Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2007 Survey Results Summary

VISN 22

Site: VA Greater Los Angeles HCS (VAOPC Los Angeles - 691GE and VAMC Sepulveda - 691A4 and VAMC West Los Angeles - 691)

Note: CHALENG data is collected from two surveys. The CHALENG Point of Contact (POC) Survey is a self-administered questionnaire completed by the local VA homeless veteran coordinator. The CHALENG Participant Survey is completed by federal, state, county, city, non-profit and for-profit agency representatives, as well as local VA staff and homeless veterans themselves. Data was collected in the summer/fall of 2007.

A. Homeless Veteran Estimates (CHALENG Point of Contact Survey):

1. Estimated Number of Homeless Veterans: 13,927

2. Estimated Number of Veterans who are Chronically Homeless: 3,573

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions (Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf).

We used the following formula to obtain this number:

> Estimated number of homeless veterans in service area **x chronically homeless rate:** percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder). (Note: # of homeless veterans in the service area comes from 2007 CHALENG POC survey. "Chronically homeless rate" comes from FY 2007 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. [Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.])

Our estimate is conservative. It DOES NOT also include veterans who do not have a substance abuse/mental health disorder but do have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Families, Housing, and Action Plans (CHALENG Point of Contact Survey)

1. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2007 by local VA homeless program: 78

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	1,000	500
Transitional Housing Beds	1,200	100
Permanent Housing Beds	150	1,500

***These are the number of beds that veterans can access, including both veteran-specific and non-veteran specific.**

3. CHALENG Point of Contact Action Plan for FY 2008*

Long-term, permanent housing	Anticipating increase in our HUD-VA Supported Housing Program which case manages veterans in independent housing.
Services for emotional or psychiatric problems	Our domiciliary has hired two psychiatrists which will oversee an expanded and more structured program for veterans with mental health issues. New Directions, Inc. is opening up a new residential program targeting OIF/OEF veterans.
Job training	Continue to utilize our expanding VA Supported Employment and Compensated Work Therapy Programs.

***The Action Plan outlines proposed strategies the local VA program and its community partners will use to address its priority needs in FY 2008.**

C. Data from the CHALENG Participant Survey

Number of Total Participant Surveys: **219**
Percentage of Participant Surveys from Homeless Veterans: **85%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	% want to work on this need now*	VHA Mean Score (nationwide)**
Personal hygiene	3.95	4%	3.42
Food	4.11	9%	3.73
Clothing	3.69	7%	3.59
Emergency (immediate) shelter	3.98	9%	3.25
Halfway house or transitional living facility	3.84	14%	3.02
Long-term, permanent housing	2.81	56%	2.46
Detoxification from substances	3.81	3%	3.32
Treatment for substance abuse	3.96	8%	3.50
Services for emotional or psychiatric problems	3.68	7%	3.43
Treatment for dual diagnosis	3.47	4%	3.25
Family counseling	3.06	2%	2.98
Medical services	4.03	9%	3.76
Women's health care	3.11	3%	3.25
Help with medication	3.77	2%	3.44
Drop-in center or day program	3.31	2%	2.98
AIDS/HIV testing/counseling	3.80	1%	3.50
TB testing	4.38	1%	3.68
TB treatment	3.76	1%	3.54
Hepatitis C testing	3.89	1%	3.60
Dental care	3.23	27%	2.64
Eye care	3.41	8%	2.93
Glasses	3.40	7%	2.92
VA disability/pension	3.12	14%	3.38
Welfare payments	3.07	1%	3.05
SSI/SSD process	3.12	4%	3.07
Guardianship (financial)	2.93	0%	2.83
Help managing money	3.62	7%	2.86
Job training	3.26	12%	3.09
Help with finding a job or getting employment	3.60	23%	3.20
Help getting needed documents or identification	3.79	1%	3.28
Help with transportation	3.73	14%	3.01
Education	3.48	10%	3.05
Child care	2.51	3%	2.47
Legal assistance	3.40	12%	2.78
Discharge upgrade	3.10	4%	3.01
Spiritual	3.61	9%	3.37
Re-entry services for incarcerated veterans	3.15	4%	2.71
Elder Healthcare	3.02	2%	3.07

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=9,132).**

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.10	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.45	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.43	1.86
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.00	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.88	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.93	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.38	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.64	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.17	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.85	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.80	1.62
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.88	1.83

***Scores of non-VA community agency representatives only. **VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

3. VA/Community Integration*

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score**	**VHA (nationwide) Mean Score****
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.66	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.83	3.58

***Scores of non-VA community agency representatives only.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

4. Existing Agreements with Community Service Types:

Service Types	**VA has existing collaborative agreement with agencies?**
Correctional Facilities (Jails, prisons, courts)	Yes
Psychiatric/substance abuse inpatient (hospitals, wards	No
Nursing homes	Yes
Faith-based organizations	Yes

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2007 Survey Results Summary

VISN 22

Site: VA Southern Nevada HCS - 593

Note: CHALENG data is collected from two surveys. The CHALENG Point of Contact (POC) Survey is a self-administered questionnaire completed by the local VA homeless veteran coordinator. The CHALENG Participant Survey is completed by federal, state, county, city, non-profit and for-profit agency representatives, as well as local VA staff and homeless veterans themselves. Data was collected in the summer/fall of 2007.

A. Homeless Veteran Estimates (CHALENG Point of Contact Survey):

1. Estimated Number of Homeless Veterans: 2,854

2. Estimated Number of Veterans who are Chronically Homeless: 640

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions (Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf).

We used the following formula to obtain this number:

> Estimated number of homeless veterans in service area **x chronically homeless rate:** percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder). (Note: # of homeless veterans in the service area comes from 2007 CHALENG POC survey. "Chronically homeless rate" comes from FY 2007 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. [Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.])

Our estimate is conservative. It DOES NOT also include veterans who do not have a substance abuse/mental health disorder but do have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Families, Housing, and Action Plans (CHALENG Point of Contact Survey)

1. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2007 by local VA homeless program: 12

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	23	300
Transitional Housing Beds	268	200
Permanent Housing Beds	257	150

***These are the number of beds that veterans can access, including both veteran-specific and non-veteran specific.**

3. CHALENG Point of Contact Action Plan for FY 2008*

Drop-in center or day program	There is a plan to develop a drop-in center/service center. VA Quality Management reports there are a large number of homeless veterans with mental health problems, because of issues related to lack of housing.
Long-term, permanent housing	VA needs to develop programs for veterans who are on fixed income and/or are not chronically mentally ill. Nevada has developed a highly successful "Housing First" program.
Treatment for dual diagnosis	Development of service contract with WestCare to provide intense treatment for dually-diagnosed veterans (men and women).

***The Action Plan outlines proposed strategies the local VA program and its community partners will use to address its priority needs in FY 2008.**

C. Data from the CHALENG Participant Survey

Number of Total Participant Surveys: **243**
Percentage of Participant Surveys from Homeless Veterans: **73%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	% want to work on this need now*	VHA Mean Score (nationwide)**
Personal hygiene	3.40	2%	3.42
Food	3.39	18%	3.73
Clothing	3.21	11%	3.59
Emergency (immediate) shelter	3.09	23%	3.25
Halfway house or transitional living facility	3.38	11%	3.02
Long-term, permanent housing	2.52	41%	2.46
Detoxification from substances	3.23	3%	3.32
Treatment for substance abuse	3.39	9%	3.50
Services for emotional or psychiatric problems	3.35	6%	3.43
Treatment for dual diagnosis	3.14	1%	3.25
Family counseling	2.95	2%	2.98
Medical services	3.74	13%	3.76
Women's health care	2.95	10%	3.25
Help with medication	3.56	3%	3.44
Drop-in center or day program	2.69	11%	2.98
AIDS/HIV testing/counseling	3.38	1%	3.50
TB testing	4.00	1%	3.68
TB treatment	3.58	0%	3.54
Hepatitis C testing	3.52	1%	3.60
Dental care	2.86	25%	2.64
Eye care	3.02	9%	2.93
Glasses	2.93	10%	2.92
VA disability/pension	3.18	12%	3.38
Welfare payments	2.93	1%	3.05
SSI/SSD process	3.11	5%	3.07
Guardianship (financial)	2.91	1%	2.83
Help managing money	3.14	1%	2.86
Job training	2.94	11%	3.09
Help with finding a job or getting employment	3.07	10%	3.20
Help getting needed documents or identification	3.37	2%	3.28
Help with transportation	3.32	14%	3.01
Education	3.10	11%	3.05
Child care	2.53	1%	2.47
Legal assistance	2.70	9%	2.78
Discharge upgrade	2.82	2%	3.01
Spiritual	3.15	3%	3.37
Re-entry services for incarcerated veterans	2.70	3%	2.71
Elder Healthcare	2.82	5%	3.07

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=9,132).**

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.75	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.95	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.23	1.86
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.48	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.05	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.03	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.13	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.38	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.20	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.98	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.02	1.62
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.15	1.83

***Scores of non-VA community agency representatives only. **VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

3. VA/Community Integration*

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score**	**VHA (nationwide) Mean Score****
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.41	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.51	3.58

***Scores of non-VA community agency representatives only.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

4. Existing Agreements with Community Service Types:

Service Types	**VA has existing collaborative agreement with agencies?**
Correctional Facilities (Jails, prisons, courts)	No
Psychiatric/substance abuse inpatient (hospitals, wards	Yes
Nursing homes	Yes
Faith-based organizations	Yes

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2007 Survey Results Summary

VISN 22

Site: VAMC Loma Linda, CA - 605

Note: CHALENG data is collected from two surveys. The CHALENG Point of Contact (POC) Survey is a self-administered questionnaire completed by the local VA homeless veteran coordinator. The CHALENG Participant Survey is completed by federal, state, county, city, non-profit and for-profit agency representatives, as well as local VA staff and homeless veterans themselves. Data was collected in the summer/fall of 2007.

A. Homeless Veteran Estimates (CHALENG Point of Contact Survey):

1. Estimated Number of Homeless Veterans: 1,360

2. Estimated Number of Veterans who are Chronically Homeless: 595

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions (Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf).

We used the following formula to obtain this number:

> Estimated number of homeless veterans in service area **x chronically homeless rate:** percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder). (Note: # of homeless veterans in the service area comes from 2007 CHALENG POC survey. "Chronically homeless rate" comes from FY 2007 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. [Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.])

Our estimate is conservative. It DOES NOT also include veterans who do not have a substance abuse/mental health disorder but do have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Families, Housing, and Action Plans (CHALENG Point of Contact Survey)

1. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2007 by local VA homeless program: 23

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	40	500
Transitional Housing Beds	176	300
Permanent Housing Beds	25	500

***These are the number of beds that veterans can access, including both veteran-specific and non-veteran specific.**

3. CHALENG Point of Contact Action Plan for FY 2008*

Long-term, permanent housing	We will continue to work with San Bernardino and Riverside counties. This has been an ongoing need for year. Our VA Supported Housing Program lost ten Section 8 vouchers which hasn't helped.
VA disability/pension	We are asking the VA Regional Office to send a staff one day a week to initiate claims and answer questions.
Help with finding a job or getting employment	There has been a decrease in the number of positions available through our Compensated Work Therapy Program. We will look into other resources.

***The Action Plan outlines proposed strategies the local VA program and its community partners will use to address its priority needs in FY 2008.**

C. Data from the CHALENG Participant Survey

Number of Total Participant Surveys: **30**
Percentage of Participant Surveys from Homeless Veterans: **84%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	% want to work on this need now*	VHA Mean Score (nationwide)**
Personal hygiene	3.34	0%	3.42
Food	3.70	8%	3.73
Clothing	3.44	0%	3.59
Emergency (immediate) shelter	2.97	24%	3.25
Halfway house or transitional living facility	3.54	16%	3.02
Long-term, permanent housing	2.93	54%	2.46
Detoxification from substances	4.04	4%	3.32
Treatment for substance abuse	4.30	24%	3.50
Services for emotional or psychiatric problems	4.07	4%	3.43
Treatment for dual diagnosis	3.33	0%	3.25
Family counseling	3.25	4%	2.98
Medical services	4.23	12%	3.76
Women's health care	3.04	4%	3.25
Help with medication	3.93	0%	3.44
Drop-in center or day program	3.11	0%	2.98
AIDS/HIV testing/counseling	4.00	0%	3.50
TB testing	4.50	0%	3.68
TB treatment	3.61	0%	3.54
Hepatitis C testing	4.37	0%	3.60
Dental care	2.50	16%	2.64
Eye care	3.07	16%	2.93
Glasses	3.07	16%	2.92
VA disability/pension	2.89	28%	3.38
Welfare payments	2.68	0%	3.05
SSI/SSD process	2.82	8%	3.07
Guardianship (financial)	2.62	0%	2.83
Help managing money	2.93	8%	2.86
Job training	2.87	12%	3.09
Help with finding a job or getting employment	3.34	28%	3.20
Help getting needed documents or identification	3.68	0%	3.28
Help with transportation	3.33	0%	3.01
Education	3.10	0%	3.05
Child care	2.29	0%	2.47
Legal assistance	2.83	8%	2.78
Discharge upgrade	2.63	8%	3.01
Spiritual	3.77	0%	3.37
Re-entry services for incarcerated veterans	2.96	0%	2.71
Elder Healthcare	3.04	4%	3.07

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=9,132).**

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.80	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.80	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00	1.86
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.60	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.20	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.40	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.40	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.60	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00	1.62
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.00	1.83

***Scores of non-VA community agency representatives only. **VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

3. VA/Community Integration*

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score**	**VHA (nationwide) Mean Score****
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.17	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.33	3.58

***Scores of non-VA community agency representatives only.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

4. Existing Agreements with Community Service Types:

Service Types	**VA has existing collaborative agreement with agencies?**
Correctional Facilities (Jails, prisons, courts)	Yes
Psychiatric/substance abuse inpatient (hospitals, wards	Yes
Nursing homes	No
Faith-based organizations	Yes

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2007 Survey Results Summary

VISN 22

Site: VAMC Long Beach, CA - 600 (Note: Long Beach estimates reported with VA Greater Los Angeles)

Note: CHALENG data is collected from two surveys. The CHALENG Point of Contact (POC) Survey is a self-administered questionnaire completed by the local VA homeless veteran coordinator. The CHALENG Participant Survey is completed by federal, state, county, city, non-profit and for-profit agency representatives, as well as local VA staff and homeless veterans themselves. Data was collected in the summer/fall of 2007.

A. Homeless Veteran Estimates (CHALENG Point of Contact Survey):

1. Estimated Number of Homeless Veterans: *13927

2. Estimated Number of Veterans who are Chronically Homeless: 0

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions (Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf).

We used the following formula to obtain this number:

> Estimated number of homeless veterans in service area **x chronically homeless rate:** percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder). (Note: # of homeless veterans in the service area comes from 2007 CHALENG POC survey. "Chronically homeless rate" comes from FY 2007 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. [Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.])

Our estimate is conservative. It DOES NOT also include veterans who do not have a substance abuse/mental health disorder but do have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Families, Housing, and Action Plans (CHALENG Point of Contact Survey)

1. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2007 by local VA homeless program: 2

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	700	100
Transitional Housing Beds	1,032	35
Permanent Housing Beds	550	100

***These are the number of beds that veterans can access, including both veteran-specific and non-veteran specific.**

3. CHALENG Point of Contact Action Plan for FY 2008*

Long-term, permanent housing	Work/support local community partners' development of long-term housing. Help veterans apply for and obtain fixed-income resources to pay for rent.
Dental Care	Encourage/solicit applications for dental care by veterans who have completed 60 days of VA Grant and Per Diem program treatment.
Emergency (immediate) shelter	1. Support emergency shelter development through partnerships with local coalitions. Plan is to increase cold weather and rainy-day shelter beds. 2. Support development of a new homeless coalition in Orange County.

***The Action Plan outlines proposed strategies the local VA program and its community partners will use to address its priority needs in FY 2008.**

C. Data from the CHALENG Participant Survey

Number of Total Participant Surveys: **68**
Percentage of Participant Surveys from Homeless Veterans: **45%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	% want to work on this need now*	VHA Mean Score (nationwide)**
Personal hygiene	3.33	10%	3.42
Food	3.75	16%	3.73
Clothing	3.63	7%	3.59
Emergency (immediate) shelter	3.07	31%	3.25
Halfway house or transitional living facility	3.00	17%	3.02
Long-term, permanent housing	2.57	47%	2.46
Detoxification from substances	3.50	5%	3.32
Treatment for substance abuse	3.77	9%	3.50
Services for emotional or psychiatric problems	3.64	14%	3.43
Treatment for dual diagnosis	3.57	9%	3.25
Family counseling	3.13	0%	2.98
Medical services	3.91	5%	3.76
Women's health care	3.48	2%	3.25
Help with medication	3.67	2%	3.44
Drop-in center or day program	3.33	5%	2.98
AIDS/HIV testing/counseling	3.66	0%	3.50
TB testing	3.97	0%	3.68
TB treatment	3.61	0%	3.54
Hepatitis C testing	3.78	0%	3.60
Dental care	2.69	34%	2.64
Eye care	2.80	7%	2.93
Glasses	2.84	9%	2.92
VA disability/pension	3.08	12%	3.38
Welfare payments	3.14	0%	3.05
SSI/SSD process	3.13	10%	3.07
Guardianship (financial)	2.89	3%	2.83
Help managing money	2.86	2%	2.86
Job training	3.28	5%	3.09
Help with finding a job or getting employment	3.48	10%	3.20
Help getting needed documents or identification	3.29	0%	3.28
Help with transportation	3.33	7%	3.01
Education	3.22	3%	3.05
Child care	2.81	3%	2.47
Legal assistance	3.09	5%	2.78
Discharge upgrade	3.21	2%	3.01
Spiritual	3.54	0%	3.37
Re-entry services for incarcerated veterans	3.02	2%	2.71
Elder Healthcare	3.25	3%	3.07

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=9,132).**

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.70	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.46	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.27	1.86
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.22	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.63	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.85	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.07	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.19	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.07	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.58	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.76	1.62
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.92	1.83

***Scores of non-VA community agency representatives only. **VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

3. VA/Community Integration*

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score**	**VHA (nationwide) Mean Score****
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.38	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.72	3.58

***Scores of non-VA community agency representatives only.**
****VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

4. Existing Agreements with Community Service Types:

Service Types	**VA has existing collaborative agreement with agencies?**
Correctional Facilities (Jails, prisons, courts)	Yes
Psychiatric/substance abuse inpatient (hospitals, wards	Yes
Nursing homes	No
Faith-based organizations	Yes

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2007 Survey Results Summary

VISN 22

Site: VAMC San Diego, CA - 664

Note: CHALENG data is collected from two surveys. The CHALENG Point of Contact (POC) Survey is a self-administered questionnaire completed by the local VA homeless veteran coordinator. The CHALENG Participant Survey is completed by federal, state, county, city, non-profit and for-profit agency representatives, as well as local VA staff and homeless veterans themselves. Data was collected in the summer/fall of 2007.

A. Homeless Veteran Estimates (CHALENG Point of Contact Survey):

1. Estimated Number of Homeless Veterans: 1,438

2. Estimated Number of Veterans who are Chronically Homeless: 754

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions (Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf).

We used the following formula to obtain this number:

> Estimated number of homeless veterans in service area **x chronically homeless rate:** percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder). (Note: # of homeless veterans in the service area comes from 2007 CHALENG POC survey. "Chronically homeless rate" comes from FY 2007 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. [Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.])

Our estimate is conservative. It DOES NOT also include veterans who do not have a substance abuse/mental health disorder but do have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Families, Housing, and Action Plans (CHALENG Point of Contact Survey)

1. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2007 by local VA homeless program: 80

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	850	200
Transitional Housing Beds	1,335	200
Permanent Housing Beds	587	2,000

***These are the number of beds that veterans can access, including both veteran-specific and non-veteran specific.**

3. CHALENG Point of Contact Action Plan for FY 2008*

Long-term, permanent housing	Continue to work with local HUD Continuum of Care group to advocate for more affordable, permanent housing.
Dental Care	Continue to refer eligible veterans to the Homeless Veterans Dental Program. Refer non-eligible veterans to community dental services.
Help with finding a job or getting employment	Continue to support providers in applying for Department of Labor Homeless Veterans Reintegration Program and other employment grants. Network and establish new relationships with community programs.

***The Action Plan outlines proposed strategies the local VA program and its community partners will use to address its priority needs in FY 2008.**

C. Data from the CHALENG Participant Survey

Number of Total Participant Surveys: **299**
Percentage of Participant Surveys from Homeless Veterans: **85%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	% want to work on this need now*	VHA Mean Score (nationwide)**
Personal hygiene	3.97	2%	3.42
Food	4.29	5%	3.73
Clothing	3.74	6%	3.59
Emergency (immediate) shelter	3.76	13%	3.25
Halfway house or transitional living facility	3.96	13%	3.02
Long-term, permanent housing	2.68	42%	2.46
Detoxification from substances	4.04	2%	3.32
Treatment for substance abuse	4.27	9%	3.50
Services for emotional or psychiatric problems	3.78	9%	3.43
Treatment for dual diagnosis	3.48	7%	3.25
Family counseling	3.13	4%	2.98
Medical services	3.98	10%	3.76
Women's health care	3.09	2%	3.25
Help with medication	3.78	2%	3.44
Drop-in center or day program	3.02	2%	2.98
AIDS/HIV testing/counseling	3.83	1%	3.50
TB testing	4.51	0%	3.68
TB treatment	3.87	0%	3.54
Hepatitis C testing	3.75	4%	3.60
Dental care	3.08	25%	2.64
Eye care	3.37	6%	2.93
Glasses	3.28	7%	2.92
VA disability/pension	2.97	16%	3.38
Welfare payments	2.64	2%	3.05
SSI/SSD process	2.73	10%	3.07
Guardianship (financial)	2.46	1%	2.83
Help managing money	2.96	7%	2.86
Job training	3.27	14%	3.09
Help with finding a job or getting employment	3.43	23%	3.20
Help getting needed documents or identification	3.88	2%	3.28
Help with transportation	4.00	6%	3.01
Education	3.45	11%	3.05
Child care	2.64	2%	2.47
Legal assistance	3.21	15%	2.78
Discharge upgrade	2.86	10%	3.01
Spiritual	3.57	8%	3.37
Re-entry services for incarcerated veterans	3.07	5%	2.71
Elder Healthcare	2.96	2%	3.07

*** % of site participants who identified this need as one of the top three they would like to work on now.**
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Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.68	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.06	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.16	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.38	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.69	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.34	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.93	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.82	1.62
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.07	1.83

***Scores of non-VA community agency representatives only. **VHA: Veterans Healthcare Administration (138 reporting POC sites, n=3,055).**

3. VA/Community Integration*

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score**	**VHA (nationwide) Mean Score****
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.65	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75	3.58

***Scores of non-VA community agency representatives only.**
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4. Existing Agreements with Community Service Types:

Service Types	**VA has existing collaborative agreement with agencies?**
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Psychiatric/substance abuse inpatient (hospitals, wards	Yes
Nursing homes	No
Faith-based organizations	Yes