



COUNCIL *on* FOUNDATIONS

Access to Care for Military Veterans and Their Families

*In Partnership with
the Military Family Research Institute at Purdue University*

March 9, 2015



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COUNCIL *on* FOUNDATIONS

Veterans Philanthropy Exchange

The Philanthropy Exchange online platform creates an unprecedented clearinghouse for philanthropic funders to share best practices. It provides a collaborative investing forum for foundations to align investments with other public and private partners for greater collective impact on services for veterans and their families.

The Veterans Philanthropy Exchange will help grantmakers efficiently gather and share high-value information, best practices, and real time communication across a variety of foundation types.

Some features of the Exchange include:

- Resource Library
- Mapping tools, powered by the Foundation Center
- Individual donor information
- Strategy building tools on best practices
- Peer to peer engagement and learning
- Calendar of Events
- Recent News on Veterans Funding
- Topical focus on issues, like homelessness, unemployment, mental health services, community reintegration, family housing, and transition planning

To be eligible to enter the Exchange, your organization must:

- Fund or be interested in funding veterans' and military families' services
- Have an independent governance structure
- Not be a government entity

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- Allows the funding community simple and instant access to discussions with their peers across the globe
- Provides a space for foundation staff to cultivate a searchable online library of best practices, resources and events
- Creates a private community where our sector's leaders can candidly seek and give advice to their peers

Military Members, Veterans and Families: Existing & Emerging Research on Health Care Access

THE MILITARY FAMILY RESEARCH INSTITUTE
Council on Foundations Webinar
March 9, 2015

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The NEW ENGLAND
JOURNAL *of* MEDICINE

ESTABLISHED IN 1812

JULY 1, 2004

VOL. 351 NO. 1

Combat Duty in Iraq and Afghanistan,
Mental Health Problems, and Barriers to Care

Charles W. Hoge, M.D., Carl A. Castro, Ph.D., Stephen C. Messer, Ph.D., Dennis McGurk, Ph.D.,
Dave I. Cotting, Ph.D., and Robert L. Koffman, M.D., M.P.H.

Perceived Stigma of Mental Health Care

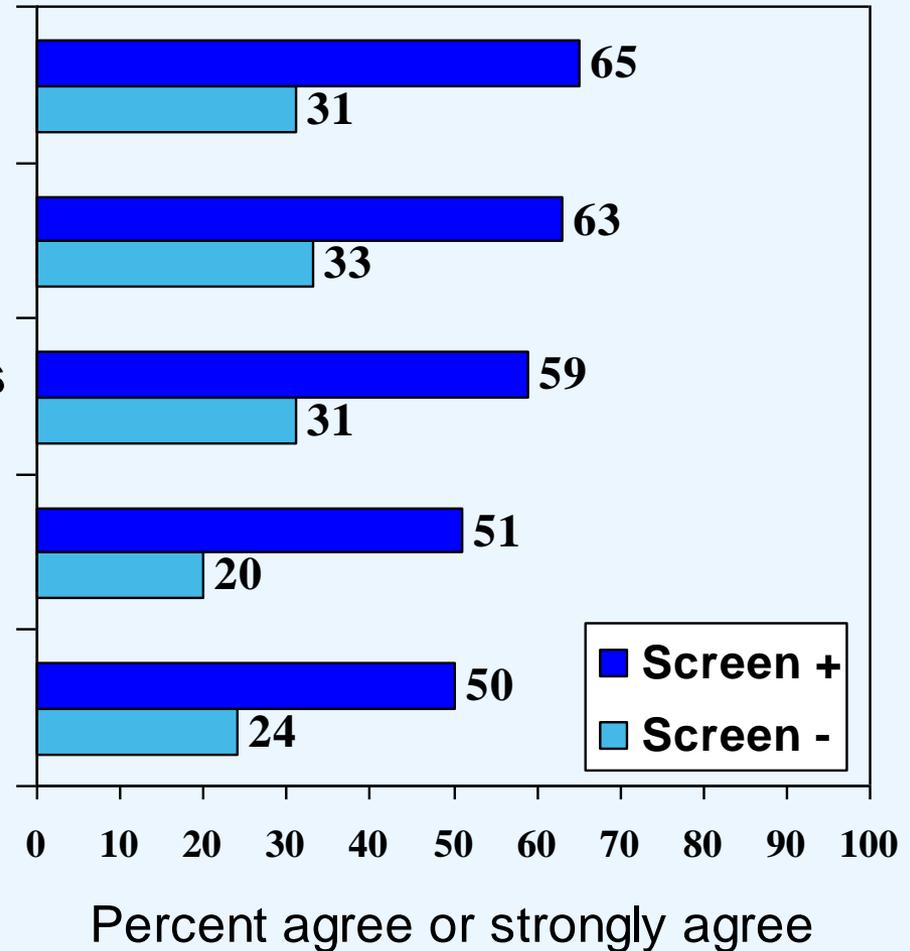
I would be seen as weak.

My unit leadership might treat me differently.

Members of my unit might have less confidence in me.

My leaders would blame me for the problem.

It would harm my career.



*Participants were asked to “rate each of the possible concerns that might affect your decision to receive mental health counseling or services if you ever had a problem”

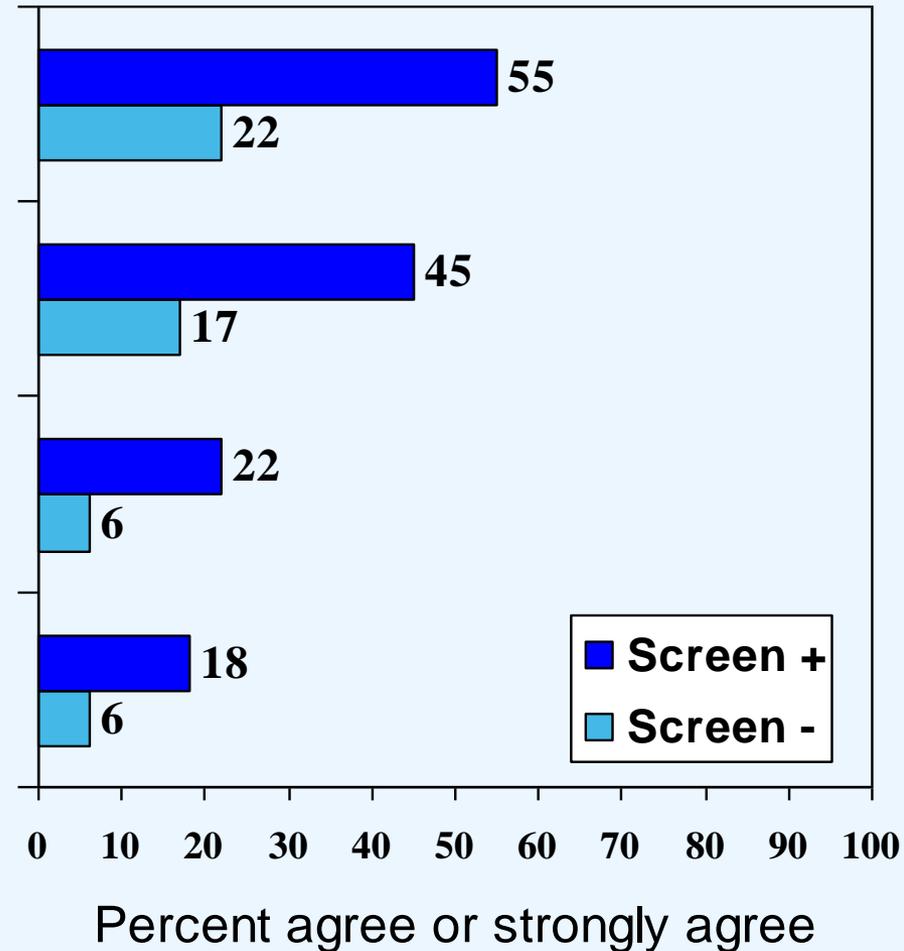
Other Perceived Barriers to Mental Health Care

There would be difficulty getting time off work for treatment.

It is difficult to schedule an appointment.

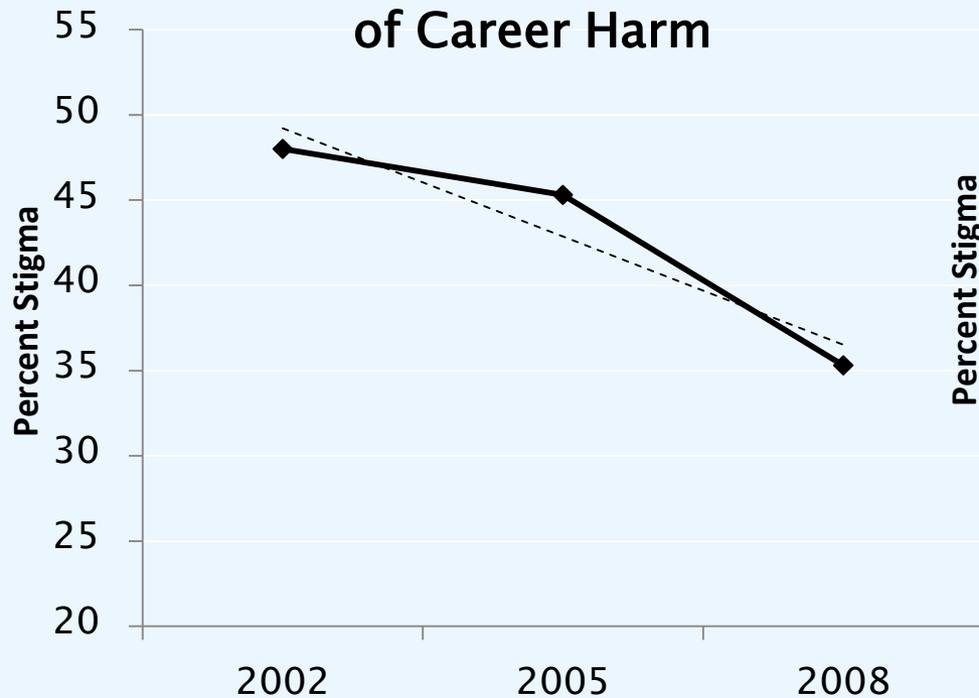
I don't know where to get help.

I don't have adequate transportation.

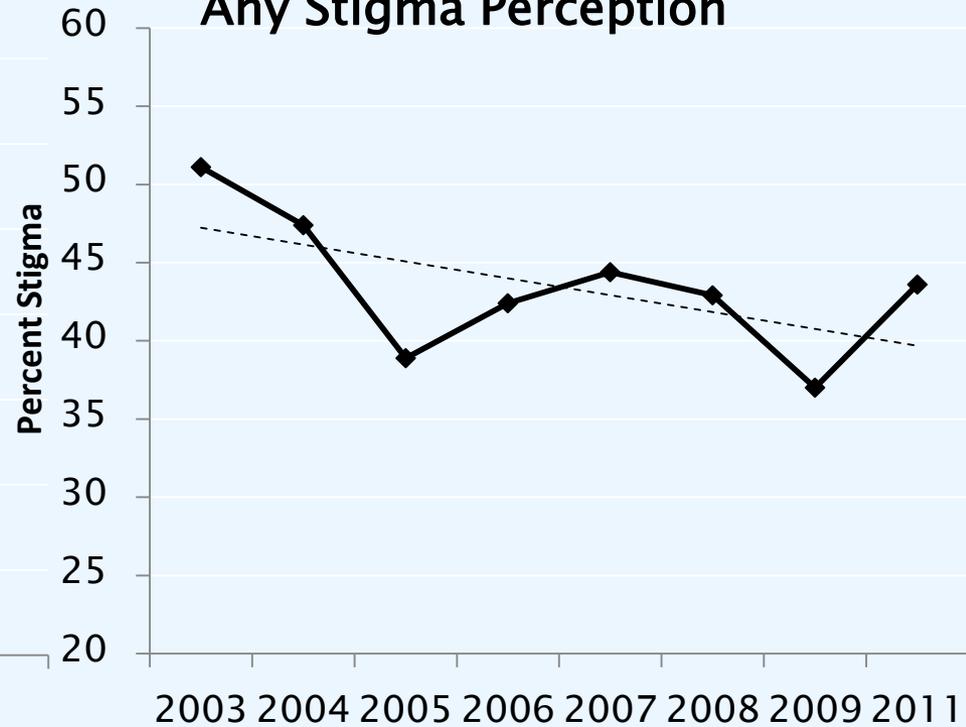


Trends in Stigma Perceptions – U.S. Soldiers

Army-Wide Survey, Perceptions of Career Harm

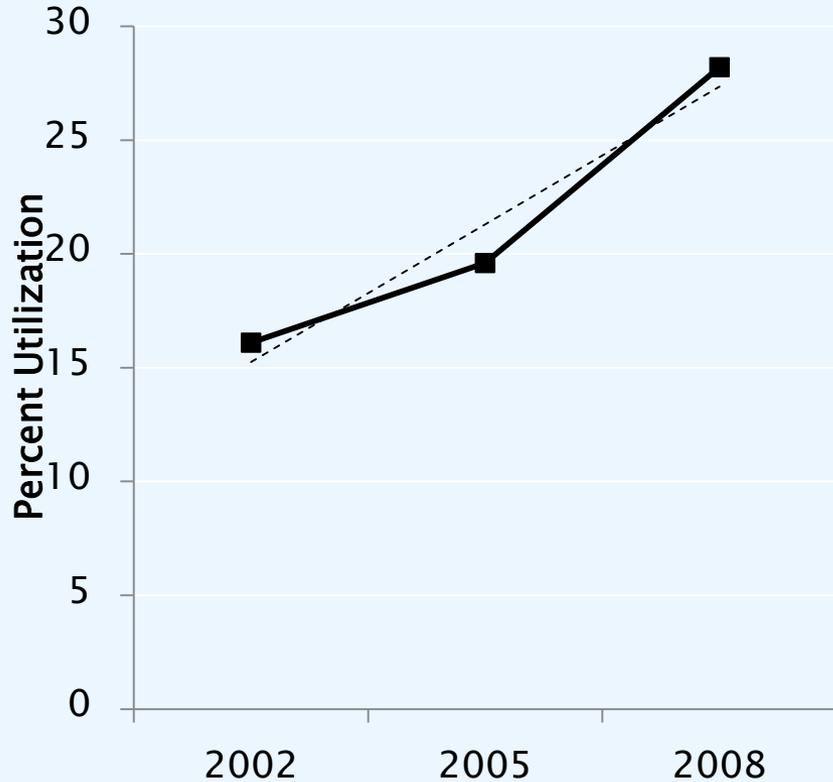


Infantry Samples – Any Stigma Perception

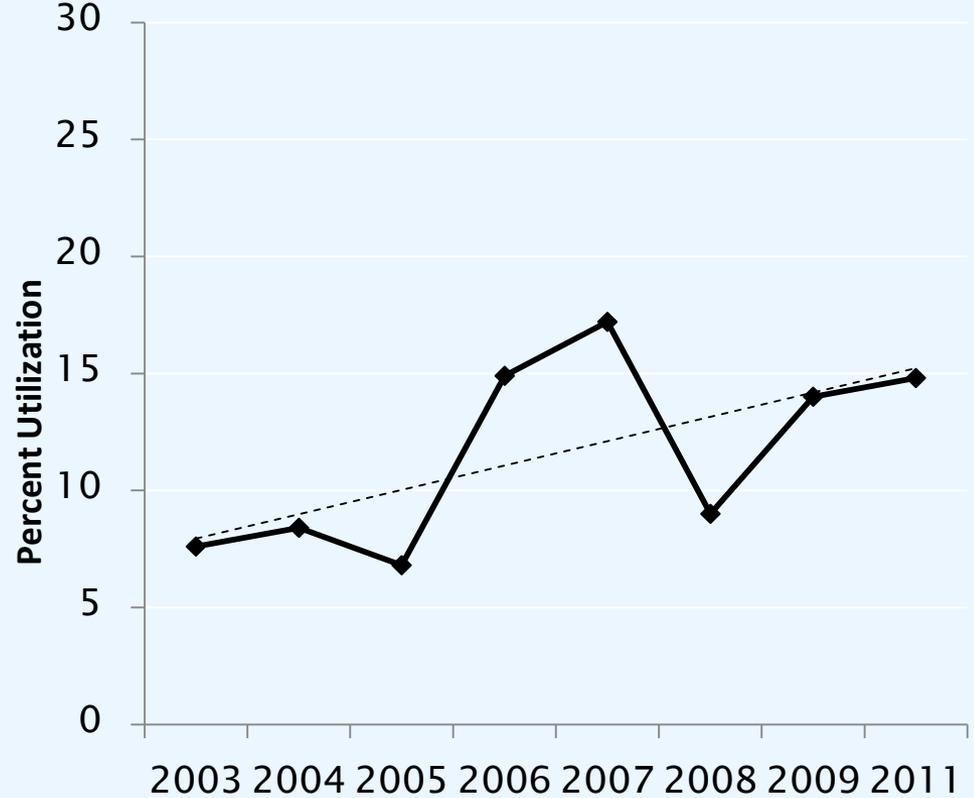


Trends in Utilization of Mental Health Services for U.S. Soldiers

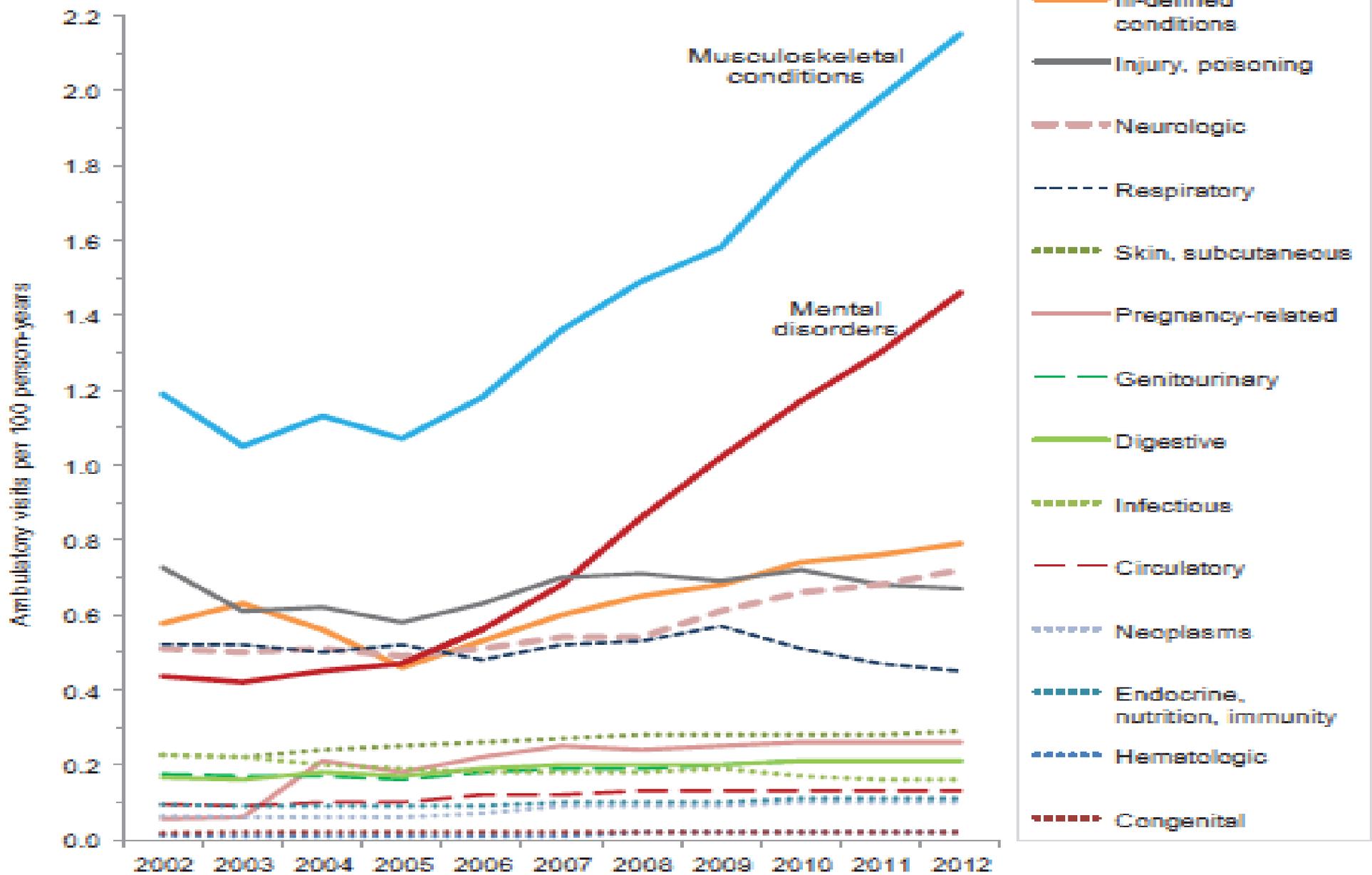
Army-Wide Surveys



Infantry Samples



DoD-Wide Diagnoses



However...

- ▶ $\geq 50\%$ of U.S. and Canadian veterans with deployment-related mental health problems do not receive care.
 - Sareen et al. Arch Gen Psych 2007; Kim PY et al Psych Serv 2010; Schell TL, et al 2008; Lu MW Psych Services 2011; Hoge CW et. al. Psych Serv 2014.)
- ▶ Individuals who start treatment often drop out. Percent who receive “minimally adequate care” ($\geq 4-8$ sessions / 6-12 months) after PTSD diagnosis:
 - VA Health Care Settings: **30-33%** (Schell et al 2010; Lu et al 2011; Spont MR Psych Serv 2010)
 - Army Active Duty: **41-51%** (Hoge et al. Psych Serv 2014)
- ▶ Recovery from PTSD as high as 70-80%, but only in treatment completers; overall recovery averages $\sim 40\%$.
- ▶ Negative attitudes toward care may be more important than stigma in predicting underutilization.
 - Kim PY Mil Psych 2011; Brown MC J Nerv Ment Dis 2011; Pietrzak RH, Psych Serv 2009; Sudom K, et al. Milit Psych 2012

3-Factor Structure for Stigma/Barriers to Care Questions

(From Kim PY, et. al. Military Psychology 2011)

	<i>Stigma</i>	<i>Neg. Att.</i>	<i>Org. Bar.</i>
Stigma; $\alpha = .93$			
It would be too embarrassing	0.65		
It would harm my career	0.75		
Members of my unit might have less confidence in me	0.87		
My unit leadership might treat me differently	0.86		
My leaders would blame me for the problem	0.70		
I would be seen as weak	0.83		
It might affect my security clearance	0.58	0.44	
Negative Beliefs; $\alpha = .83$			
I do not trust mental health professionals		0.52	
My leaders discourage the use of mental health services		0.58	0.44
Psych problems tend to work themselves out without help		0.77	
Getting mental health treatment should be a last resort		0.74	
A fellow Soldier's problems are none of my business		0.62	
I would think less of a team member if I knew he or she was receiving mental health counseling		0.66	
Organizational Barriers; $\alpha = .81$			
Mental health services are not available			0.76
I do not know where to get help			0.76
It is difficult to get an appointment			0.80
There would be difficulty getting time off work for treatment	0.54		0.58

Reasons for Dropping Out of Care for PTSD + Soldiers (N=23)	Number (%)
Felt like you could take care of your problems on your own	15 (65.2)
Did not have sufficient time with the MH professional	14 (60.9)
Too busy with work	12 (52.2)
Stigma (concerned that unit members or leaders might treat you differently or lose confidence in you)	12 (52.2)
Treatment didn't seem to be working	11 (47.8)
Appointments not available or too far apart	11 (47.8)
Worried that the MH treatment would not be kept confidential	11 (47.8)
Didn't feel comfortable with the mental health professional	11 (47.8)
Didn't feel that the MH professional was sufficiently caring	9 (39.1)
Did not like the way the MH professional communicated	9 (39.1)
Felt judged or misunderstood by the MH professional	9 (39.1)
Did not like the treatment option of medication offered	9 (39.1)
Did not feel that the mental health professional was competent	8 (34.8)
Did not like the treatment option of talk therapy offered	7 (30.4)
Mental health professional moved/you PCS'd	4 (17.4)
Transportation not available	2 (8.7)
Got better and didn't need further treatment	2 (8.7)

Clinical Implications

- ▶ A large percent of those in need do not seek care to begin with.
- ▶ Of those who seek care, 30–33% of Veterans and 40–50% of AD Soldiers receive “minimally adequate care.”
- ▶ Dropping out of care is the most important predictor of treatment failure in clinical trials.
- ▶ There are many reasons for drop out.
- ▶ Therefore, the most promising strategies to improve treatment efficacy are those that address engagement, therapeutic rapport, and treatment retention.

Strategies to Consider

▶ Organizational Strategies

- Ensure adequate appointment availability.
- Evaluate how mental health care is structured and marketed.
- Primary care interventions, embedded MH care

▶ Patient–Oriented Strategies

- Motivational interviewing to address perceptions of self–reliance
- Incorporating patient preferences in treatment
- Education to foster hope and positive expectations.

▶ Clinician–Oriented Strategies

- Establish ongoing simple measures of patient feedback
 - Clinician strategies to improve rapport and communication
- Consider occupational perspective in treatment of veterans

* Miller SD et al, J Brief Therapy 2006; Swift et al Profess Psych 2012; Hoge CW et al 2014

Thank you!

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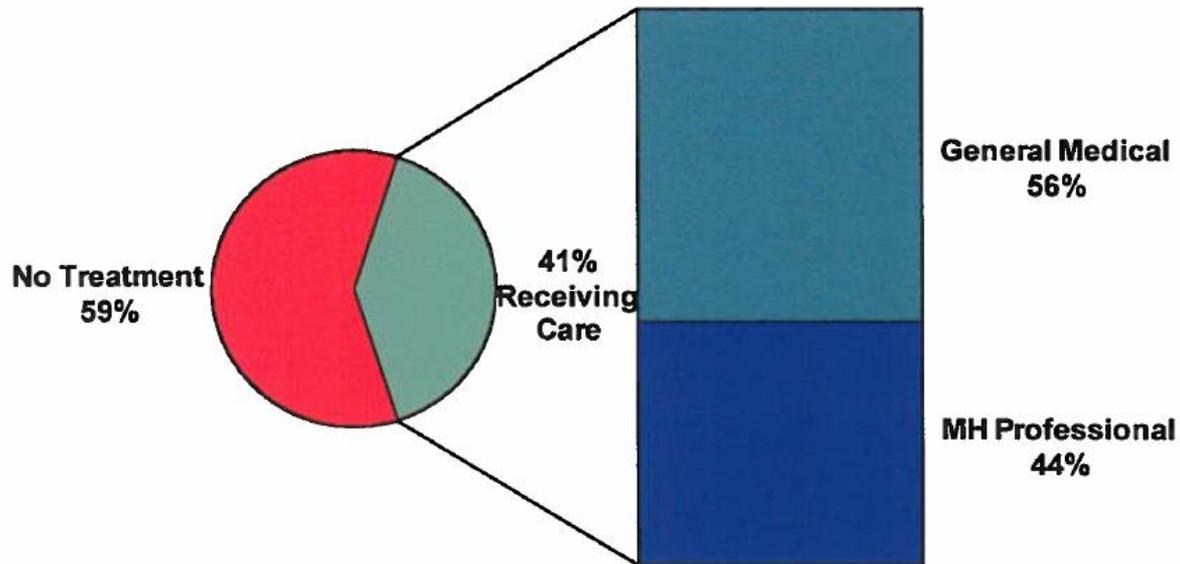
Improving Access to Mental Health Services for Military & Families

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Senior Health Scientist
Behavioral & Policy Science
RAND Corporation



Primary Care is the 'De Facto' Mental Health System

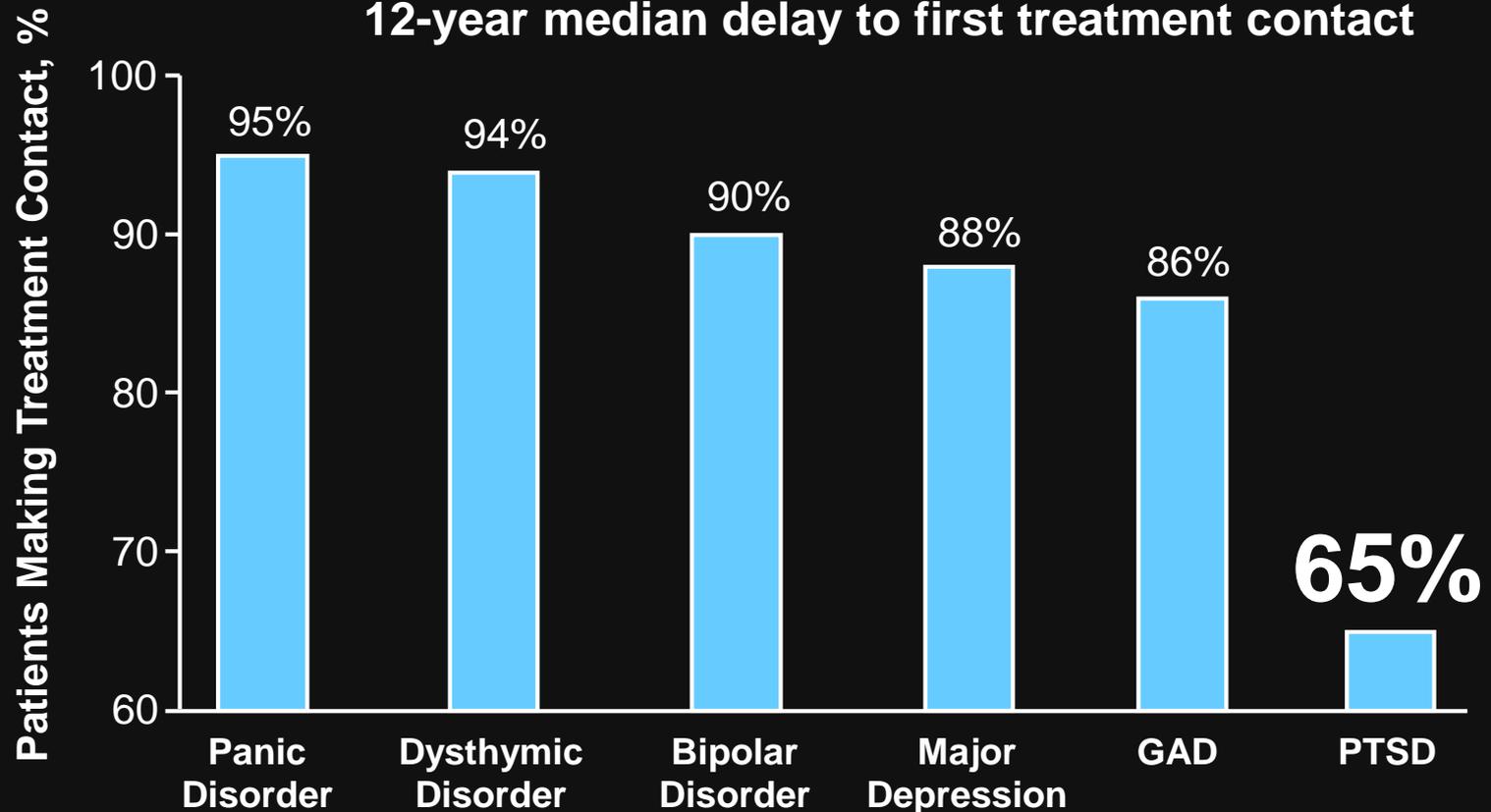


Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Systems & Access for PTSD

Lifetime Probability of Treatment Contact

7% contact within year of PTSD onset and
12-year median delay to first treatment contact



GAD, generalized anxiety disorder.

Wang PS, et al. *Arch Gen Psychiatry*. 2005;62:603-613.

How Can We Improve Service Access?

- Increase the reach of effective treatments
- Intensify efforts to engage those with needs
- Maximize continuity once treatment is initiated

RESPECT-Mil

Re-Engineering Systems of Primary Care Treatment in the Military

Defense Centers of Excellence for Psychological Health & TBI

Office of The Surgeon General, Army

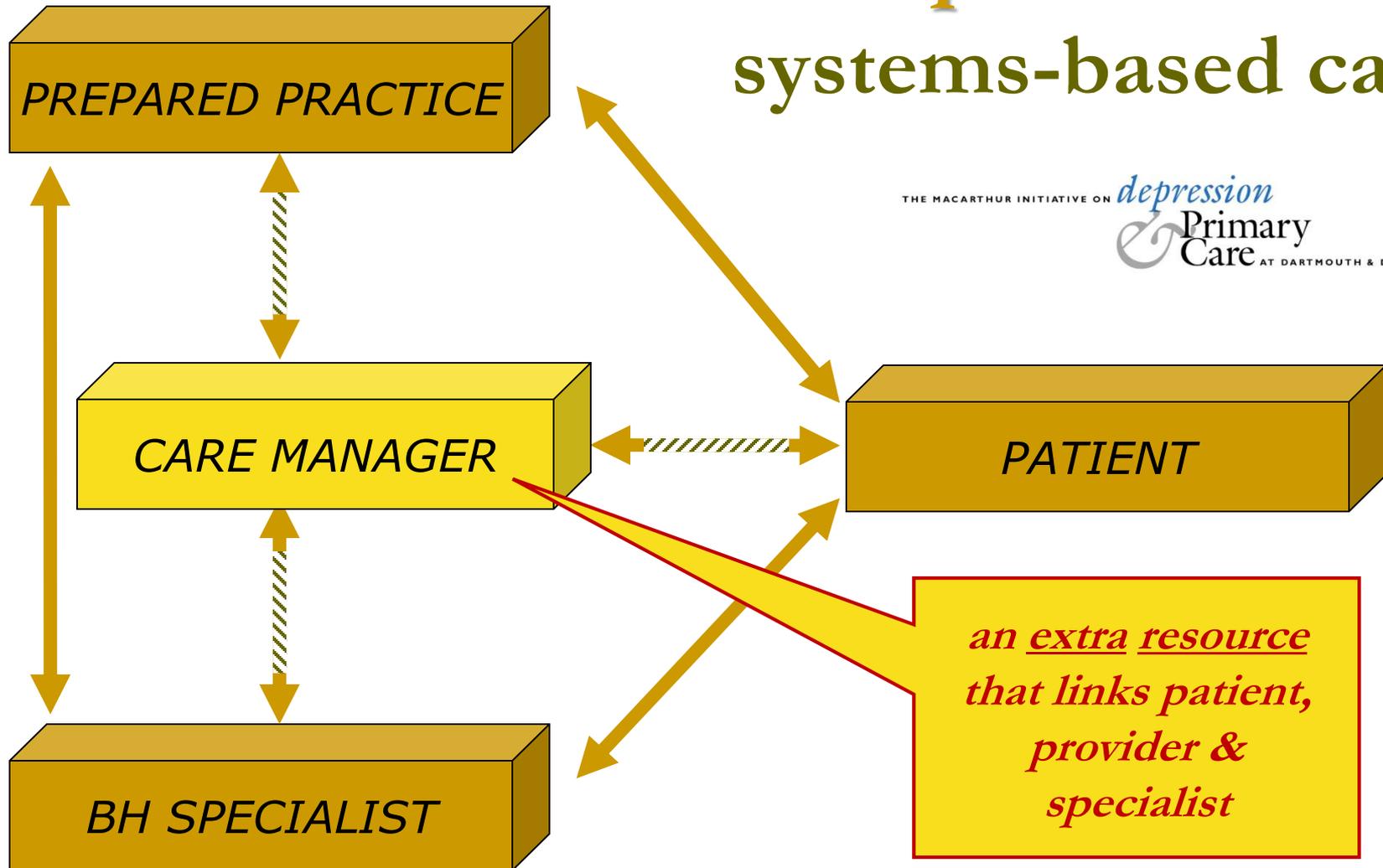
Deployment Health Clinical Center

Uniformed Services University

3CM[®]



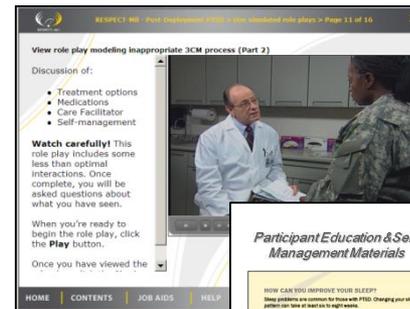
3 Component Model systems-based care



RESPECT-Mil

Evidence-based systems approach to PTSD & depression care

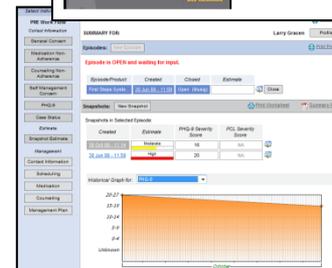
- ★ Codified hardcopy manuals
- ★ Web-based provider training
- ★ Military self-help materials
- ★ PHQ-9 and PTSD Checklist used to monitor outcome
- ★ Uses 'FIRST-STEPS' web registry to track treatment effects in real time
- ★ 97 worldwide Primary Care clinics
- ★ Screening for PTSD and depression rose from 2.5% to 93% of PC visits
- ★ ~3.5M visits screened (2007-2013)



Provider Web Training

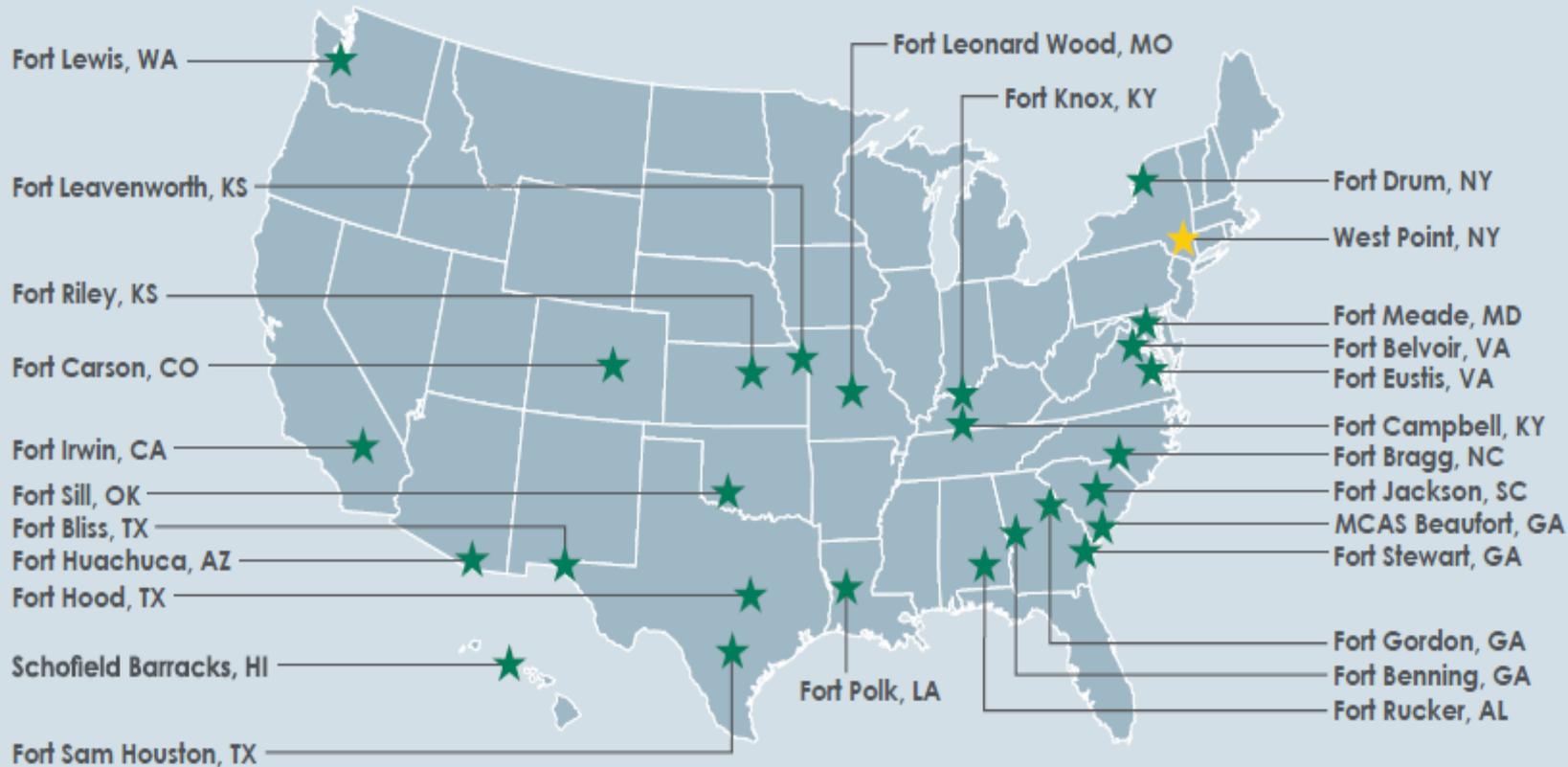


Patient Self-Help materials



Web-Based Care Management Support & Benchmark Metric Reporting

RESPECT-MIL WORLDWIDE SITES



★ Fully Implemented Sites ★ Partially Implemented Sites



STEPS-UP Team



Principal Investigators

Initiating: Michael Freed, PhD (USU / DHCC)

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Partnering: Lisa Jaycox, PhD (RAND Corporation)

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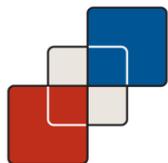
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STEPS UP

Stepped enhancement of
PTSD services using primary care



RESPECT-Mil

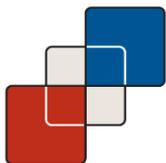
Implementation Approach

- ★ Micro: Clinic level implementation
- ★ Meso: Site level implementation (R-SIT)
- ★ Macro: Program implementation (R-MIT)

Intervention Description

STEPS-UP Adds...

1. Centralized components to maximize model fidelity and scalability and to extend hours and resources for clinics
 - ☆ centralized model implementation and oversight
 - ☆ centralized care management option for mobile patients
 - ☆ centralized phone therapy approach
 - ☆ centralized, weekly psychiatrist case reviews with all nurse care managers
2. Care manager training in engagement to maximize duration and continuity of follow-up
 - ☆ motivational interviewing
 - ☆ behavioral activation
 - ☆ problem solving strategies



STEPS UP

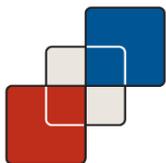
Stepped enhancement of
PTSD services using primary care

Intervention Description

STEPS-UP Adds...

3. Stepped psychosocial treatment options for primary care
 - ☆ web-based, nurse assisted self-administered CBT
 - ☆ phone-based CBT with flexible, modularized delivery sequence
 - ☆ face-to-face brief therapy with a mental health specialist working in primary care

4. Population emphasis bolstered with web-based decision support
 - ☆ produces registries that stratify risk and monitor outcomes
 - ☆ supports timely stepping of care for non-response
 - ☆ reduces time from recognition to first treatment
 - ☆ bolsters treatment duration and continuity



STEPS UP

Stepped enhancement of
PTSD services using primary care

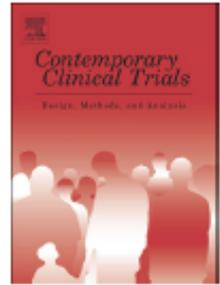
	Usual PC	BHOP	RESPECT-Mil	STEPS-UP
Implementation Approach	provider level	clinic level	installation level	central level
Screening	depression alcohol	depression alcohol	PTSD depression alcohol mania	PTSD depression alcohol mania
Case Management	none	no	local	local central
Stepped Care	no	no	meds	meds therapy
Self Management Support	no	no	no	yes
Patient & Provider Ed	no	yes	yes	yes
Measurement-based Care	no	no	yes	yes
Routine Specialist Case Review	no	no	yes	yes
Embedded Specialist	no	yes	no	yes
IT Support	no	no	clinical	clinical panel



Contents lists available at [ScienceDirect](#)

Contemporary Clinical Trials

journal homepage: www.elsevier.com/locate/conclintrial



Implementing collaborative primary care for depression and posttraumatic stress disorder: Design and sample for a randomized trial in the U.S. military health system [☆]



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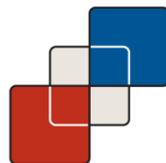
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STEPS UP

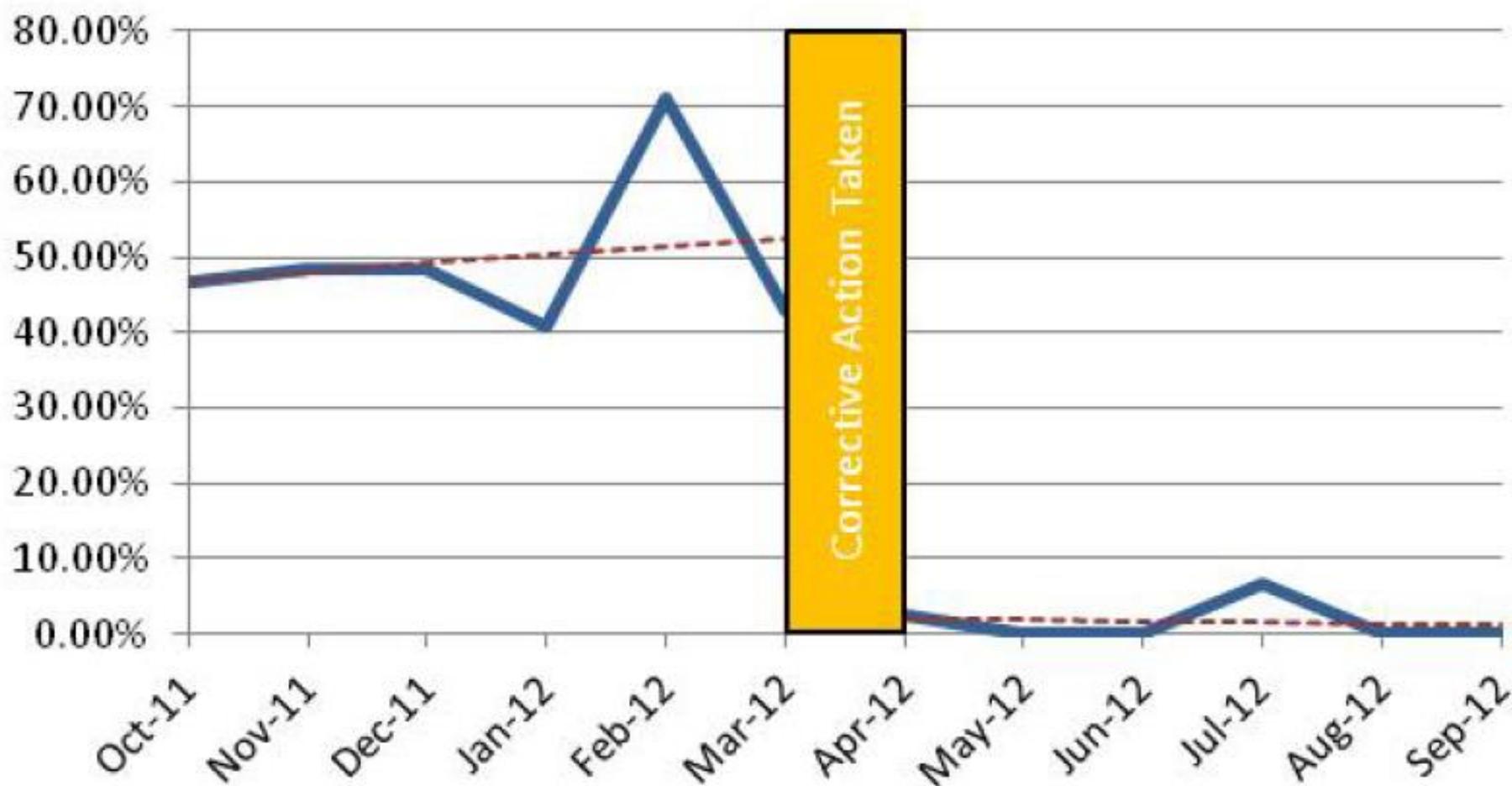
Stepped enhancement of
PTSD services using primary care

Benefits of Central Assistance

Suicide Assessment Monitoring

- ★ Performed semi-annual monthly centralized monitoring of missed primary care suicide assessments by site
- ★ Discovered one high volume installation that performed poorly
- ★ RSIT notification, site visit, command brief
- ★ Increased frequency of monitor to monthly

Missing Suicide Risk Assessment Rate - Ft. BRAVO

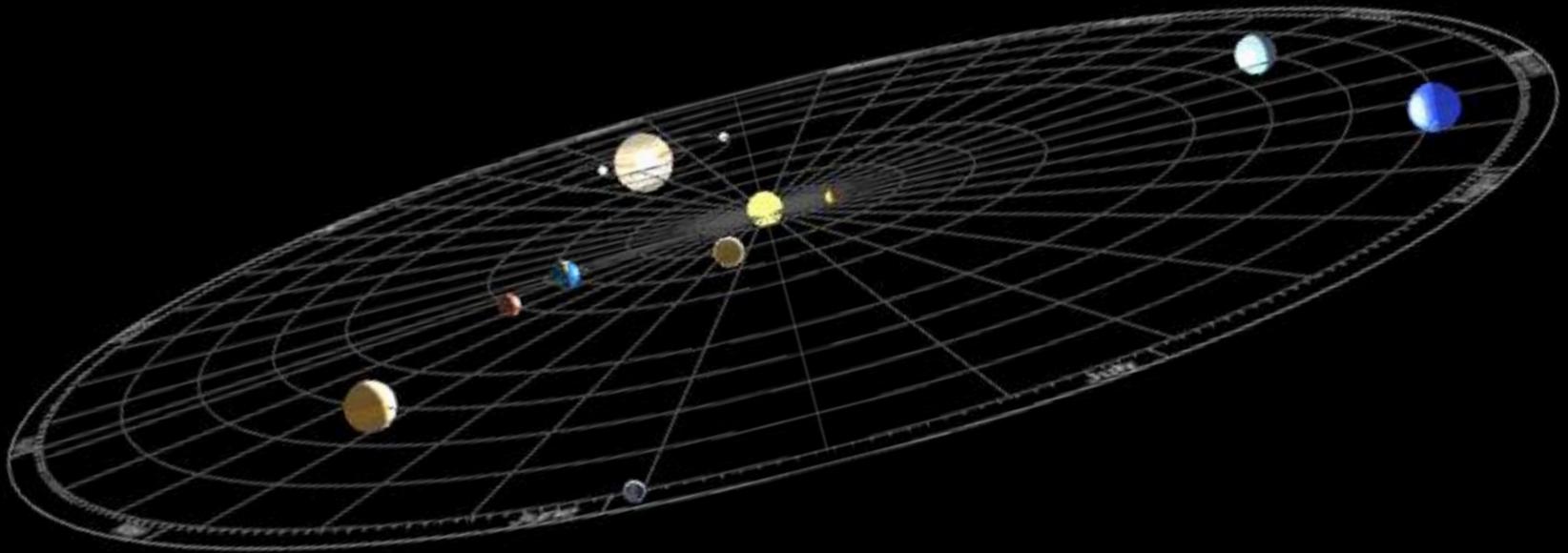


What Have We Learned?

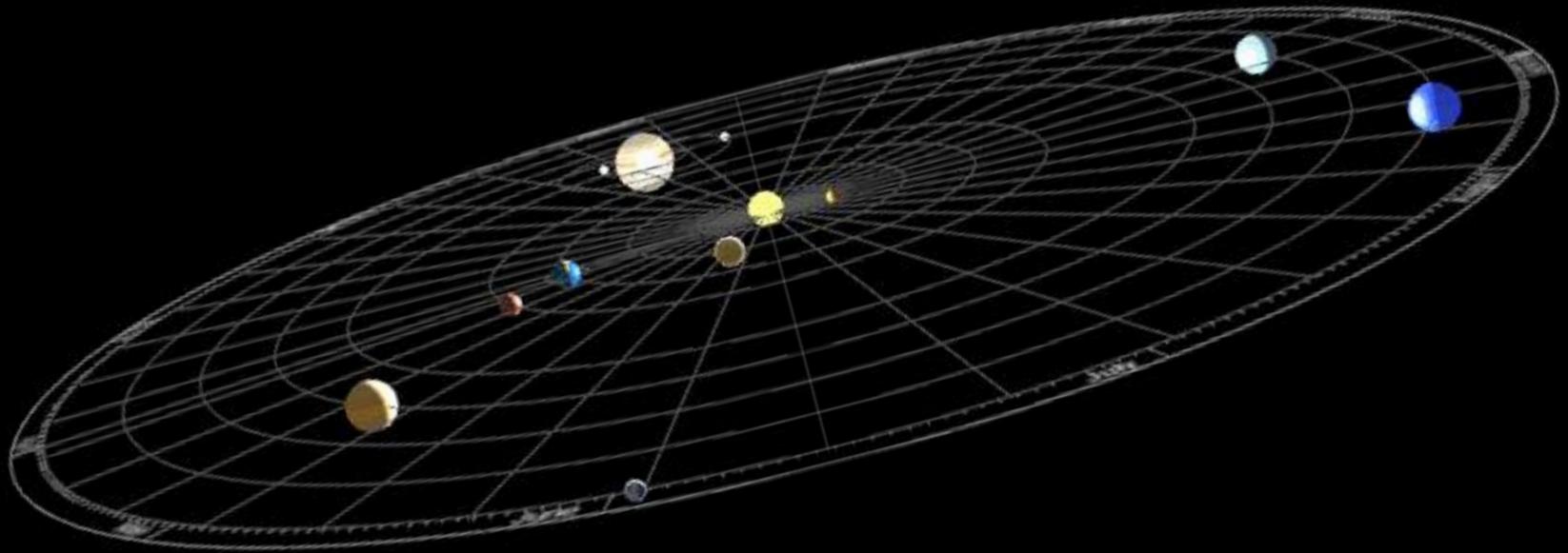
Evidence-based Access for Military & Families

- Screening and specialist co-location neither necessary nor sufficient
- We can improve...
 - access to quality services
 - outcomes of PTSD & depression
- Requires systems emphasis and redesign of care processes

Central Assistance Helps Practices Remain In Orbit



Questions?



Challenges and Opportunities for the Development of the
Behavioral Health Workforce:
The Capacity to Serve Veterans, Service Members, and
Military Families

Allen S. Daniels, Ed.D.

The Need for Mental Health and Substance Use Care

- The current need for behavioral health services (National Survey on Drug Use and Health 2011):
 - Approximately 45.9 million adults aged 18 or older (20% of adults) had any mental illness in the past year.
 - Approximately 11.1 million adults aged 18 or older (4.9% of adults) reported an unmet need for mental health care in the past year.
 - Approximately 21.6 million persons aged 12 or older (8.4%) needed treatment for an illicit drug or alcohol use problem.
- Medical costs for treating patients with chronic medical conditions and comorbid mental health/substance use disorder is 2-3 times higher than those who don't have comorbid conditions (Milliman, 2014).

Three Driving forces for Expanded Coverage of Mental Health and Substance Use Conditions

1. **Mental Health Parity and Addiction Equity Act (2008)**

Removed restrictive barriers to the coverage of mental health and substance use conditions

2. **Patient Protection and Affordable Care Act (2010)**

Expanded health care coverage and standardized benefit requirements – including mental health and substance use conditions

3. **Executive Order – Improving Access to Mental Health Services for Veterans, Service Members, and Military Families (2012)**

Ensuring that all veterans, service members (Active, Guard, and Reserve) and their families receive the mental health care they need

Workforce Issues Challenge the Availability and Quality of Care for Mental Health and Substance Use Conditions

- **Supply** - By 2015, the American Psychiatric Association predicts a shortage of about 22,000 child psychiatrists and 2,900 geriatric psychiatrists
- **Distribution** - 77% of US counties had a severe shortage of prescribers - psychiatrists, and almost 20% have an unmet need for non-prescriber therapists (Hoge et al., 2013)
- **Diversity** - Minorities are under-represented among disciplines with only 6.2% of psychologists, 12.6% of social workers, 5.6% of advanced-practice psychiatric nurses, and 21.3% of psychiatrists (SAMHSA MH-US, 2010). More than 50% of Psychiatrists and Psychologists are > age 50, and > 40% of Social Workers and Counselors are > 40 years of age (BLS/DoL, 2011).
- **Retention** – High turnover rates (between 18% and 40%) exist in the behavioral health workforce (SAMHSA Report to Congress, 2013)

Executive Order (2012) – Guidance for Improving Access to Mental Health Services for Veterans, Service Members, and

Key Priority Areas

Military Families

- Suicide Prevention
- Enhanced Partnerships Between the VA and Community Providers
- Expanded Department of Veterans Affairs Mental Health Services Staffing – including training and hiring 800 Peer Specialist Counselors
- Improved Research and Development (PTSD, TBI, other mental health conditions)
- Military and Veterans Mental Health Interagency Task Force – oversee and track progress, and support evidence based care

Annapolis Coalition's Framework for Improving the Behavioral Health Workforce

The Annapolis Framework

Area	Specific goals
Broadening the concept of "workforce"	<ol style="list-style-type: none">1. Expand the roles of individuals in recovery and their families to actively participate in and influence their own care, provide care and support to others, and educate the workforce2. Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness3. Expand the role and capacity of all health and social service providers, through interprofessional collaboration, to meet the needs of people with mental and substance use conditions
Strengthening the workforce	<ol style="list-style-type: none">4. Implement systematic recruitment and retention strategies at the federal, state, and local levels5. Increase the relevance, effectiveness, and accessibility of training and education6. Foster the development of supervisors and leaders in all sectors of the workforce
Creating structures to support the workforce	<ol style="list-style-type: none">7. Establish financing systems that enable employee compensation commensurate with required education and levels of responsibility8. Build a technical assistance infrastructure that promotes adoption of workforce best practices9. Implement a national research and evaluation program on behavioral health workforce development

Source: Hoge et al., Health Affairs, 2013

Questions?

Thank You!

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FAMILY FOCUSED SYSTEMS OF CARE

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Overview

- Impact of military service, deployment, and trauma on family relationships, emphasizing data from OEF/OIF/OND conflicts
- Family-focused interventions
 - Couples programs
 - Family interventions
- Characteristics of a strong family-focused system of care



When a soldier serves, a family serves

Family Characteristics -- IOM 2013 report

Demographic Characteristic	Active-Duty (percent or number) (N=1,411,425)	Reserve (percent or number) (N=847,934)
Percent married	56.6%	47.7%
Percent in dual-military marriages	6.5% ^a	2.6% ^b
Percent of married members in dual military marriage	11.5%	5.5%
Percent with children (overall)	44.2%	43.3%^d
Percent married to civilian, with children	36.1%	32.5%
Percent dual-military with children	2.8%	1.5%
Percent single with children	5.3%	9.4%
Average number of children of members with children	2.0	2.0
Percent of children ages 0 to 5	42.6%	28.8%

Military Service Can Be Demanding for Families

- Clear benefits *of military service* though it can be demanding for families
- **Deployment** is challenging for families
 - Higher rates of depression, anxiety, and health service use in spouses (Mansfield et al. 2010; SteelFisher et al. 2008)
 - Higher rates of behavioral problems in military children (Cozza et al., 2005; Lincoln et al., 2008; Sheppard et al., 2010); Higher rates of hopelessness, depression and suicidal thoughts in teenagers (Cederbaum et al, 2013)
- Living with someone with **PTSD** can be hard
 - Returning veterans with PTSD show greater levels of family problems (Allen et al., 2010) and intimate partner aggression than those without PTSD (Teten et al., 2010)--bilateral
 - Partners and children evidence more relationship distress and deployment-related psychological problems (Erbes et al, 2011; Gewirtz et al, 2010; Sayers et al, 2009)

Family problems often motivate Veterans to seek treatment

- Although returning Veterans are reluctant to seek mental health treatments (Hoge et al, 2004), family problems often prompt them to seek help (Sayers et al, 2009)
- They often prefer mental health services that include family members when they do seek treatment (Batten et al, 2009; Meis et al, 2012).
- However, individual treatment is the norm for many deployment-related psychological health issues

Examples of Family/Couple interventions

- **Couples treatment for PTSD** (randomized controlled trials (RCTS) by Monson et al, 2012; Sautter et al, in press)—
 - Improves PTSD and relationship problems simultaneously—more efficient than individual tx for PTSD.
- **Several family-based approaches using a resiliency framework** to address deployment stress (e.g. FOCUS, Lester et al, 2012). These programs appear to benefit child and adult participants.

Important points to consider when considering the needs of Military/Veteran families

- Clinical need has often out-paced systematic research; IOM reports cite need for more systematic research on family and couple-based interventions
- Families of origin also are impacted by military service—parents, siblings are underserved
- Military members become civilians—move out of DoD circle of care and there may be limited resources in the community

Characteristics of Strong Family-Focused System of Care

- At a most basic level, routinely conceptualizing individuals as members of a family system
- Screen for military service in self or family members across settings (health facilities, schools, mental health settings, etc.)
- Provide interventions that have the capacity to involve the family, as appropriate—they are effective and efficient
- Incorporate information on the mutual interplay of stressors and strengths among family members
- Have mental health providers who are competent in Military and Veterans' issues and culture

To Learn More

- IOM (Institute of Medicine). 2014. *Preventing psychological disorders in service members and their families: An assessment of programs*. Washington, DC: The National Academies Press.

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Questions?



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Thank You for Joining Us for **Access to Care for Military Veterans and Their Families**

In partnership with the Military Family Research Institute at Purdue University

Upcoming Webinar:

Perspectives on Solving Veteran Homelessness

April 7, 2015, 2:00pm EST

Hosted by the National Association of Veteran-Serving Organizations

Registration: <https://navso.ngpvanhost.com/events/solving-veteran-homelessness>