# Case Presentation Overview

Housing Transitions

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# Overview of CoP Case Presentations

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- One case will be presented from each *site*
  - If there are multiple case managers at your site, we encourage you to present one Veteran case together
- This will provide an opportunity to work through a Veteran case, enhance your use of CTI, get feedback about resources & supports, and help navigating challenges
- We encourage you to pick a Veteran currently on your caseload in months 1-3, *if possible*
  - If you are having trouble identifying a Veteran reach out to us

# CoP Case Presentations

- Link to sign up:

https://appt.link/ht-queri-community-of-practice/CoPCaseConsultationSignUp

- Today we are will demonstrating a mock case presentation:
  - We will showcase information to include in your case presentation and answer any questions
  - A handout with talking points for your case presentation will also be provided via email

# CoP Case Presentations

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- **Information to include in your case presentations:**
  - Demographic information (e.g., age, race and ethnicity, gender)
  - Reason for homelessness/housing instability
  - Health, mental health and substance use concerns
  - Veteran's strengths
  - Existing resources and supports
  - Veteran's goals and progress toward goals
  - Challenges within case management & applying CTI
  - One question or point of feedback from the group

# Case presentation: Example

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# Mock case presentation: Background

- **Demographic information** (age, gender, race & ethnicity, marital status, sexual orientation, current housing situation):
  - Medical, mental health and substance use concerns
  - CTI phase
- **Reason for homelessness/ housing instability:**
- **Existing supports** (financial, family, social):

# Case presentation 1: Background

- **Veteran's strengths**:
- **What is challenging?**
- **What areas do you want feedback on from the group?**

# Case presentation 1: CTI phase & goals

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- **Goals**
  - What are the Veteran's 1-3 goals for current phase?
  - What are action steps for the goals in the current phase?
  - How is goal achievement going?
  - What are facilitators or barriers to the Veteran accomplishing goals for this Phase?
  - What resources and supports linkages are being established to address goal?

# Case presentation 2: Reflection & planning

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- **Planning for the future/upcoming phase?**
  - Thinking ahead, what goals may need to be adjusted or repeated?
  - How are you transferring skills to the Veteran?
  - How are you promoting autonomy and independence in housing?

# Next steps

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- **Next CoP: January 17th, 2024**

  10-11am AKST/ 11am-12pm PST / 12-1pm MST / 1-2pm CST / 2-3pm EST

  - **Case Presentations (2 cases) + 10 minutes of CTI content**

- **(Optional) Drop-in Hour: January 24th, 2024**

  11-12am AKST/ 12am-1pm PST / 1-2pm MST / 2-3pm CST / 3-4pm EST

  - Stop by if you have questions, would like to discuss a case, or have a burning desire to learn more about CTI!

# Veteran Vignette

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***Demographic Information:*** *Mr. Williams is a 72-year-old, Black Vietnam Veteran who moved into his apartment a little over 2 months ago and is about to start Phase 2 of CTI. He became homeless 7 years ago after his wife left him and he lost his job and savings due to his heavy drinking. He was living in several abandoned RVs for 2 years before he entered housing. He lives alone, without a partner. His new apartment is about 45 minutes from the prior area where he was staying in an RV.*

***Existing supports:*** *He receives $1800 a month in service-connected disability and receives assistance with food though it typically is not enough to cover the full month. He has two children that live in a neighboring state that he talks to about once a month. He wants to visit them but does not have enough financial resources to pay for a train or plane ticket. His relationship with them is somewhat strained due to his past behavior when he was heavily drinking – he frequently called asking his children for money and a place to stay, and got angry when they refused.*

# Veteran Vignette

***Challenges:*** *His primary care doctor advised him to monitor his glucose levels at least once per day, but lately he has been misplacing his glucose meter and is only checking about once a week. Mr. Williams no longer drinks as often as he did in the RV, though on two occasions in the last month he consumed 4 drinks and also overspent at the sports bar he frequents on Fridays with his Veteran friends. This left him without enough money for groceries, so he skipped some meals. He is far away from his Vet buddies he used to camp with and wants to get a truck to be able to do that again.*

***Strengths:*** *Mr. Williams is independent and is prefers to do things on his own without assistance. He is very handy – can fix things around his home for the most part and enjoys working with his hands. He enjoys socializing with other Veterans and makes friends easy, spending time in nature, and watching basketball.*

***Area of feedback:*** *Since we are about to meet to discuss goals for Phase 2 I'd love to get feedback on how goals may be adjusted given that, for the most part, he has been achieving his goals, though there has been some slips. I am anticipating he will not think these slips are a big deal. I want to hel him develop a system for remembering to test his glucose and I would like to introduce him to the VA's harm reduction groups.*

# Veteran Vignette

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***Goal1:*** *In Phase 1, Mr. Williams identified two broad recovery goals: 1) "Get his diabetes under control" and 2) "Stop drinking so much." His smart goal for Phase 1 related to managing diabetes was "Establish a primary care doctor at the VA closet to his new apartment and attend 1 appointment to identify at least 2 steps he can take toward managing his glucose levels. He needed to establish a new primary care doctor closer to his apartment so I connected him to Homeless Patient Aligned Care Team (HPACT) at the local VA and he was assigned a primary care doctor that he is satisfied with. Took the bus route with him to and from his first appointment and made sure he knew how to get there/ liked his PC doctor. He had a follow-up appointment that he missed so after that I showed him how to document his appointments in his phone, and we've written down how to contact the VA if he is unsure of when his next appointment is.*

*His doctor recommended using a glucose monitor and to walk or exercise for 20 minutes a day, and eating 3 balanced meals with a small snack between meals.*

# Veteran Vignette

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***Goal 2:*** *Mr. Williams is not ready to quit drinking completely, though he is interested in reducing how much he drinks. We worked on some harm reduction around his drinking. His smart goal for Phase 1 related to his drinking was to drink alcoholic beverages 1-2 days per week consuming no more than 3 drinks across a 4 hour period each day. He agreed to drink only when he is watching basketball at the local tavern which he does with a few Veteran buddies a few nights a week. So he is not drinking in his home or alone, since bringing alcohol home leads to more binge drinking and he has fallen several times at home while drunk.*

*He agreed to explore the idea of a harm reduction program in Phase 2, but wanted to test it out on his own first.*