

## CHALENG 2007 Survey Results Summary

### VISN 12

#### Site: VAH Hines, IL - 578 and VA Chicago HCS (VAMC Chicago (LS) - 537A4 and VAMC Chicago (WS) - 537)

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: 698

2. Estimated Number of Veterans who are Chronically Homeless: 199

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 Kaspro, 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: 22**

**2. Housing Inventory**

<b>Housing Inventory</b>	<b>Beds*</b>	<b># of additional beds site could use</b>
Emergency Beds	1,510	0
Transitional Housing Beds	1,353	114
Permanent Housing Beds	4,228	325

\*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\***

<b>Long-term, permanent housing</b>	We will continue to partner with community agencies in submitting grants for funding. We will continue to partner with the Illinois Department of Veterans Affairs, Veterans Benefits Administration (VBA) Vet Centers.
<b>Family counseling</b>	We will strengthen relationship with local Vet Centers to make more family counseling available to homeless veterans.
<b>Spiritual</b>	We will strengthen our relationship with VA Chaplain Services to offer more services to our homeless veterans.

\*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: 38

Percentage of Participant Surveys from Homeless Veterans: 53%

#### 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	3.46	0%	3.42
Food	3.79	9%	3.73
Clothing	3.22	4%	3.59
Emergency (immediate) shelter	3.46	30%	3.25
Halfway house or transitional living facility	3.44	9%	3.02
Long-term, permanent housing	2.82	65%	2.46
Detoxification from substances	3.58	0%	3.32
Treatment for substance abuse	3.71	17%	3.50
Services for emotional or psychiatric problems	3.85	13%	3.43
Treatment for dual diagnosis	3.71	13%	3.25
Family counseling	2.97	0%	2.98
Medical services	4.13	9%	3.76
Women's health care	2.96	4%	3.25
Help with medication	3.97	0%	3.44
Drop-in center or day program	3.03	0%	2.98
AIDS/HIV testing/counseling	3.74	0%	3.50
TB testing	3.91	0%	3.68
TB treatment	3.59	0%	3.54
Hepatitis C testing	3.80	0%	3.60
Dental care	3.19	4%	2.64
Eye care	2.78	4%	2.93
Glasses	2.69	9%	2.92
VA disability/pension	3.09	4%	3.38
Welfare payments	2.76	0%	3.05
SSI/SSD process	2.91	9%	3.07
Guardianship (financial)	2.58	4%	2.83
Help managing money	3.27	4%	2.86
Job training	3.22	22%	3.09
Help with finding a job or getting employment	3.46	26%	3.20
Help getting needed documents or identification	3.70	0%	3.28
Help with transportation	3.54	4%	3.01
Education	3.31	4%	3.05
Child care	2.38	0%	2.47
Legal assistance	2.44	9%	2.78
Discharge upgrade	2.58	0%	3.01
Spiritual	3.09	0%	3.37
Re-entry services for incarcerated veterans	2.84	9%	2.71
Elder Healthcare	2.75	0%	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\*

<b>Implementation Scale</b> <b>1 = None</b> , no steps taken to initiate implementation of the strategy. <b>2 = Low</b> , in planning and/or initial minor steps taken. <b>3 = Moderate</b> , significant steps taken but full implementation not achieved. <b>4 = High</b> , strategy fully implemented.	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>Interagency Coordinating Body</b> - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.06	2.56
<b>Co-location of Services</b> - Services from the VA and your agency provided in one location.	2.19	1.89
<b>Cross-Training</b> - Staff training about the objectives, procedures and services of the VA and your agency.	1.94	1.86
<b>Interagency Agreements/ Memoranda of Understanding</b> - 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
<b>Interagency Client Tracking Systems/ Management Information Systems</b> - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.56	1.59
<b>Pooled/Joint Funding</b> - Combining or layering funds from the VA and your agency to create new resources or services.	1.94	1.67
<b>Uniform Applications, Eligibility Criteria, and Intake Assessments</b> – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.81	1.75
<b>Interagency Service Delivery Team/ Provider Coalition</b> - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.69	2.15
<b>Consolidation of Programs/ Agencies</b> - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.33	1.94
<b>Flexible Funding</b> – 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.	2.06	1.61
<b>Use of Special Waivers</b> - 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.	1.88	1.62
<b>System Integration Coordinator Position</b> - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.50	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\*

<b>Integration Scale:</b> 1 (low) to 5 (high)	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>VA Accessibility:</b> In general, how accessible do you feel VA services are to homeless veterans in the community?	3.47	3.57
<b>VA Service Coordination:</b> Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.74	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:

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

## CHALENG 2007 Survey Results Summary

### VISN 12

#### Site: VAH Madison, WI - 607

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: 75

2. Estimated Number of Veterans who are Chronically Homeless: 20

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 Kaspro, 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: 0**

**2. Housing Inventory**

<b>Housing Inventory</b>	<b>Beds*</b>	<b># of additional beds site could use</b>
Emergency Beds	297	0
Transitional Housing Beds	334	0
Permanent Housing Beds	515	289

\*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\***

<b>Long-term, permanent housing</b>	"Housing First" (long-term permanent housing) is a growing trend in our area. We are involved in submitting grant requests for this program type.
<b>Emergency (immediate) shelter</b>	Will continue to work with our local HUD Continuum of Care providers to address this need.
<b>Treatment for substance abuse</b>	Increase local and rural outreach to nonprofit agencies to ensure veterans are being identified and referred.

\*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: 58

Percentage of Participant Surveys from Homeless Veterans: 37%

#### 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	3.61	2%	3.42
Food	3.71	17%	3.73
Clothing	3.65	4%	3.59
Emergency (immediate) shelter	3.28	26%	3.25
Halfway house or transitional living facility	3.24	16%	3.02
Long-term, permanent housing	2.59	38%	2.46
Detoxification from substances	3.53	13%	3.32
Treatment for substance abuse	3.55	20%	3.50
Services for emotional or psychiatric problems	3.64	20%	3.43
Treatment for dual diagnosis	3.34	9%	3.25
Family counseling	3.16	7%	2.98
Medical services	3.95	6%	3.76
Women's health care	3.13	7%	3.25
Help with medication	3.48	2%	3.44
Drop-in center or day program	3.22	4%	2.98
AIDS/HIV testing/counseling	3.43	0%	3.50
TB testing	3.82	2%	3.68
TB treatment	3.71	4%	3.54
Hepatitis C testing	3.70	4%	3.60
Dental care	3.09	17%	2.64
Eye care	3.30	7%	2.93
Glasses	2.98	6%	2.92
VA disability/pension	3.44	11%	3.38
Welfare payments	2.85	0%	3.05
SSI/SSD process	3.23	15%	3.07
Guardianship (financial)	3.21	2%	2.83
Help managing money	3.24	0%	2.86
Job training	3.27	9%	3.09
Help with finding a job or getting employment	3.43	11%	3.20
Help getting needed documents or identification	3.64	0%	3.28
Help with transportation	3.54	6%	3.01
Education	3.24	2%	3.05
Child care	2.75	0%	2.47
Legal assistance	3.17	2%	2.78
Discharge upgrade	3.27	2%	3.01
Spiritual	3.16	7%	3.37
Re-entry services for incarcerated veterans	2.69	4%	2.71
Elder Healthcare	3.48	0%	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\*

<b>Implementation Scale</b> <b>1 = None</b> , no steps taken to initiate implementation of the strategy. <b>2 = Low</b> , in planning and/or initial minor steps taken. <b>3 = Moderate</b> , significant steps taken but full implementation not achieved. <b>4 = High</b> , strategy fully implemented.	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>Interagency Coordinating Body</b> - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.76	2.56
<b>Co-location of Services</b> - Services from the VA and your agency provided in one location.	2.07	1.89
<b>Cross-Training</b> - Staff training about the objectives, procedures and services of the VA and your agency.	2.10	1.86
<b>Interagency Agreements/ Memoranda of Understanding</b> - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.66	2.26
<b>Interagency Client Tracking Systems/ Management Information Systems</b> - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.86	1.59
<b>Pooled/Joint Funding</b> - Combining or layering funds from the VA and your agency to create new resources or services.	1.76	1.67
<b>Uniform Applications, Eligibility Criteria, and Intake Assessments</b> – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00	1.75
<b>Interagency Service Delivery Team/ Provider Coalition</b> - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.26	2.15
<b>Consolidation of Programs/ Agencies</b> - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.21	1.94
<b>Flexible Funding</b> – 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.	1.96	1.61
<b>Use of Special Waivers</b> - 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.	2.21	1.62
<b>System Integration Coordinator Position</b> - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.37	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\*

<b>Integration Scale:</b> 1 (low) to 5 (high)	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>VA Accessibility:</b> In general, how accessible do you feel VA services are to homeless veterans in the community?	3.71	3.57
<b>VA Service Coordination:</b> Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00	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:

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

## CHALENG 2007 Survey Results Summary

### VISN 12

#### Site: VAMC Iron Mountain, MI - 585

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

2. Estimated Number of Veterans who are Chronically Homeless: 1

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 Kaspro, 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: 0**

**2. Housing Inventory**

<b>Housing Inventory</b>	<b>Beds*</b>	<b># of additional beds site could use</b>
Emergency Beds	20	0
Transitional Housing Beds	15	0
Permanent Housing Beds	10	0

\*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\***

<b>Job training</b>	We will partner with our VA Compensated Work Therapy program to help homeless veterans get job training.
<b>Halfway house or transitional living facility</b>	We are developing formal agreements with the Tomah and Milwaukee VA Domiciliary programs.
<b>Help with transportation</b>	We will continue to work with VA to set aside funds for bus tickets. We will also coordinate transportation with the Disabled American Veterans van system.

\*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: 24

Percentage of Participant Surveys from Homeless Veterans: 0%

#### 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	3.05	6%	3.42
Food	3.73	13%	3.73
Clothing	3.78	6%	3.59
Emergency (immediate) shelter	3.37	6%	3.25
Halfway house or transitional living facility	2.32	13%	3.02
Long-term, permanent housing	2.41	38%	2.46
Detoxification from substances	3.32	13%	3.32
Treatment for substance abuse	3.69	19%	3.50
Services for emotional or psychiatric problems	3.46	31%	3.43
Treatment for dual diagnosis	3.24	6%	3.25
Family counseling	3.18	6%	2.98
Medical services	3.86	6%	3.76
Women's health care	3.27	6%	3.25
Help with medication	3.36	0%	3.44
Drop-in center or day program	2.68	0%	2.98
AIDS/HIV testing/counseling	3.64	0%	3.50
TB testing	3.76	0%	3.68
TB treatment	3.55	0%	3.54
Hepatitis C testing	3.86	0%	3.60
Dental care	2.10	19%	2.64
Eye care	2.43	0%	2.93
Glasses	2.95	0%	2.92
VA disability/pension	3.60	13%	3.38
Welfare payments	3.10	0%	3.05
SSI/SSD process	3.10	0%	3.07
Guardianship (financial)	2.75	0%	2.83
Help managing money	2.71	6%	2.86
Job training	3.00	25%	3.09
Help with finding a job or getting employment	3.14	19%	3.20
Help getting needed documents or identification	3.20	0%	3.28
Help with transportation	2.45	19%	3.01
Education	3.10	13%	3.05
Child care	2.67	6%	2.47
Legal assistance	2.65	6%	2.78
Discharge upgrade	3.40	0%	3.01
Spiritual	3.47	6%	3.37
Re-entry services for incarcerated veterans	2.90	0%	2.71
Elder Healthcare	3.15	0%	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\*

<b>Implementation Scale</b> <b>1 = None</b> , no steps taken to initiate implementation of the strategy. <b>2 = Low</b> , in planning and/or initial minor steps taken. <b>3 = Moderate</b> , significant steps taken but full implementation not achieved. <b>4 = High</b> , strategy fully implemented.	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>Interagency Coordinating Body</b> - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.87	2.56
<b>Co-location of Services</b> - Services from the VA and your agency provided in one location.	2.00	1.89
<b>Cross-Training</b> - Staff training about the objectives, procedures and services of the VA and your agency.	2.18	1.86
<b>Interagency Agreements/ Memoranda of Understanding</b> - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.95	2.26
<b>Interagency Client Tracking Systems/ Management Information Systems</b> - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.64	1.59
<b>Pooled/Joint Funding</b> - Combining or layering funds from the VA and your agency to create new resources or services.	1.45	1.67
<b>Uniform Applications, Eligibility Criteria, and Intake Assessments</b> – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.59	1.75
<b>Interagency Service Delivery Team/ Provider Coalition</b> - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.09	2.15
<b>Consolidation of Programs/ Agencies</b> - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.68	1.94
<b>Flexible Funding</b> – 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.	1.55	1.61
<b>Use of Special Waivers</b> - 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.	1.64	1.62
<b>System Integration Coordinator Position</b> - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.32	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\*

<b>Integration Scale:</b> 1 (low) to 5 (high)	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>VA Accessibility:</b> In general, how accessible do you feel VA services are to homeless veterans in the community?	3.68	3.57
<b>VA Service Coordination:</b> Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.85	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:

<b>Service Types</b>	<b>VA has existing collaborative agreement with agencies?</b>
<b>Correctional Facilities (Jails, prisons, courts)</b>	Yes
<b>Psychiatric/substance abuse inpatient (hospitals, wards)</b>	Yes
<b>Nursing homes</b>	Yes
<b>Faith-based organizations</b>	Yes

## CHALENG 2007 Survey Results Summary

### VISN 12

#### Site: VAMC Milwaukee, WI - 695

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: 216

2. Estimated Number of Veterans who are Chronically Homeless: 56

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 Kaspro, 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: 3**

**2. Housing Inventory**

<b>Housing Inventory</b>	<b>Beds*</b>	<b># of additional beds site could use</b>
Emergency Beds	335	0
Transitional Housing Beds	71	50
Permanent Housing Beds	676	201

\*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\***

<b>Long-term, permanent housing</b>	Continue to support efforts of Milwaukee and Racine Continuums of Care to increase permanent housing availability.
<b>Help with finding a job or getting employment</b>	Increase referrals from VA Grant and Per Diem programs to VA Compensated Work Therapy/Supported Employment programs and local employers.
<b>Dental Care</b>	Increase use of local dental providers for veterans who are ineligible for VA care. Increase use of Wisconsin Health Care Aid grants to eligible veterans.

\*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: 126

Percentage of Participant Surveys from Homeless Veterans: 70%

#### 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	3.87	1%	3.42
Food	4.14	5%	3.73
Clothing	3.85	5%	3.59
Emergency (immediate) shelter	3.61	13%	3.25
Halfway house or transitional living facility	3.55	12%	3.02
Long-term, permanent housing	2.71	53%	2.46
Detoxification from substances	3.97	4%	3.32
Treatment for substance abuse	4.04	15%	3.50
Services for emotional or psychiatric problems	3.70	17%	3.43
Treatment for dual diagnosis	3.32	5%	3.25
Family counseling	2.99	4%	2.98
Medical services	4.02	8%	3.76
Women's health care	3.06	1%	3.25
Help with medication	3.96	2%	3.44
Drop-in center or day program	3.12	3%	2.98
AIDS/HIV testing/counseling	3.57	1%	3.50
TB testing	4.16	0%	3.68
TB treatment	3.72	0%	3.54
Hepatitis C testing	3.68	0%	3.60
Dental care	2.81	21%	2.64
Eye care	3.23	9%	2.93
Glasses	2.99	2%	2.92
VA disability/pension	3.07	22%	3.38
Welfare payments	2.44	2%	3.05
SSI/SSD process	2.52	8%	3.07
Guardianship (financial)	2.71	2%	2.83
Help managing money	3.26	7%	2.86
Job training	2.91	15%	3.09
Help with finding a job or getting employment	3.17	24%	3.20
Help getting needed documents or identification	3.32	4%	3.28
Help with transportation	3.23	4%	3.01
Education	3.22	11%	3.05
Child care	2.49	3%	2.47
Legal assistance	2.77	5%	2.78
Discharge upgrade	2.95	3%	3.01
Spiritual	3.28	5%	3.37
Re-entry services for incarcerated veterans	2.77	6%	2.71
Elder Healthcare	2.87	1%	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\*

<b>Implementation Scale</b> <b>1 = None</b> , no steps taken to initiate implementation of the strategy. <b>2 = Low</b> , in planning and/or initial minor steps taken. <b>3 = Moderate</b> , significant steps taken but full implementation not achieved. <b>4 = High</b> , strategy fully implemented.	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>Interagency Coordinating Body</b> - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.74	2.56
<b>Co-location of Services</b> - Services from the VA and your agency provided in one location.	1.44	1.89
<b>Cross-Training</b> - Staff training about the objectives, procedures and services of the VA and your agency.	1.41	1.86
<b>Interagency Agreements/ Memoranda of Understanding</b> - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.59	2.26
<b>Interagency Client Tracking Systems/ Management Information Systems</b> - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.30	1.59
<b>Pooled/Joint Funding</b> - Combining or layering funds from the VA and your agency to create new resources or services.	1.26	1.67
<b>Uniform Applications, Eligibility Criteria, and Intake Assessments</b> – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.26	1.75
<b>Interagency Service Delivery Team/ Provider Coalition</b> - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.56	2.15
<b>Consolidation of Programs/ Agencies</b> - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.26	1.94
<b>Flexible Funding</b> – 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.	1.26	1.61
<b>Use of Special Waivers</b> - 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.	1.26	1.62
<b>System Integration Coordinator Position</b> - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.26	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\*

<b>Integration Scale:</b> 1 (low) to 5 (high)	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>VA Accessibility:</b> In general, how accessible do you feel VA services are to homeless veterans in the community?	3.39	3.57
<b>VA Service Coordination:</b> Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.21	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:

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

## CHALENG 2007 Survey Results Summary

### VISN 12

#### Site: VAMC North Chicago, IL - 556

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: 93

2. Estimated Number of Veterans who are Chronically Homeless: 17

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 Kaspro, 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**

<b>Housing Inventory</b>	<b>Beds*</b>	<b># of additional beds site could use</b>
Emergency Beds	205	64
Transitional Housing Beds	276	0
Permanent Housing Beds	265	77

\*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\***

<b>Long-term, permanent housing</b>	Continue to work with Lake County Coalition for the Homeless and Habitat for Humanity to develop 20 units of permanent housing; advocate for same with HUD and B.R.A.C.
<b>Emergency (immediate) shelter</b>	Support/encourage efforts of P.A.D.S. and the Lake County Coalition for the Homeless to develop more year-round shelter sites.
<b>Help managing money</b>	Support I-Plus in their efforts to supply and expand money management services to homeless veterans, especially the chronically homeless and dually diagnosed.

\*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: 55

Percentage of Participant Surveys from Homeless Veterans: 68%

#### 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	3.99	2%	3.42
Food	4.02	10%	3.73
Clothing	3.76	10%	3.59
Emergency (immediate) shelter	3.59	27%	3.25
Halfway house or transitional living facility	3.57	24%	3.02
Long-term, permanent housing	2.80	58%	2.46
Detoxification from substances	4.10	4%	3.32
Treatment for substance abuse	3.99	6%	3.50
Services for emotional or psychiatric problems	3.82	10%	3.43
Treatment for dual diagnosis	3.69	6%	3.25
Family counseling	2.91	4%	2.98
Medical services	4.24	14%	3.76
Women's health care	3.52	4%	3.25
Help with medication	4.12	0%	3.44
Drop-in center or day program	3.65	6%	2.98
AIDS/HIV testing/counseling	3.54	0%	3.50
TB testing	3.94	0%	3.68
TB treatment	3.73	0%	3.54
Hepatitis C testing	3.96	0%	3.60
Dental care	3.37	14%	2.64
Eye care	3.30	4%	2.93
Glasses	2.92	8%	2.92
VA disability/pension	3.10	19%	3.38
Welfare payments	2.68	0%	3.05
SSI/SSD process	2.84	13%	3.07
Guardianship (financial)	3.00	0%	2.83
Help managing money	3.31	12%	2.86
Job training	3.22	10%	3.09
Help with finding a job or getting employment	3.74	6%	3.20
Help getting needed documents or identification	3.60	0%	3.28
Help with transportation	3.16	8%	3.01
Education	3.23	4%	3.05
Child care	2.64	4%	2.47
Legal assistance	2.92	6%	2.78
Discharge upgrade	3.26	4%	3.01
Spiritual	3.63	2%	3.37
Re-entry services for incarcerated veterans	3.06	6%	2.71
Elder Healthcare	3.33	0%	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\*

<b>Implementation Scale</b> <b>1 = None</b> , no steps taken to initiate implementation of the strategy. <b>2 = Low</b> , in planning and/or initial minor steps taken. <b>3 = Moderate</b> , significant steps taken but full implementation not achieved. <b>4 = High</b> , strategy fully implemented.	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>Interagency Coordinating Body</b> - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.10	2.56
<b>Co-location of Services</b> - Services from the VA and your agency provided in one location.	1.75	1.89
<b>Cross-Training</b> - Staff training about the objectives, procedures and services of the VA and your agency.	1.75	1.86
<b>Interagency Agreements/ Memoranda of Understanding</b> - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00	2.26
<b>Interagency Client Tracking Systems/ Management Information Systems</b> - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.55	1.59
<b>Pooled/Joint Funding</b> - Combining or layering funds from the VA and your agency to create new resources or services.	1.40	1.67
<b>Uniform Applications, Eligibility Criteria, and Intake Assessments</b> – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.35	1.75
<b>Interagency Service Delivery Team/ Provider Coalition</b> - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.85	2.15
<b>Consolidation of Programs/ Agencies</b> - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.65	1.94
<b>Flexible Funding</b> – 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.	1.40	1.61
<b>Use of Special Waivers</b> - 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.	1.55	1.62
<b>System Integration Coordinator Position</b> - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.80	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\*

<b>Integration Scale:</b> 1 (low) to 5 (high)	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>VA Accessibility:</b> In general, how accessible do you feel VA services are to homeless veterans in the community?	4.05	3.57
<b>VA Service Coordination:</b> Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.42	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:

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

## CHALENG 2007 Survey Results Summary

### VISN 12

#### Site: VAMC Tomah, WI - 676

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: 575

2. Estimated Number of Veterans who are Chronically Homeless: 57

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 Kaspro, 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: 0**

### **2. Housing Inventory**

<b>Housing Inventory</b>	<b>Beds*</b>	<b># of additional beds site could use</b>
Emergency Beds	130	50
Transitional Housing Beds	183	75
Permanent Housing Beds	125	50

**\*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\***

<b>Long-term, permanent housing</b>	Work with local low-income housing organization in helping veterans find housing. Our VA Mental Health Intensive Case Management (MHICM) program also helps veterans with mental illness find housing.
<b>Dental Care</b>	Dental care is being provided for homeless veterans who are eligible under VHA Directive 2002-080. We received a generous donation to be used for dental care for ineligible veterans.
<b>Help with finding a job or getting employment</b>	Our VA Compensated Work Therapy program is very active and works with clients in our VA Grant and Per Diem 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: 67

Percentage of Participant Surveys from Homeless Veterans: 72%

#### 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	3.80	1%	3.42
Food	4.12	6%	3.73
Clothing	3.66	4%	3.59
Emergency (immediate) shelter	3.55	12%	3.25
Halfway house or transitional living facility	3.20	19%	3.02
Long-term, permanent housing	2.29	46%	2.46
Detoxification from substances	3.69	0%	3.32
Treatment for substance abuse	3.87	4%	3.50
Services for emotional or psychiatric problems	3.69	10%	3.43
Treatment for dual diagnosis	3.56	1%	3.25
Family counseling	2.83	12%	2.98
Medical services	4.00	10%	3.76
Women's health care	3.05	0%	3.25
Help with medication	3.94	3%	3.44
Drop-in center or day program	2.84	1%	2.98
AIDS/HIV testing/counseling	3.37	1%	3.50
TB testing	4.10	0%	3.68
TB treatment	3.73	1%	3.54
Hepatitis C testing	3.53	1%	3.60
Dental care	2.84	28%	2.64
Eye care	3.64	0%	2.93
Glasses	3.49	4%	2.92
VA disability/pension	3.20	16%	3.38
Welfare payments	2.59	1%	3.05
SSI/SSD process	3.12	12%	3.07
Guardianship (financial)	2.88	0%	2.83
Help managing money	3.30	12%	2.86
Job training	2.89	18%	3.09
Help with finding a job or getting employment	3.06	22%	3.20
Help getting needed documents or identification	3.63	4%	3.28
Help with transportation	3.67	6%	3.01
Education	3.18	12%	3.05
Child care	2.27	0%	2.47
Legal assistance	3.09	9%	2.78
Discharge upgrade	2.97	1%	3.01
Spiritual	3.39	4%	3.37
Re-entry services for incarcerated veterans	2.63	7%	2.71
Elder Healthcare	3.08	0%	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\*

<b>Implementation Scale</b> <b>1 = None</b> , no steps taken to initiate implementation of the strategy. <b>2 = Low</b> , in planning and/or initial minor steps taken. <b>3 = Moderate</b> , significant steps taken but full implementation not achieved. <b>4 = High</b> , strategy fully implemented.	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>Interagency Coordinating Body</b> - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.44	2.56
<b>Co-location of Services</b> - Services from the VA and your agency provided in one location.	1.83	1.89
<b>Cross-Training</b> - Staff training about the objectives, procedures and services of the VA and your agency.	2.06	1.86
<b>Interagency Agreements/ Memoranda of Understanding</b> - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.94	2.26
<b>Interagency Client Tracking Systems/ Management Information Systems</b> - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.44	1.59
<b>Pooled/Joint Funding</b> - Combining or layering funds from the VA and your agency to create new resources or services.	1.33	1.67
<b>Uniform Applications, Eligibility Criteria, and Intake Assessments</b> – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.17	1.75
<b>Interagency Service Delivery Team/ Provider Coalition</b> - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.17	2.15
<b>Consolidation of Programs/ Agencies</b> - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67	1.94
<b>Flexible Funding</b> – 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.	1.39	1.61
<b>Use of Special Waivers</b> - 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.	1.50	1.62
<b>System Integration Coordinator Position</b> - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.61	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\*

<b>Integration Scale:</b> 1 (low) to 5 (high)	<b>Site Mean Score</b>	<b>VHA (nationwide) Mean Score**</b>
<b>VA Accessibility:</b> In general, how accessible do you feel VA services are to homeless veterans in the community?	3.28	3.57
<b>VA Service Coordination:</b> Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.50	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:

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