program review committee staff – operating without consideration of evidence-based approaches or current best practices for housing veterans.

There have, however, been a few recent events that indicate the department's partial willingness to make progress in certain areas:

1. converting the West Street Houses to Patriots' Landing, which is a transitional housing arrangement mainly for veteran families, with case management services provided by a private nonprofit;
2. allowing nonprofit agencies to come to the Home to assess interested veterans for possible participation in the federal Supportive Services for Veteran Families (SSVF) program, which could help them obtain off-campus housing;
3. offering tours of the Home to legislators and stakeholders; and
4. agreeing to participate in the state's Homeless Management Information System (HMIS), which is electronic tracking of a person's use of homeless services statewide.

Although these events are short of fully transforming the Home's residential service program as recommended by committee staff, they point to DVA becoming more responsive and possibly open to making more fundamental changes in the future. Despite these efforts, *it is clear that additional coordination and collaboration is needed between the Home and external stakeholders if changes are to occur.*¹ *Strong leadership from the Home's administrators and program managers is vital to this objective.* Committee staff recommends:

18. DVA should fully coordinate and collaborate with key stakeholders who focus on veteran issues, particularly affordable housing for veterans, to identify ways to continually improve the Veterans' Home's services using evidence-based approaches and best practices. As part of this effort, the department should develop a stronger working relationship with the federal VA in Connecticut to better understand the VA's housing programs for veterans, while providing the VA an opportunity to more fully understand the Home's programs.

Committee staff recently became aware of two important internal issues at the Home that point to either a leadership void or potential leadership conflict. The first deals with direct care staffing levels at the Home's long-term care facility, and the second with a newly-formed Residential Plus Program (assisted living-type program) for the Home's domiciliary residents.

Health Care Facility administration and staffing. The acting commissioner recently created an Executive Assistant position within the commissioner's office. The unclassified position is analogous to a chief of staff or deputy commissioner. The person serving in the new position previously held the classified position of planning director, and was responsible for the planning, lab, and information technology functions of the department.

The new Executive Assistant retains responsibility of his previous functions, but now oversees the Health Care Facility (HCF). The HCF administrator reports to the Executive Assistant instead of directly to the commissioner, as in years past. This change in and of itself is not necessarily unique, except the HCF budget is almost half of the department's total budget, amounting to more than any other function of the Home.² Given the relatively small size of the DVA's budget compared to other state agencies, it would seem to make sense organizationally that the administrator of the department's largest expenditure function would be a direct-report to the commissioner, as was previously the case. In contrast, the domiciliary administrator continues to report to the commissioner.

Through the Executive Assistant, staffing changes have occurred at the Health Care Facility, primarily to lower overtime costs. As discussed in the previous chapter, the facility has been instructed to decrease its direct care standard from the current 3.7 hours per resident per day to 3.5, thus reducing the direct care nursing staff required per shift. Although this change will result in fewer hours the nursing staff spends with residents over the course of a day, the

¹ Committee staff has learned from VA-Connecticut that it recently offered the DVA commissioner an opportunity to temporarily suspend VA referrals to the Home, giving it an opportunity to make improvements to its facilities that both the VA and department consider necessary. The commissioner agreed, and such referrals are on hold (at least as of December 2, 2014).

² FY 14 total expenditures for the department were \$28.8 million. Health Care Facility expenditures totaled \$14 million, or just under 50 percent of the department's total expenditures.

department has said the new staffing levels are still well above the minimum required under state licensing requirements.³ The current HCF administrator does not agree the standard should be lower because that person believes resident care could be compromised. On the other hand, the department's administration has said it needs to find increased efficiencies and has identified a lower direct care staffing standard at the HCF as a key area for cost savings. Committee staff understands both viewpoints, and believes the commissioner and Board of Trustees should continue to monitor the situation, as recommended in Chapter IV.

Residential Plus Program. This new program was designed as a way to fill the Home's void in care for residents in the Residential Facility whose needs were too complex for that setting, but did not rise to the level of care provided by the Health Care Facility. The Residential Plus Program (RPP) allows residents to live in the Residential Facility near its medical clinic, with increased nursing care to assist residents with activities of daily living. Nurse's aides from the Health Care Facility provide the additional care, on first and second shifts only. There are about 13 residents in the program.

Admissions to the Residential Plus Program were stopped in June 2014 by the previous commissioner to address issues. The DVA has admitted *the program was poorly designed, does not follow the necessary state Department of Public Health licensure guidelines that could be applicable, and has required more nursing and janitorial staff than originally anticipated.* Apparently, some work with DPH has progressed, but the program remains in administrative limbo.

Committee staff believes the difficulties experienced by RPP, including the suspension of new admissions to the program, point to a larger issue DVA must address: how the department plans to accommodate residents who are aging in place. The average age of domiciliary residents is 61, and almost a quarter of respondents to the committee staff's survey indicated they have no intention of ever moving out of the Home. These factors collectively mean *the Home needs to sufficiently address its aging domiciliary care population who need additional services the Home is not currently prepared to offer.*

19. The Department of Veterans' Affairs should work with its Board of Trustees on devising a strategy and program to address the issue of residents who are aging in place. A well-designed plan should be developed by October 1, 2015. A summary of the plan should be forwarded to the department's legislative committees of cognizance, and included in the board's 2015 annual report. If needed, additional resources should be requested of the legislature.

Performance Oversight and Monitoring

The department has not engaged in any strong internal efforts to evaluate the quality and outcomes of its services. Program accountability has become a routine business practice for most state-contracted nonprofits, but the Department of Veterans' Affairs has demanded little from the Home, which accounts for the vast majority of the department's focus and resources. It is unsurprising, then, that the department has not regularly produced for its Board of Trustees or for

³ DVA notes the current state Chronic Disease Hospital licensing requirements for nurse staffing equate to 2.75 hours per patient per day.

the legislature any quality or outcome data that could have indicated problems, particularly within domiciliary care.

At the same time, *minimal external accountability of the Home has been required*. For example, the board has not been fully active (until recently) or independent of DVA, and the legislature has not included DVA in its Results-Based Accountability (RBA) efforts. The legislature also splits responsibility for the department between two committees, Veterans' Affairs and Public Safety and Security, which might have created confusion over who is responsible for overseeing the Home's programs and performance.

Board of Trustees. State law requires the establishment of a 17-member Board of Trustees for the DVA, comprised of the commissioner and 16 members appointed by the governor and legislative leaders.⁴ Board members are volunteers, and their service is coterminous with their appointing authority. The board is required to:

- meet quarterly and “upon the call of the commissioner;”
- advise and assist the commissioner in: the Veterans' Home's operation; administration, expansion, or modification of the department's existing programs and services; and development of new programs and services;
- review and approve any regulations concerning admission, discharge, or transfer procedures, as well as a per diem fee schedule for programs, services, and benefits; and
- develop an annual report on its activities and recommendations for improving service delivery and new programs, and submit the report to the governor and DVA's legislative committees of cognizance.

The Board of Trustees failed to meet between December 2010 and September 2012. It tried to meet in early 2012, but did not achieve a quorum so the meeting was canceled. Since then, the board has met quarterly. In its most recent audit of the department (covering fiscal years 2011-13), the state auditors also found the board did not meet its statutory requirements for meeting or providing sufficient notice of its meetings.

Table V-1 shows, *attendance at recent board meetings has been sporadic*, with a quorum not reached in two of its last eight meetings. *A review of the board's minutes also shows certain members missing numerous meetings.* For example, one member missed all eight meetings, another was absent for six meetings, and three members did not attend five meetings. In addition, at no time since at least September 2012 has there been a full complement of members appointed to the board, although the number of vacancies has been decreasing; only one vacancy needed to be filled as of October 2014.

⁴ C.G.S. Sec. 27-102n.

Table V-1. Department of Veterans Affairs Board of Trustees: Activity					
<i>Calendar Year</i>	<i>Number Attending meeting</i>	<i>Number Absent from meeting</i>	<i>Quorum met*</i>	<i>Number Appointed</i>	<i>Number of vacant appointments</i>
2012					
September	10	2	✓	11	6
2013					
January	6	7	No	12	5
March	9	4	✓	12	5
June	6	7	No	12	5
September	10	4	✓	13	4
2014					
January	8	7	✓	14	3
June	9	7	✓	15	2
October	12	4	✓	15	2
*According to statute, a quorum of the board is a majority of its members. Source: PRI staff analysis of DVA data.					

The board has failed to fulfill one of its duties and appears not to have been highly engaged with the overall performance of the Veterans' Home. The board has not met its statutory requirement of producing an annual report since 2007. In addition, based on a review of the board's minutes since late 2012, until recently it has had very limited discussion on the Home's overall performance in meeting its missions. Committee staff believes the board needs to take a more proactive approach to fulfilling its role, but also needs more information from the department for that to occur. State law does not require the board to have a chairperson, unlike other state governmental boards in Connecticut, which may have contributed to the board's low engagement.

The acting commissioner appears to want a more active, transparent board, based on a recent board meeting attended by committee staff. For example, the commissioner requested the board members work on different ad-hoc committees to examine various operations of the Home, with reports made back to the full board. There also were commitments for more input from residents, to properly advertise board meetings, and to complete the required annual reports on time.

These initiatives are signs the board is progressing in a positive direction. Committee staff believes, however, additional work by the board is necessary to strengthen its oversight and monitoring role of the Veterans' Home. The following recommendations are made to that end:

20. The Board of Trustees should be strengthened in the following ways:

- a. All current and new board members should fully understand and work toward their role to advise and assist the commissioner on the Home's programs, services, and administration. Members should request the**

necessary information from the department to appropriately monitor the Home's overall progress towards meeting its missions and the department should provide the information in a timely manner.

- b. The board should develop (and submit to the legislature and governor) an annual report by February 15 of its previous calendar year's activities. At minimum, the report should include the Home's progress in fulfilling its mission based on programmatic outcomes.
- c. A full complement of members should be appointed to the board by March 1, 2015. The appointing authorities should continue to ensure members are appointed in a timely way when vacancies occur.
- d. The governor should appoint a chairperson, other than the DVA commissioner, from among the members of the board. The chairperson should have the authority to call meetings of the board, as should a majority of the board membership.
- e. Beginning January 1, 2015, any board member who fails to attend three consecutive meetings or who fails to attend 50 percent of all meetings held during any calendar year should be deemed to have resigned from the board.
- f. Board membership should include one veteran from each of the Home's permanent and transitional housing programs, and long-term care facility. The members should be elected yearly, or upon a member's resignation, by fellow residents, and serve in a non-voting capacity on the board.
- g. All meeting notices, minutes, and reports of the board should be prominently posted on the department's website (and provided in accordance with all current statutory requirements). The information should be kept current, with meeting minutes posted to the website within seven days after each board meeting (with an indication that they are considered "draft" until approved by the board). Any historical information pertaining to the board – dating back to at least January 1, 2012 – also should be posted.

Program monitoring. A proper data management system with the ability to produce accurate and timely information regarding quality is vital to the Home's overall performance. The data management deficiencies previously discussed impede the Home's collection and analysis of critical data. Without adequate and timely information, proper oversight and monitoring is not possible.

The Home is making some improvements to its data systems. It is currently transferring to an electronic health records system. The move, part of a federal requirement, is scheduled to begin implementation in 2015. The intended result is a modernized record-keeping system that should prove very helpful in tracking and managing resident data. In addition, the Home continues work on implementing its strategic plan of upgrading the agency's computer network infrastructure with support from the Department of Administrative Services.

Progress in these areas, while important, only addresses part of the Home's current data issues. The Home still needs to develop relevant performance measures, and then collect and analyze the data to fully evaluate program quality – including outcomes – to ensure the Home is meeting its mission. The Home must develop the internal capacity to determine whether its programs are operating well and improving the lives of its residents. Program review committee staff recommends:

- 21. The Department of Veterans' Affairs should establish an internal workgroup to examine the overall capacity of the department's management information system. The workgroup should include agency leadership, program managers, and the Department of Administrative Services. The group should review the program data currently collected by program managers and the system(s) used to collect the data. The group should develop appropriate measures to gauge programmatic implementation and outcomes and ensure the data necessary to support such examination is collected and maintained. Once the workgroup's review is completed, it should report its findings to the department's Board of Trustees.**
- 22. Beginning January 1, 2016, and annually thereafter, the department should develop an annual Results-Based Accountability-style report card to fully capture its performance based on RBA principles. The report card should be promptly distributed to the Board of Trustees and the legislature's committees of cognizance, and posted on the department's website.**

Another way the Home can help monitor its performance is to formally solicit and use feedback from residents about their overall satisfaction with the Home and its services, which is not done either for domiciliary- or nursing-care. Committee staff found its surveys of residents (and local veteran liaisons) very informative. The response rate to the domiciliary care survey, in particular, was positive and showed many residents wanted to have their opinions and thoughts considered in how the Home operates and can be improved. Residents at the Health Care Facility were also appreciative that their feedback was requested.

- 23. The Veterans' Home should collect residents' feedback through an anonymous annual survey regarding, at minimum, specific services and program components. The results should be formally shared with all residents and the Board of Trustees. The board should include the results in its annual reports.**

The Home needs to monitor its own performance and continually work to improve resident satisfaction. Surveys of residents can be one mechanism to provide the Home, Board of Trustees, and external stakeholders with honest feedback from residents about their experiences at, and perceptions of, the Home.

Public Relations

The Home has been hindered by deficient outreach and public relations. In discussions with key stakeholders throughout the state who work on veterans issues, including a survey of local veterans liaisons, many were either unfamiliar with the Veterans' Home and its services or

had limited knowledge. The Home's Stand Down event seemed to be the most widely known aspect of the Home.

The department's practice has been to not actively solicit donations, either individual- or corporate-based, aside from its Stand Down event. It is unclear to committee staff why this choice was made. The DVA does accept donations, and there is information on its website about how donations to the Home may be made. Given the Home's many needs, it only makes sense to proactively seek donations that could serve to enhance the Home's physical structure and services to its veterans.

The Home has been portrayed negatively in the press recently. In addition, a core group of residents and some from outside the facility have levied accusations against the Home for several years that continue to plague the agency, and various lawsuits have been brought against the agency. Committee staff believes it would serve the department well to do all it can to proactively enhance its public perception, including the possibility of a "rebranding" effort, particularly for the Veterans' Home.⁵ To that end, the department is seeking a "manager of community advocacy" position along with a legislative liaison, which should go a long way in helping the department with its external affairs.

Long-Range Planning

The intent of this report's recommendations involving domiciliary care is to move the Home toward a system that more clearly delineates transitional housing from permanent supportive housing, with the goal of providing better quality of life for the Home's residents. The timeframe to implement the recommendations is considered short-term. Additional long-term work is needed to fully determine what the Home should reflect or represent from a philosophical and practical perspective.

Appropriateness of the Home's institutional setting. Most of the Home's buildings, although structurally well-built, are approaching 80 years old. Given the era when the buildings were constructed, the main Residential Facility was built around a "barracks" design, and the entire facility has a distinct institutional feel, both visually and programmatically.

There is debate around whether a portion of veterans prefers to live in the Home's domiciliary care (presuming financial and logistical ability to live elsewhere) and if the Home, in its current capacity and physical structure, should continue to be an option for veterans from the state's perspective. This debate is about whether it is appropriate for people to live, long-term, in an institutionalized setting. Generally housing policy in Connecticut has shifted to community-based living. Many institutions that provided essentially permanent housing for people with mental disorders or developmental disabilities have been closed, while others are being phased

⁵ Committee staff believes part of this effort should be to remove the fence surrounding the campus as quickly as possible. The fence only adds to the perception that the Home is an institution-style complex. Although there may have been good reason for the fence in the past, it is no longer needed. The state also should consider renaming the Home as a "rebranding" effort and to better differentiate its different housing programs, as recommended by committee staff.

out. There is also greater emphasis on providing medical and life care services in the community for persons who need nursing care, instead of admitting people to nursing homes.

Veterans in domiciliary care, however, actively can choose to continue to live in an institutional setting, which changes the question somewhat.⁶ Some staff at the Home believe certain veterans are happiest and healthiest there, due to the structure and veteran camaraderie the staff perceives. That sentiment was also conveyed by several residents at the committee's two public hearings on this study. Others are concerned that there must continue to be a place where a veteran can always live, provided the person meets admission requirements.

Housing First versus transitional housing. As discussed in Chapter I, Housing First – the practice of permanently housing homeless persons without preconditions and followed by any necessary supportive services – is an evidence-based approach and implemented by multiple federal housing programs for veterans. It is possible the DVA, however, has not adopted any Housing First-oriented programs, or more aggressively encouraged the Home's residents to move off campus to permanent housing, because there is still some debate around the effectiveness of transitional housing (loosely, the Home's current model) and permanent supportive housing using the Housing First approach.

Many of those providing or most familiar with transitional housing programs assert that transitional housing is a necessary or preferred step for homeless veterans, who might particularly thrive in a more structured environment. Transitional housing for persons leaving incarceration or chronic homelessness, or who are in substance use recovery, might also be appropriate, in the view of some. The huge philosophical shift needed to embrace Housing First's embodiments of permanent supportive housing and rapid rehousing, which prioritize housing in the community, can be a difficult change. Concern also exists that there simply are not enough affordable housing units to fully move from a transitional housing to a Housing First approach. These concerns are understandable, even though little research exists on supporting the efficacy of transitional housing.

Setting the debates aside, it cannot be ignored that the Veterans' Home houses well over 200 domiciliary care veterans. Some are short-term residents, and others are not. The Home, however, is not meeting accepted supportive services standards for either population, which must change in the short- and long-term.

Vision. The Department of Veterans' Affairs, like many state agencies, has felt pressed by the fiscal climate over the last several years. Nevertheless, it is a responsibility of leadership to propose a vision of how to best serve clients, even in tough budgetary times.⁷ While such a vision might have been privately held, nothing has been produced – either on paper, or in terms of a philosophical shift at the Home. It is possible that a clear statement of how effectively homeless veterans are being served in its domiciliary care, how that compares to evidence-based

⁶ For example, 24 percent of respondents to committee staff's survey of domiciliary residents indicated they do not plan on ever leaving the Home. Several residents who testified at the committee's public hearings also said the Home has been a positive influence in their lives and, in some cases, saved their lives.

⁷ C.G.S. Sec. 27-102l(c)(6) gives the DVA commissioner the power and duty to develop a long-range plan.. To date, no such plan has been developed to committee staff's knowledge.

practices, and what it would take to bridge any gap, would have been sufficiently compelling to produce any needed resources. The agency transformed its long-term health care program in 2008 through building a new facility, but has not taken any focused steps to do the same for its domiciliary care, which serves more people with different needs.

Committee staff believes Connecticut is at a critical crossroads with its Veterans' Home. An important opportunity exists to create a long-term vision for how the state provides residential services and care for veterans, not only at the Veterans' Home, but statewide through nonprofit service agencies. In addition to this study, a working group of key stakeholders under the direction of the Lieutenant Governor has been created to examine the Home and decide if its services and campus are in need of change, including a full review of the Home's facilities.⁸ Combined, and working in coordination, these initiatives can establish the necessary improvements for how the State Veterans' Home can best serve Connecticut's veterans, now and in the future.⁹

⁸ The Veterans' Home has numerous facilities-related issues. For example, there are over 200,000 square feet of vacant space that must be minimally maintained to retain the structural integrity of the buildings (at the department's expense), doors that do not meet current federal standards for persons with disabilities, and no sprinkler system in the Residential Facility's main dining hall. DVA is in the process of securing funding to address some of the safety-related facilities problems. The legislature recently approved \$500,000 to conduct a facilities review at the Home.

⁹Program review committee staff encourages the Lieutenant Governor's working group, as part of its efforts to examine the Home, to assess the need and capacity for transitional and permanent supportive housing (as well as residential substance use treatment) among Connecticut veterans statewide.

Appendices

Housing First

Achieving permanent (supportive) housing through a Housing First approach has become a key strategy for federal homelessness programs. Developed as a concept in the early 1990s, Housing First is a service delivery framework designed to fight homelessness, and not a specific program. Housing First programs are intended for homeless individuals who are the house permanently.¹ The federal Substance Abuse and Mental Health Services Administration has identified Housing First as an evidence-based best practice for serving people experiencing chronic homelessness.²

What is it? The Housing First framework has two core components: 1) quickly move people from dire or precarious living conditions, such as living on the street or in emergency shelters, straight to permanent housing; and 2) eliminate preconditions to permanent housing.³ Securing permanent housing for someone experiencing homelessness fulfills the basic human need of housing, and is seen as the first step toward dealing with the issue of homelessness – particularly chronic homelessness.⁴ Complete fidelity to the model means sobriety, completion of a treatment program, psychiatric stability, or employment are not preconditions to permanent housing.

Housing First can also extend to helping people on the verge of losing housing, remain there. This involves offering financial or other resources to stabilize the immediate threat of homelessness then serves to help the problem from reoccurring.

Housing First support services vary but usually include case management and community-based clinical teams to provide continuous access to: crisis intervention; mental health, primary care, and addictions treatment; financial management; landlord and family mediation; and employment.⁵ Although Housing First emphasizes a combination of housing and supports, clients are not required to engage in services to obtain or maintain housing.⁶ While

¹ Pearson, Carol L., Gretchen Locke, Ann Elizabeth Montgomery, and Larry Buron, 2007, *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*, U.S. Department of Housing and Urban Development, Office of Policy Development and Research. <http://www.huduser.org/portal/publications/hsgfirst.pdf> (accessed November 4, 2014).

² Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based and Effective Programs and Practices, Pathways' Housing First Program. <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=365> (accessed November 5, 2014).

³ Tsemberis, Sam. *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*, (2010), as cited in *European Journal of Homelessness*, Vol. 5, No. 2, December 2011. <http://www.feantsaresearch.org/IMG/pdf/review-2-3.pdf> (accessed November 2, 2014).

⁴ *Ibid*

⁵ *Ibid*

⁶ U.S. Interagency Council on Homelessness, *Housing First*, Washington, D.C. Undated. http://usich.gov/usich_resources/solutions/explore/housing_first/ (accessed November 22, 2014).

consumers can refuse support services, some Housing First programs may require meetings with a team member at least four to six times monthly to ensure their safety and well-being.⁷

Housing First is a markedly different approach from “housing readiness” to ending homelessness. Within the housing readiness model, people experiencing homelessness may cycle through various phases of housing (e.g., emergency shelters and transitional housing) and be required to meet certain conditions, such as participation in treatment programs, before “gaining” permanent housing.⁸ The Housing First approach focuses on the housing component first, and commits to working with clients as long as they need assistance.

How effective is it? In addition to recognition by SAMHSA as an evidence-based best practice, additional national research points to the overall efficacy of Housing First as a viable approach to ending homelessness, including among veterans. The National Center for Homelessness Among Veterans determined studies have demonstrated that Housing First is a clinically effective and fiscally efficient model of permanent supportive housing that can be implemented successfully in VA Homeless Programs. Housing First works because Veterans are more likely to achieve stability and improved quality of life when the risks, uncertainty, and trauma associated with homelessness are removed.⁹

According to the U.S. Interagency Council on Homelessness, Housing First programs have been shown to have higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis services and institutions.¹⁰ Specific research around residential stability shows, for a two-year time frame, Housing First participants were stably housed for 19 months compared to 7 months for participants in traditional programs that made treatment and sobriety prerequisites for housing.¹¹

Two key VA programs have initiated a Housing First approach, and the VA’s longstanding transitional housing program seems to be moving toward incorporating several concepts associated with Housing First, as discussed in Chapter I.

⁷ Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based and Effective Programs and Practices, Pathways’ Housing First Program. First Program.

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=365> (accessed November 5, 2014).

⁸ Tsemberis, Sam. *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*, (2010), as cited in European Journal of Homelessness, Vol. 5, No. 2, December 2011.

<http://www.feantsaresearch.org/IMG/pdf/review-2-3.pdf> (accessed November 2, 2014).

⁹ VA National Center on Homelessness Among Veterans <http://www.endveteranhomelessness.org/housing-first-veteran-centered-care>. (accessed November 17, 2014).

¹⁰ U.S. Interagency Council on Homelessness, *The Housing First Checklist: A Practical Tool for Assessing Housing First in Practice*. Undated. http://usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf (accessed November 20, 2014).

¹¹ Substance Abuse and Mental Health Services Administration. <http://www.nrepp.samhsa.gov>. (accessed November 19, 2014).

Appendix B

Table B-1. HUD-VASH in Connecticut, FFYs 2008-2014									
<i>VA-Medical Center</i>	<i>Location of High Need</i>	<i>FY 2008</i>	<i>FY 2009</i>	<i>FY 2010</i>	<i>FY 2011</i>	<i>FY 2012</i>	<i>FY 2013</i>	<i>FY2014 Rd. 1</i>	<i>Total</i>
Danbury Community-Based Outpatient Clinic	Danbury	0	0	15	0	0	0	0	15
Newington	Hartford	0	35	15	50	50	0	0	135
Newington	Hartford and Statewide	0	0	25	0	0	10	42	77
John J. McGuirk Outpatient Clinic (New London)	New London	0	0	25	0	0	0	0	25
Waterbury Community-Based Outpatient Clinic	Waterbury	0	35	25	25	40	0	0	125
West Haven	Bridgeport	0	0	0	0	0	15	0	30
West Haven	Bridgeport and Statewide	0	0	25	0	10	15	0	50
West Haven	New Haven	0	35	0	0	50	0	0	85
West Haven	West Haven	70	0	25	0	15	15	12	137
Total		70	105	155	75	165	55	54	679
Source of data: U.S. Department of Housing and Urban Development.									

Appendix C

Table C-1. Supportive Services for Veteran Families Grant Awards in Connecticut, FFY 14		
<i>Grantee</i>	<i>Award Amount</i>	<i>Number of Participants Served</i>
Community Renewal Team, Inc. (CRT)	\$519,000	~175 participant households in the Central Connecticut Counties of Hartford, Middlesex, New London, and New Haven
The Workplace, Inc.	\$1,256,494	~240 participant households in Southwest and South-central Connecticut
Columbus House, Inc.	\$1,487,245	~300 participant households in New Haven, New London and Middlesex Counties
Source: Department of Veterans Affairs: 2014 SSVF Awards. http://www.va.gov/HOMELESS/ssvf/docs/FY2014_Grantees_SSVF_Abstract_Website_Version_August2014.pdf		

Domiciliary Resident Survey

The program review committee staff surveyed the Veterans' Home's domiciliary residents living in the main Residential Facility (i.e., the Domicile), Fellowship House, and STAR apartments. The survey and its accompanying logistics were one of the major ways in which the committee staff gathered information on the residents' experiences, perceptions, and satisfaction regarding the Home. This appendix describes survey distribution efforts, collection, participation, and data entry and analysis. It also provides the survey results, which were entered into a copy of the survey (with spacing adjustments to make room for the results).

Pre-Distribution

In late September, the program review committee staff sent a letter to all Veterans' Home residents (except those in Patriots' Landing). The letter notified them of the committee's study and requested their participation in multiple, upcoming ways: the domiciliary resident survey; the committee's October and November public hearings; interviews with some Health Care Facility residents; and attending a Veterans' Council meeting.

In late October, the committee staff issued another letter, this time to only domiciliary residents. The letter informed the residents that the survey would be delivered shortly and asked them to participate in a community meeting, scheduled for Monday, November 3, so committee staff could introduce the survey to them and answer any questions. No Home staff attended the meeting, at the program review committee staff's request.

The community meeting was held. An estimated 60 to 70 residents were present for all or part of the meeting. Committee staff answered questions about the study, the survey, and the impacts of both. They also heard numerous complaints. The meeting lasted nearly an hour.

Distribution and Collection

Program review committee staff delivered the survey to residents via the Home's mail system on the afternoon of Monday, November 3. The survey was anonymous; no names were collected and neither the surveys nor the envelopes were numbered to track which residents had responded. To limit the possibility of a resident filling out multiple, copied surveys, residents were instructed to return their surveys in enclosed envelopes.

Survey collection was done both in-person and through the mail. The study team members alternated turns sitting at a table in the dining hall during the entirety of all three meals for the two days following survey delivery (Tuesday and Wednesday). The team collected the surveys in an open box. Many residents chose to use the opportunity to speak with the committee staff about the study and/or the Home. A few residents returned the survey via mail. The deadline for receipt was Friday, November 7. Some surveys were received well after the deadline; these were reviewed by committee staff but not included in the analysis, which was nearly complete by the following Friday.

Participation

Ninety-six surveys were returned on-time, of the 223 distributed, for a response rate of 43 percent. Survey respondents seem to have been very slightly younger than the whole domiciliary population, with median ages of 61 and 62, respectively. Some caution in this respect is necessary because the share who chose not to provide an age was fairly large (9 percent). All three of the domiciliary populations surveyed – main Residential Facility, Fellowship House, and STAR – were represented in the responses, with slight under-representation from Fellowship House residents (14 percent of responses, versus 16 percent of the population) and correspondingly higher over-representation from main Residential Facility residents.

There seems to have been substantial over-representation from Veteran Workers, who were about 58 percent of respondents but only 38 percent of the domiciliary population. The effects of this over-representation are unclear.

Data Entry and Analysis

Survey data were entered into Excel by a legislative nonpartisan administrative assistant. The study staff analyzed the data using SPSS and converted text responses to the most frequently responded categories, to facilitate data analysis.

The results follow, entered into a copy of the survey. The survey's spacing has been adjusted to accommodate the results and this document's margins. The original survey was two double-sided pages.

**Legislative Program Review Committee
State Veterans' Home: Residents Survey**

General Information

[Note: M= indicates the percent of missing a response to the particular question. The percentages in the response options were calculated excluding the missing responses.]

1. In your current stay, how long have you lived at the Veterans' Home? **(circle one)** *Missing=1%*
 - a. 3 months or less: 5%
 - b. 3 - 6 months: 6%
 - c. 6 months - one year: 8%
 - d. 1 - 3 years: 20%
 - e. 3 - 5 years: 7%
 - f. 5 - 10 years: 36%
 - g. 10 - 20 years: 15%
 - h. more than 20 years: 2%

2. How old are you? _____ years *Median = 61 years. 25th percentile: 56 and 75th: 66*

3. What part of the Residential Facility do you currently live in? **(circle one)** *M=2%*
 - a. Main Domicile: 85%
 - b. Fellowship House: 14%
 - c. STAR: 1%

4. Which Veteran Improvement Program (VIP) are you currently in? **(circle one)** *M=4%*
 - a. Accelerated: 2%
 - b. Standard: 15%
 - c. Extended: 21%
 - d. None (by my choice): 15%
 - e. I don't know: 47%

5. How many different times have you lived at the Home, including your current stay? **(circle one)** *M=1%*
 - a. This is my first time: 76%
 - b. 2 times: 21%
 - c. 3 times: 1%
 - d. 4 or more times: 2%

6. If you've lived at the Home before, were you ever involuntarily discharged? **(circle one)** Yes No
Of those who indicated they had lived there before and responded to this question, 43% said yes.

7. Are you currently: **(circle Yes or No to each question)**
 - a. A Veteran Worker? *M=10%* Yes: 58% No: 42%
 - b. Employed off campus? *M=20%* Yes: 4% No: 96%
 - c. Looking for a job off campus? *M=18%* Yes: 29% No: 71%
 - d. Applying for Veteran benefits or a program that could help you move off campus? *M=15%* Yes: 38% No: 62%
 - e. Enrolled in education or a job training program? *M=20%* Yes: 12% No: 88%

Overall

8. What is the main reason you live at the Veterans' Home? **(circle only one answer)** *M=1%*
Percentages below include all responses, including the 22% who marked more than one answer
 - a. My current off-campus job does not pay me enough or give me the fringe benefits I need to move out: 3%
 - b. I like being around other veterans: 0%
 - c. It is an affordable place to live: 16%

- d. The Home’s services (medical, substance use treatment, social work, and/or education and job) help me: 27%
- e. I think of it as my retirement home: 14%
- f. I have no other place to live: 52%
- g. Other reason: 21%
9. Overall, how satisfied are you with living at the Veterans’ Home? **(circle one)** $M=3\%$
- a. Very satisfied: 15% b. Satisfied: 34% c. Neutral: 33% d. Dissatisfied: 11% e. Very dissatisfied: 7%
10. If you are “Dissatisfied” or “Very dissatisfied” with living at the Home, briefly explain why: *[Free response, not analyzed statistically but were read]*
11. When do you want to live outside the Veterans’ Home? **(circle one)** $M=4\%$
- a. Right now: 16% b. In less than a year: 10% c. In a year or two: 35%
- d. More than two years from now: 15% e. Never, I want to stay: 24%
12. On average, how often do you leave the Veterans’ Home campus (not including for medical appointments)? **(circle one)** $M=3\%$
- a. Daily: 35% b. Weekly: 40% c. Every few weeks: 13% d. Monthly: 4%
- e. Every few months: 5% f. Yearly: 1% g. Never: 1%
13. Are you satisfied with how often you get off campus? **(circle one)** $M=4\%$ Yes: 76% No: 24%
14. If you answered “No” to Question 13, why aren’t you satisfied? **(circle all that apply)**
- a. The transportation provided by the Home or CT Transit does not meet my needs: 39%
- b. I mostly have to rely on family or friends to provide transportation: 36%
- c. I usually can’t leave without staff approval, due to pass restriction: 18%
- d. I don’t want to go through a Security check when I re-enter campus, so I don’t leave: 11%
- e. I’m concerned I will relapse into bad habits, so I don’t leave: 0%
- f. Other reason(s): 39%

Quality of Services

15. How satisfied are you with the condition of the Home’s facilities? **(mark for each area, using an “x”)**

<u>Facility Condition</u>	<i>Very Satisfied</i>	<i>Satisfied</i>	<i>Neutral</i>	<i>Dissatisfied</i>	<i>Very Dissatisfied</i>	<i>Have not used</i>
a. Your main living area $M=3\%$	18%	42%	23%	10%	5%	2%
b. Bathrooms $M=2\%$	16%	48%	18%	13%	5%	0%

c. Dining hall <i>M=3%</i>	12%	41%	24%	16%	8%	0%
d. Winners' Circle <i>M=1%</i>	13%	35%	33%	8%	4%	7%
e. Inside common areas <i>M=1%</i>	15%	32%	40%	10%	2%	2%
f. Outside grounds/common areas <i>M=2%</i>	21%	45%	27%	3%	2%	2%

16. How satisfied are you with how well the Veterans' Home staff helps you? (mark for each service, using an "x")

<u>Service</u>	<i>Very Satisfied</i>	<i>Satisfied</i>	<i>Neutral</i>	<i>Dissatisfied</i>	<i>Very Dissatisfied</i>	<i>I don't need or want help with this</i>
a. Achieve your goals to move off-campus <i>M=10%</i>	6%	15%	38%	9%	17%	14%
b. Find off-campus employment: <i>M=12%</i>	4%	6%	42%	9%	14%	25%
c. Find off-campus housing: <i>M=10%</i>	4%	7%	44%	11%	16%	19%
d. Deal with substance use issues: <i>M=10%</i>	20%	21%	20%	2%	4%	34%
e. Deal with mental health issues: <i>M=8%</i>	14%	16%	30%	6%	8%	27%
f. Connect with family or friends: <i>M=9%</i>	12%	21%	26%	9%	6%	26%
g. Receive on-site medical care: <i>M=10%</i>	23%	26%	23%	15%	6%	7%
h. Find recreation activities: <i>M=8%</i>	14%	22%	33%	18%	8%	6%
i. Find transportation: <i>M=10%</i>	13%	26%	34%	15%	4%	9%
j. Eat appropriate food: <i>M=10%</i>	13%	27%	26%	15%	17%	2%

17. How would you feel if the Veterans' Home offered private living quarters (with common bathrooms) to all residents in the main domicile? (circle one) *M=9%*

- a. I would like this: 81% b. I would not care: 16% c. I would not like this: 3%

18. How often do you think you're treated fairly by the Home's staff? (circle one) *M=5%*

- a. All of the time: 26% b. Most of the time: 34% c. About half of the time: 11% d. Sometimes: 22% e. Never: 7%

19. How often do you feel safe at the Veterans' Home? (circle one) *M=4%*

- a. All of the time: 50% b. Most of the time: 38% c. About half of the time: 8% d. Sometimes: 3% e. Never: 1%

Complaints

20. How comfortable are you with bringing any complaint you have to the Home's staff? **(circle one)** $M=4\%$
- | | | | | |
|----------------------|-----------------|-------------|-------------------|------------------------|
| a. Very comfortable: | b. Comfortable: | c. Neutral: | d. Uncomfortable: | e. Very uncomfortable: |
| 12% | 23% | 23% | 21% | 22% |
21. Within the last two years, have you complained to Veterans' Home staff about anything or about any other staff person at the Home? **(circle one)** $M=4\%$ Yes: 39% No: 61%
22. If you have complained to staff in the last two years: **(circle one for each question below)**
- a. Do you feel staff paid attention to you about your complaint(s)? $M=39\%$ Yes: 42% No: 58%
- b. Was your complaint(s) resolved to your satisfaction? $M=39\%$ Yes: 29% No: 71%
- c. If your complaint(s) was not resolved to your satisfaction, did staff explain their decision to you?
 $M=48\%$ Yes: 38% No: 62%
- d. How were you treated by staff after you complained? $M=43\%$ a. Better: 9% b. The same: 64% c. Worse: 27%
23. If you have not complained about anything to staff, why not? [Free response; $M=39\%$]
No need to complain/problem is not a big deal: 41% *Don't think anything would change: 27%*
Fear of staff retaliation: 24% *Other: 8%*
24. Within the last two years, have you brought any complaints to the Veterans' Council? **(circle one)** $M=9\%$
Yes: 31% No: 69%
25. If you have complained to the Veterans' Council within the last two years: **(circle one answer for each question)**
- a. Do you feel the Council paid attention to you about your complaint(s)? $M=54\%$ Yes: 41% No: 59%
- b. Was your complaint(s) resolved to your satisfaction? $M=54\%$ Yes: 27% No: 73%
- c. If your complaint(s) was not resolved to your satisfaction, did the Council explain the decision to you?
 $M=54\%$ Yes: 31% No: 69%
26. If you have not complained to the Veterans' Council, why not? [Free response; $M=35\%$]
Nothing would change: 35% *Too close to staff/administration: 32%*
No need to complain / problem is not a big deal: 24% *Fear of staff retaliation: 5%*
Other: 5% *Fear of resident retaliation: 3%*
27. Overall, how satisfied are you with the Veterans' Council's ability to get results for residents? **(circle one)**
 $M=9\%$
- | | | | | |
|--------------------|---------------|-------------|------------------|-----------------------|
| a. Very satisfied: | b. Satisfied: | c. Neutral: | d. Dissatisfied: | e. Very dissatisfied: |
| 7% | 10% | 41% | 20% | 22% |

Campus Rules

28. How do you rate the rules at the Veterans' Home? **(circle one)** $M=4\%$
- a. Too strict: 47% b. About right: 49% c. Not strict enough: 4%
29. Based on the Home's existing rules, do you think conduct charges/violations are issued: **(circle one)**
 $M=5\%$
- a. Too often: 42% b. About the right amount of time: 50% c. Not enough times: 9%
30. How do you rate the penalties for breaking the Home's current rules? **(circle one)** $M=7\%$
- a. Too tough: 43% b. About right: 47% c. Not tough enough: 10%
31. How often do you think you're treated fairly by staff at the Home when you're involved in a conduct/charge violation? **(circle one)** $M=13\%$
- a. All of the time: 13% b. Most of the time: 39% c. About half of the time: 13% d. Sometimes: 12% e. Never: 21%
32. If you think some rules at the Home should be changed or eliminated, which rules do you suggest? **(list up to three)** [*Free response; M=41%*]
1. *Eliminate Breathalyzers: 26%*
 2. *Eliminate pass restrictions: 20%*
 3. *Eliminate trunk / gate inspections: 16%*
 4. *Eliminate need to get a pass or swipe a card: 14%*
 5. *Eliminate program fee: 14%*
 6. *Eliminate curfew: 7%*
 7. *Change / be more flexible on lights out: 4%*
 8. *Relax meal dress requirements: 4%*
 9. *Relax indoor phone use policies: 4%*
- Other changes written in, not gathering more than 1 response each: 41%*

Thank you for completing the survey. Please include a separate sheet with any additional thoughts, concerns, or suggestions.

Appendix E

Table E-1. Domiciliary Resident Rules	
	<i>Can Result in Immediate Discharge</i>
Personal living space and possessions	
1. No heat-generating or flammable items (e.g., hot plate, coffee pot, microwave, propane); cigarettes, lighters, and matches <i>are</i> permitted	
2. No moving existing or adding additional furniture without permission	
3. Items may be taped or posted only on the inside of personal lockers (not on walls or furniture)	
4. Lock valuables and medication not kept at the B Clinic	
5. Have B Clinic permission for all medications kept in living space	
6. Keep personal living space clean	
7. No pets or pornography	
Campus-wide behavior: No --	
1. On-campus alcohol or illegal drugs, including un-prescribed drugs (sale, consumption or possession), or paraphernalia	X
2. Intoxication (≥ 0.08 blood alcohol content) or positive substance use test	
3. Weapons or ammunition	X
4. Bullying	X
5. Assault	X
6. Behavior that did or could harm people or property	X
7. Borrowing or lending money, or selling items or services	
8. Gambling	X
9. Leaving campus without a pass (<i>Note: Generally residents are free to leave and return as they please between 6 a.m. and midnight, and passes may be acquired for absences during overnight hours. See below for explanation.</i>)	
10. Theft	X
11. Interfering with emergency equipment, people responding to an emergency, or exit signs	X
12. Refusal to submit to a random or directed substance use test	X-by reg. only
13. Entering a restricted area	X
14. Accumulating five minor violations (from any category in this chart)	X
15. Disorderly conduct (e.g., loud disagreements)	
Community living	
1. From 10 p.m. to 6 a.m., be quiet and use earphones with radios, televisions, and computers	
2. Get consent from a resident before entering his/her living space	
3. Stay in the common areas and in one's own wing	

Table E-1. Domiciliary Resident Rules	
	<i>Can Result in Immediate Discharge</i>
4. Talk on cell phones in common areas and outside (not in rooms or dining hall)	
5. Smoke in designated outside areas	X*
6. Visitors, welcome between 10:30 a.m. and 8 p.m., must sign in with Security and remain in common areas	
Motor vehicles	
1. During the first 90 days living at the Home, a vehicle may be parked on-campus but not used, except for vocational or educational purposes	
2. Obtain a permit from Security for parking and driving on-campus	
3. Submit to a Security inspection of the vehicle upon moving in, and at any other time Security staff request	
4. Follow all traffic signs and roads on-campus	
<p>*Although smoking anywhere than in a designated area is considered a major violation by state regulation, Veterans' Home managers indicated that they would not discharge someone for it (similar to non-compliance with a requested drug screen). Instead, a verbal warning would be given for a first instance, and a violation for a second and proceeding instances. Designated smoking areas are: porches of the the Fellowship House and East and West Domicile porches; picnic tables in the quadrangle between the Domicile buildings; and outside the STAR program building and Patriots' Landing homes. Domiciliary care veterans may smoke whenever they choose, as long as it is in a designated area.</p> <p>Note: For the past few years, the Home has not issued violations for failing to follow one's own treatment plan, which state regulation classifies as a minor offense.</p> <p>Source: PRI staff review of the Veterans' Home Residential Facility Rules and Regulations Handbook and of applicable state regulation (R.C.S.A. 27-102(d)-200 through -201).</p>	

Town Veteran Liaison Survey

The program review committee staff surveyed towns' veteran contact persons. The contacts act as a conduit to towns for information from Department of Veterans' Affairs (DVA) and others. They also assist veterans who are seeking assistance or information. This survey contributed to the committee staff's understanding of how the Home is perceived, how actively DVA seeks referrals to the Home, and from whom the Home receives referrals. This appendix discusses survey methods and participation. It also contains the survey results.

Methods

In October, DVA's Office of Advocacy and Assistance provided program review committee staff with a list of towns' designated veteran contact persons. There were 117 people on the list, with some towns having multiple representatives. Of them, 12 had no e-mail address and 10 of the given e-mail addresses were invalid. Therefore, the survey was distributed to 95 town veteran contacts, representing 87 towns.

The survey was developed, fielded, and analyzed using Survey Monkey, an online tool. A link to the survey was sent to the town veteran contacts via an e-mail message from program review committee staff on Tuesday, November 4. Recipients were requested to complete the survey by Friday, November 7, and to coordinate with other designated contacts from their town to ensure only one person (speaking for all the contacts) participated.

Participation

Of the 95 town veteran contacts sent a survey, 34 responded. If instructions were followed and only one person from each of the 87 towns filled out a survey, the response rate was 39 percent. Basing the response rate on the number of recipients (not towns) included, the rate drops slightly, to 36 percent.

It is important to note that the town veteran contact list did not include anyone from some of Connecticut's cities. Only two of the state's larger cities (distinct from inner-ring suburbs) were represented. Therefore, the survey should not be considered to give a strong sense of how the contacts for the most populous towns think of and refer to the Home. There were no other obvious geographic shortcomings of the survey participant list.

Results

The results are presented below:

- 1. How many people live in your town?**
 - a. Under 5,000: 18%
 - b. 5,000 to 25,000: 56%
 - c. 25,001 to 50,000: 9%

- d. 50,000 to 100,000: 9%
 - e. More than 100,000: 9%
 - f. No response: 0% of respondents
- 2. In the last two years, have you referred anyone to the Connecticut State Veterans' Home for admission to the Home's Health Care Facility (similar to a nursing home)?**
- a. Yes: 18%
 - b. No: 82%
 - c. No response: 0% of respondents
- 3. About how many people have you referred to the Home's Health Care Facility?**
- a. A few (3 or under): 100%
 - b. Some (4 or more): 0%
 - c. Many (10 or more): 0%
 - d. No response: 0% of those who said they had referred someone
- 4. In the last two years, have you referred anyone to the Veterans' Home for admission to the Home's domiciliary (residential services for homeless veterans)?**
- a. Yes: 15%
 - b. No: 85%
 - c. No response: 3% of respondents
- 5. About how many people have you referred to the Home's domiciliary?**
- a. A few (3 or under): 100%
 - b. Some (4 or more): 0%
 - c. Many (10 or more): 0%
 - d. No response: 0% of those who said they had referred someone
- 6. Overall, what is your opinion of the Veterans' Home's Health Care Facility (similar to a nursing home)?**
- a. Favorable: 18%
 - b. Unfavorable: 6%
 - c. Neutral: 18%
 - d. I don't know enough about it to have an opinion: 59%
 - e. No response: 0% of respondents
- 7. Please explain your opinion, if you'd like to. *[free response; answers have been categorized below and some people's responses included in multiple categories, when multiple aspects mentioned]***
- a. Facilities mentioned
 - i. Favorably: 2 people
-

- ii. Unfavorably: 1 person [*Note: The comment was that the facility was old, so the respondent may have been confusing it with domiciliary care*]
 - b. Staff mentioned
 - i. Favorably: 3 people
 - ii. Unfavorably: 1 person [*Note: This comment was by the person who responded that the facility was old, so the respondent may have been confusing it with domiciliary care*]
 - c. Distance to location mentioned
 - i. Unfavorably: 1 person
 - d. Rules mentioned
 - i. Favorably: 1 person
 - e. Other (1 person each):
 - i. Favorable: “Important” for veterans with “special needs”
 - ii. Neutral: Had visited once, for Stand Down
 - iii. Unfavorable: Multiple veterans “refuse[d] to talk to me after I mentioned it as an option” [*Note: This comment was by the person who responded that the facility was old, so the respondent may have been confusing it with domiciliary care*]
 - f. No response: 80% of respondents
 - 8. Overall, what is your opinion of the Veterans’ Home’s domiciliary (residential services for homeless veterans)?**
 - a. Favorable: 27%
 - b. Unfavorable: 9%
 - c. Neutral: 12%
 - d. I don’t know enough about it to have an opinion: 53%
 - e. No response: 0% of respondents
 - 9. Please explain your opinion, if you’d like to.** [*free response; answers have been categorized below and some people’s responses included in multiple categories, when multiple aspects mentioned*]
 - a. Facilities mentioned: 0
 - b. Staff mentioned: 0
 - c. Distance to location mentioned
 - i. Unfavorably: 1 person
 - d. Rules mentioned
 - i. Favorably: 1 person
 - ii. Unfavorably: 1 person
 - e. Other (1 person each):
 - i. Favorable:
 - 1. “Important” for veterans with “special needs”
-

2. One veteran was referred and was appreciative.
3. Veterans look happy there.
- ii. Neutral: Had visited once, for Stand Down
- iii. Unfavorable:
 1. Last resort option: “absolutely no other options”
 2. “They don’t want to be segregated from mainstream society.”
- f. No response: 85% of respondents

10. In the last two years, has the Veterans’ Home or the State Department of Veterans’ Affairs (DVA) contacted you to give you basic information about the Home? (Exclude notifications about the annual Stand Down event or other DVA services)

- a. Yes: 12%
- b. No: 85%
- c. I don’t remember: 3%
- d. No response: 0% of respondents

11. In the last two years, has the Veterans’ Home or the State DVA encouraged you to refer people for admission to the Home?

- a. Yes: 6%
- b. No: 91%
- c. I don’t know: 3%
- d. No response: 3% of respondents

Appendix G

Table G-1. Other State Veterans' Homes Domiciliary Care				
	<i>Transitional / "housing readiness"</i>	<i>Capacity (Dom. Only)</i>	<i>Recent Ave. Occupancy Rate (%)*</i>	<i>24-hour nursing care at same home?</i>
10 Largest Domiciles				
California: Yountville	No	817	72%	Yes
<i>Connecticut</i>	<i>Yes</i>	488	51	<i>Yes</i>
Massachusetts: Chelsea	Yes	305	81	Yes
Ohio: Sandusky	No	300	54	Yes
California: Barstow	No	220	30	Yes
California: Chula Vista	No	220	60	Yes
Minnesota: Hastings	Yes	200	76	No
W. Virginia: Barboursville	Yes	195	44	No
Maryland	No	168	80	Yes
Pennsylvania: Hollidaysburg	No**	167	83	Yes
Surrounding States				
Massachusetts: Chelsea	<i>See above</i>			
New York	N/A	0	N/A	N/A
Rhode Island	Yes	79***	11	Yes
<p>*Average from September 2012 to May 2013. **Serves homeless veterans. Lacks the employment and case management services, as well as program design, necessary to be considered transitional, according to that home's staff. ***Current actual capacity is 1, according to a home administrator. Sources: "Transitional/'housing readiness approach'" determination made by PRI staff upon review of each home's website and, for Rhode Island, Massachusetts, and Pennsylvania, telephone conversations with high-level home managers. Current "Dom. [Domiciliary] capacity" was provided by personnel from the United States Department of Veterans Affairs in October 2014. "Recent Ave. Occupancy Rate (%)" was accessed on July 3, 2014 via: http://www.nonvacare.va.gov/state-homes.asp.</p>				