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

CHALENG 2007 Survey Results Summary

VISN 3

Site: VA Hudson Valley HCS (VAMC Castle Point - 620A4 and VAH Montrose - 620)

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: 7,000

2. Estimated Number of Veterans who are Chronically Homeless: 1902

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	400	30
Transitional Housing Beds	0	260
Permanent Housing Beds	31	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	Work with Westchester County Continuum of Care in their request for funding to create 14 beds for homeless veterans. Also, continue to implement Peer Housing Location Assistance Group (PHLAG) project.
Halfway house or transitional living facility	Implement two VA Grant and Per Diem awards (60 beds) in Westchester County. Continue to work with Dutchess County Continuum of Care in developing housing for the homeless veterans.
Help with finding a job or getting employment	Collaborate with Carpenters Union which offers apprenticeship 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: **82**
Percentage of Participant Surveys from Homeless Veterans: **60%**

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	3.86	0%	3.42
Food	3.80	7%	3.73
Clothing	3.65	7%	3.59
Emergency (immediate) shelter	3.29	15%	3.25
Halfway house or transitional living facility	2.54	48%	3.02
Long-term, permanent housing	2.03	68%	2.46
Detoxification from substances	3.82	5%	3.32
Treatment for substance abuse	4.27	10%	3.50
Services for emotional or psychiatric problems	4.02	5%	3.43
Treatment for dual diagnosis	3.61	8%	3.25
Family counseling	2.68	1%	2.98
Medical services	4.15	7%	3.76
Women's health care	3.42	1%	3.25
Help with medication	3.95	3%	3.44
Drop-in center or day program	3.04	3%	2.98
AIDS/HIV testing/counseling	3.99	1%	3.50
TB testing	4.22	0%	3.68
TB treatment	3.97	0%	3.54
Hepatitis C testing	4.21	3%	3.60
Dental care	3.49	8%	2.64
Eye care	3.94	0%	2.93
Glasses	3.99	0%	2.92
VA disability/pension	3.05	11%	3.38
Welfare payments	2.44	1%	3.05
SSI/SSD process	2.78	8%	3.07
Guardianship (financial)	2.53	0%	2.83
Help managing money	3.11	4%	2.86
Job training	2.89	19%	3.09
Help with finding a job or getting employment	2.95	29%	3.20
Help getting needed documents or identification	3.29	0%	3.28
Help with transportation	3.15	5%	3.01
Education	2.92	4%	3.05
Child care	2.47	3%	2.47
Legal assistance	2.70	4%	2.78
Discharge upgrade	2.87	4%	3.01
Spiritual	3.32	1%	3.37
Re-entry services for incarcerated veterans	3.06	7%	2.71
Elder Healthcare	3.03	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*

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.	1.92	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.83	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.	2.33	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.	1.52	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.67	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.	1.83	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.	2.17	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.92	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.	1.83	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?	3.40	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.79	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	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 3

Site: VA New Jersey HCS (VAMC East Orange - 561 and VAMC Lyons - 561A4)

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: 3,500

2. Estimated Number of Veterans who are Chronically Homeless: 1835

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: 0

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	0	40
Transitional Housing Beds	114	50
Permanent Housing Beds	0	400

***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*

Help with transportation	VA New Jersey will hire two van drivers and partner with community agency for additional support.
Help with finding a job or getting employment	Explore outside employment options. We are now using a comprehensive testing system to identify individual barriers to employment with subsequent action to address them.
Long-term, permanent housing	Explore permanent housing options offered by state resources, community agencies and independent providers.

***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: **80**
Percentage of Participant Surveys from Homeless Veterans: **95%**

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	4.47	0%	3.42
Food	4.54	4%	3.73
Clothing	3.88	4%	3.59
Emergency (immediate) shelter	4.36	8%	3.25
Halfway house or transitional living facility	3.75	19%	3.02
Long-term, permanent housing	3.11	42%	2.46
Detoxification from substances	4.27	4%	3.32
Treatment for substance abuse	4.61	9%	3.50
Services for emotional or psychiatric problems	4.10	7%	3.43
Treatment for dual diagnosis	3.96	4%	3.25
Family counseling	3.70	0%	2.98
Medical services	4.67	9%	3.76
Women's health care	3.97	0%	3.25
Help with medication	4.48	4%	3.44
Drop-in center or day program	3.81	0%	2.98
AIDS/HIV testing/counseling	4.10	2%	3.50
TB testing	4.49	0%	3.68
TB treatment	4.11	0%	3.54
Hepatitis C testing	4.03	4%	3.60
Dental care	3.92	6%	2.64
Eye care	4.41	4%	2.93
Glasses	4.31	2%	2.92
VA disability/pension	3.37	25%	3.38
Welfare payments	3.62	0%	3.05
SSI/SSD process	2.78	13%	3.07
Guardianship (financial)	3.05	2%	2.83
Help managing money	3.93	11%	2.86
Job training	3.30	19%	3.09
Help with finding a job or getting employment	3.54	36%	3.20
Help getting needed documents or identification	3.80	8%	3.28
Help with transportation	3.88	11%	3.01
Education	3.40	11%	3.05
Child care	2.77	2%	2.47
Legal assistance	3.59	21%	2.78
Discharge upgrade	3.02	2%	3.01
Spiritual	4.04	4%	3.37
Re-entry services for incarcerated veterans	3.35	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*

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.	2.25	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.50	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.50	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.	2.25	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.	1.00	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.25	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.	2.25	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75	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.	1.25	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.	1.50	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.	1.75	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?	3.00	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.67	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 3

Site: VAMC Bronx, NY - 526, VA New York Harbor HCS (VAMC Brooklyn - 630A4 and VAMC New York - 630)

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: 6,500

2. Estimated Number of Veterans who are Chronically Homeless: 2183

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: 14

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	7,000	0
Transitional Housing Beds	500	250
Permanent Housing Beds	345	1,000

***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	1. Continue partnership with New York City Department of Homeless Service to provide additional housing. 2. Continue Peer Housing Location Assistance Group program where peer workers help veterans find community housing. 3. Request restoration of Section 8 vouchers for our HUD-VA Supported Housing program.
Dental Care	Utilize VA Central Office funding to provide dental care for homeless veterans in VA Domiciliary and VA Grant and Per Diem programs.
Re-entry services for incarcerated veterans	Work with the VISN re-entry specialist on a needs assessment of resources and services needed to serve veterans coming out of prison.

***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: **169**
Percentage of Participant Surveys from Homeless Veterans: **46%**

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	4%	3.42
Food	3.59	14%	3.73
Clothing	3.28	7%	3.59
Emergency (immediate) shelter	3.41	16%	3.25
Halfway house or transitional living facility	2.97	14%	3.02
Long-term, permanent housing	2.60	73%	2.46
Detoxification from substances	3.73	5%	3.32
Treatment for substance abuse	3.83	11%	3.50
Services for emotional or psychiatric problems	3.75	10%	3.43
Treatment for dual diagnosis	3.56	2%	3.25
Family counseling	2.99	2%	2.98
Medical services	3.97	9%	3.76
Women's health care	2.95	2%	3.25
Help with medication	3.59	2%	3.44
Drop-in center or day program	3.26	2%	2.98
AIDS/HIV testing/counseling	3.87	2%	3.50
TB testing	3.96	1%	3.68
TB treatment	3.76	0%	3.54
Hepatitis C testing	3.77	0%	3.60
Dental care	2.62	27%	2.64
Eye care	3.32	0%	2.93
Glasses	3.34	2%	2.92
VA disability/pension	3.27	7%	3.38
Welfare payments	2.94	1%	3.05
SSI/SSD process	3.10	5%	3.07
Guardianship (financial)	2.76	1%	2.83
Help managing money	2.93	4%	2.86
Job training	2.84	11%	3.09
Help with finding a job or getting employment	2.97	18%	3.20
Help getting needed documents or identification	3.20	3%	3.28
Help with transportation	3.06	3%	3.01
Education	2.90	4%	3.05
Child care	2.47	2%	2.47
Legal assistance	2.59	5%	2.78
Discharge upgrade	2.90	1%	3.01
Spiritual	3.33	2%	3.37
Re-entry services for incarcerated veterans	2.80	23%	2.71
Elder Healthcare	3.08	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.	2.41	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.96	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.75	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.	2.28	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.	1.52	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.49	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.	1.72	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.	1.83	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75	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.	1.49	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.	1.63	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.	1.56	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.	3.00	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:

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 3

Site: VAMC Northport, NY - 632

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: 296

2. Estimated Number of Veterans who are Chronically Homeless: 45

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: 6

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	406	0
Transitional Housing Beds	226	0
Permanent Housing Beds	497	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*

Long-term, permanent housing	Work with community housing providers and/or private landlords to create ten new permanent housing beds in either Suffolk or Nassau Counties.
Help with finding a job or getting employment	Our goal: all new veterans in our programs will be vocationally assessed and referred to one or more of the following: the VA Vocational Rehabilitation Program; the VA Regional Officer counselor for Chapter 31 specialized services; the DOL-HVRP (Department of Labor Homeless Veterans Reintegration Program at United Veterans Beacon House, Inc.
Services for emotional or psychiatric problems	Goal: all new veterans accepted into our programs will be assessed for emotional/psychiatric problems and referred to appropriate VA treatment programs including outpatient, day treatment, and specialty PTSD and substance abuse services.

***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: **56**
Percentage of Participant Surveys from Homeless Veterans: **17%**

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	3.36	6%	3.42
Food	3.74	4%	3.73
Clothing	3.50	6%	3.59
Emergency (immediate) shelter	4.16	13%	3.25
Halfway house or transitional living facility	3.51	13%	3.02
Long-term, permanent housing	2.87	50%	2.46
Detoxification from substances	3.68	6%	3.32
Treatment for substance abuse	3.86	8%	3.50
Services for emotional or psychiatric problems	3.68	21%	3.43
Treatment for dual diagnosis	3.53	6%	3.25
Family counseling	3.31	6%	2.98
Medical services	4.14	4%	3.76
Women's health care	3.83	6%	3.25
Help with medication	3.68	4%	3.44
Drop-in center or day program	3.24	10%	2.98
AIDS/HIV testing/counseling	3.85	2%	3.50
TB testing	4.07	0%	3.68
TB treatment	4.02	0%	3.54
Hepatitis C testing	3.96	4%	3.60
Dental care	2.98	12%	2.64
Eye care	3.35	4%	2.93
Glasses	3.29	0%	2.92
VA disability/pension	3.48	8%	3.38
Welfare payments	3.47	0%	3.05
SSI/SSD process	3.44	6%	3.07
Guardianship (financial)	3.09	4%	2.83
Help managing money	2.98	17%	2.86
Job training	3.31	8%	3.09
Help with finding a job or getting employment	3.29	19%	3.20
Help getting needed documents or identification	3.63	2%	3.28
Help with transportation	3.00	21%	3.01
Education	3.10	21%	3.05
Child care	2.61	2%	2.47
Legal assistance	3.08	8%	2.78
Discharge upgrade	2.98	2%	3.01
Spiritual	3.58	0%	3.37
Re-entry services for incarcerated veterans	2.94	6%	2.71
Elder Healthcare	3.65	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*

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.	2.81	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.15	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.17	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.	2.68	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.	1.73	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.79	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.	2.15	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.	2.48	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.04	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.	1.84	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.	1.92	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.	2.35	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?	3.78	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.89	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	No
Nursing homes	Yes
Faith-based organizations	Yes