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

CHALENG 2007 Survey Results Summary

VISN 16

Site: VA Central Arkansas Veterans HCS - 598

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: 600

2. Estimated Number of Veterans who are Chronically Homeless: 238

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: 9

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	364	0
Transitional Housing Beds	605	0
Permanent Housing Beds	653	34

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

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

Long-term, permanent housing	We will continue use of HUD-VASH Section 8 vouchers for low-income individuals, and the Jericho Continuum of Care program for formerly incarcerated veterans. We also use special HUD prevention funds to maintain veterans in housing.
Dental Care	We will continue to refer eligible veterans to VA Dental Services. Those homeless veterans not eligible are referred to the River City Ministry.
Emergency (immediate) shelter	We plan to increase our presence in local shelters. We provide health maintenance and recovery dynamics groups at Union Rescue Mission Adult Rehabilitation Center. We will also be implementing groups at the Salvation Army Transient Lodge. It is our expectation that these services will increase the willingness of providers to extend more immediate shelter beds to 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: **48**
Percentage of Participant Surveys from Homeless Veterans: **40%**

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	3.92	10%	3.42
Food	4.09	10%	3.73
Clothing	3.72	15%	3.59
Emergency (immediate) shelter	3.26	32%	3.25
Halfway house or transitional living facility	3.29	12%	3.02
Long-term, permanent housing	2.96	37%	2.46
Detoxification from substances	3.74	2%	3.32
Treatment for substance abuse	3.72	12%	3.50
Services for emotional or psychiatric problems	3.63	15%	3.43
Treatment for dual diagnosis	3.38	2%	3.25
Family counseling	3.02	5%	2.98
Medical services	3.95	5%	3.76
Women's health care	3.46	2%	3.25
Help with medication	3.81	2%	3.44
Drop-in center or day program	4.29	5%	2.98
AIDS/HIV testing/counseling	3.95	7%	3.50
TB testing	3.88	2%	3.68
TB treatment	3.82	2%	3.54
Hepatitis C testing	3.68	5%	3.60
Dental care	2.87	24%	2.64
Eye care	3.49	10%	2.93
Glasses	3.30	7%	2.92
VA disability/pension	3.48	5%	3.38
Welfare payments	3.22	5%	3.05
SSI/SSD process	3.05	7%	3.07
Guardianship (financial)	3.09	0%	2.83
Help managing money	3.09	7%	2.86
Job training	3.16	5%	3.09
Help with finding a job or getting employment	3.42	10%	3.20
Help getting needed documents or identification	3.30	0%	3.28
Help with transportation	3.22	7%	3.01
Education	3.24	5%	3.05
Child care	2.83	2%	2.47
Legal assistance	2.70	5%	2.78
Discharge upgrade	3.17	0%	3.01
Spiritual	3.25	7%	3.37
Re-entry services for incarcerated veterans	2.90	2%	2.71
Elder Healthcare	3.13	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.	2.56	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.69	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.81	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.	2.56	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.	1.81	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.31	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.	1.75	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.	2.00	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.88	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.	1.69	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.	1.81	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.	1.69	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?	3.69	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.06	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 16

Site: VA Gulf Coast HCS - 520, Biloxi, MS, Pensacola, FL

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: 275

2. Estimated Number of Veterans who are Chronically Homeless: 89

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	100	40
Transitional Housing Beds	0	50
Permanent Housing Beds	0	250

***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*

Food	Two soup kitchens have recently closed. Will work with the community to find alternative sources of food.
Treatment for substance abuse	Have been experiencing long waits to get veterans into programs. Plan is to find other referral sources that are more timely.
Dental Care	Plan is to strengthen relationship with free medical clinic which offers dental 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: **37**
Percentage of Participant Surveys from Homeless Veterans: **73%**

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

Need	Site Mean Score	% want to work on this need now*	VHA Mean Score (nationwide)**
Personal hygiene	3.71	3%	3.42
Food	4.03	11%	3.73
Clothing	3.65	14%	3.59
Emergency (immediate) shelter	3.70	14%	3.25
Halfway house or transitional living facility	3.38	23%	3.02
Long-term, permanent housing	2.17	46%	2.46
Detoxification from substances	3.56	3%	3.32
Treatment for substance abuse	3.50	11%	3.50
Services for emotional or psychiatric problems	3.30	11%	3.43
Treatment for dual diagnosis	3.30	3%	3.25
Family counseling	3.27	3%	2.98
Medical services	3.86	14%	3.76
Women's health care	3.00	0%	3.25
Help with medication	3.74	0%	3.44
Drop-in center or day program	2.71	9%	2.98
AIDS/HIV testing/counseling	3.88	3%	3.50
TB testing	3.82	0%	3.68
TB treatment	3.56	0%	3.54
Hepatitis C testing	3.82	0%	3.60
Dental care	2.97	11%	2.64
Eye care	3.09	0%	2.93
Glasses	3.03	0%	2.92
VA disability/pension	2.64	17%	3.38
Welfare payments	2.61	6%	3.05
SSI/SSD process	2.85	3%	3.07
Guardianship (financial)	2.61	0%	2.83
Help managing money	2.94	6%	2.86
Job training	3.06	11%	3.09
Help with finding a job or getting employment	3.00	26%	3.20
Help getting needed documents or identification	3.67	3%	3.28
Help with transportation	3.32	9%	3.01
Education	3.45	9%	3.05
Child care	3.21	6%	2.47
Legal assistance	3.03	3%	2.78
Discharge upgrade	3.18	6%	3.01
Spiritual	4.33	11%	3.37
Re-entry services for incarcerated veterans	3.03	3%	2.71
Elder Healthcare	3.38	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.	2.00	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.38	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.25	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.	1.50	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.00	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.38	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.	1.38	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.38	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.38	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.	1.25	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?	3.50	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.63	3.58

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

4. Existing Agreements with Community Service Types:

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

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

CHALENG 2007 Survey Results Summary

VISN 16

Site: VAMC Alexandria, LA - 502

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: 7,200

2. Estimated Number of Veterans who are Chronically Homeless: 2480

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	119	200
Transitional Housing Beds	32	200
Permanent Housing Beds	913	200

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

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

Drop-in center or day program	Will encourage local homeless coalition to spearhead development of a drop-in center.
Emergency (immediate) shelter	Will encourage community providers to partner with VA to expand number of emergency shelter beds.
Long-term, permanent housing	Will continue working with local housing authority to propose a new VA Supported Housing program.

***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: **104**
Percentage of Participant Surveys from Homeless Veterans: **36%**

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	3.26	12%	3.42
Food	3.44	26%	3.73
Clothing	3.42	16%	3.59
Emergency (immediate) shelter	3.27	31%	3.25
Halfway house or transitional living facility	3.17	18%	3.02
Long-term, permanent housing	2.69	30%	2.46
Detoxification from substances	3.53	7%	3.32
Treatment for substance abuse	3.66	12%	3.50
Services for emotional or psychiatric problems	3.36	3%	3.43
Treatment for dual diagnosis	3.13	14%	3.25
Family counseling	2.92	1%	2.98
Medical services	3.83	8%	3.76
Women's health care	3.24	7%	3.25
Help with medication	3.66	3%	3.44
Drop-in center or day program	2.63	8%	2.98
AIDS/HIV testing/counseling	3.33	5%	3.50
TB testing	3.60	1%	3.68
TB treatment	3.40	1%	3.54
Hepatitis C testing	3.29	0%	3.60
Dental care	2.71	22%	2.64
Eye care	2.97	7%	2.93
Glasses	2.92	5%	2.92
VA disability/pension	3.14	13%	3.38
Welfare payments	2.65	1%	3.05
SSI/SSD process	2.98	9%	3.07
Guardianship (financial)	2.47	0%	2.83
Help managing money	2.83	3%	2.86
Job training	2.41	5%	3.09
Help with finding a job or getting employment	2.52	8%	3.20
Help getting needed documents or identification	3.05	1%	3.28
Help with transportation	2.98	9%	3.01
Education	2.64	4%	3.05
Child care	2.18	7%	2.47
Legal assistance	2.41	1%	2.78
Discharge upgrade	2.78	3%	3.01
Spiritual	3.20	5%	3.37
Re-entry services for incarcerated veterans	2.31	3%	2.71
Elder Healthcare	2.86	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.	2.77	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.27	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.93	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.	2.31	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.	1.89	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.14	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.	2.04	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.	2.18	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.	1.71	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.	1.93	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.	2.04	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?	3.47	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.52	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	Yes
Faith-based organizations	Yes

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

VISN 16

Site: VAMC Fayetteville, AR - 564

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: 500

2. Estimated Number of Veterans who are Chronically Homeless: 139

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	160	50
Transitional Housing Beds	83	15
Permanent Housing Beds	72	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*

Halfway house or transitional living facility	We are in the process of contracting for ten beds in Northwest Arkansas and four beds in Fort Smith. With the 34 VA Grant and Per Diem beds and ten contract beds in Joplin, Missouri, this will bring our total to 58.
Long-term, permanent housing	Quality Life Associates (Fayetteville, AR) is building a 55-unit project. There will be apartments available for low-income people.
Help with transportation	Will continue to use Disabled American Veterans (DAV) van system, Ozark Regional Transit System, and the University of Arkansas Free Transit-System. The House, Inc. (Joplin, MO) received a DAV van for transporting 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: **34**
Percentage of Participant Surveys from Homeless Veterans: **62%**

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	4.18	0%	3.42
Food	4.27	13%	3.73
Clothing	3.66	9%	3.59
Emergency (immediate) shelter	4.00	19%	3.25
Halfway house or transitional living facility	3.91	13%	3.02
Long-term, permanent housing	2.83	53%	2.46
Detoxification from substances	4.24	0%	3.32
Treatment for substance abuse	4.18	0%	3.50
Services for emotional or psychiatric problems	3.86	6%	3.43
Treatment for dual diagnosis	3.47	6%	3.25
Family counseling	3.09	6%	2.98
Medical services	4.24	9%	3.76
Women's health care	3.77	0%	3.25
Help with medication	4.30	0%	3.44
Drop-in center or day program	3.37	3%	2.98
AIDS/HIV testing/counseling	3.88	0%	3.50
TB testing	4.15	0%	3.68
TB treatment	3.85	0%	3.54
Hepatitis C testing	4.09	0%	3.60
Dental care	2.97	28%	2.64
Eye care	3.44	19%	2.93
Glasses	3.03	16%	2.92
VA disability/pension	3.55	6%	3.38
Welfare payments	3.39	3%	3.05
SSI/SSD process	3.28	6%	3.07
Guardianship (financial)	3.06	0%	2.83
Help managing money	3.21	6%	2.86
Job training	2.91	3%	3.09
Help with finding a job or getting employment	3.24	6%	3.20
Help getting needed documents or identification	3.44	3%	3.28
Help with transportation	3.65	22%	3.01
Education	3.79	6%	3.05
Child care	2.32	19%	2.47
Legal assistance	2.84	3%	2.78
Discharge upgrade	3.14	0%	3.01
Spiritual	4.12	9%	3.37
Re-entry services for incarcerated veterans	3.50	3%	2.71
Elder Healthcare	3.65	3%	3.07

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

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.30	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.90	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.20	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.	2.90	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.	1.60	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.90	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.	2.90	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.	2.70	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.30	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.	1.60	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.10	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?	4.90	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.70	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	Yes
Faith-based organizations	Yes

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

CHALENG 2007 Survey Results Summary

VISN 16

Site: VAMC Houston, TX - 580

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: 4,000

2. Estimated Number of Veterans who are Chronically Homeless: 1057

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: 10

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	1,185	0
Transitional Housing Beds	2,926	1,000
Permanent Housing Beds	1,259	2,000

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

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

Long-term, permanent housing	Will contract with US. Vets to utilize some of the new Shelter Plus Care funds for permanent housing.
Emergency (immediate) shelter	Work with local homeless coalition to utilize their rapid re-housing program: a "Housing First" model that puts individuals into permanent housing immediately, bypassing shelter and transitional housing stays.
Services for emotional or psychiatric problems	Work with courts on jail diversion pilot project and with Houston Police Department to refer veterans with psychiatric issues to our VA -- rather than being arrested.

***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: **88**
Percentage of Participant Surveys from Homeless Veterans: **56%**

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	3%	3.42
Food	4.02	6%	3.73
Clothing	3.74	10%	3.59
Emergency (immediate) shelter	3.70	22%	3.25
Halfway house or transitional living facility	3.63	12%	3.02
Long-term, permanent housing	2.46	49%	2.46
Detoxification from substances	3.65	8%	3.32
Treatment for substance abuse	3.96	10%	3.50
Services for emotional or psychiatric problems	3.64	13%	3.43
Treatment for dual diagnosis	3.29	9%	3.25
Family counseling	3.14	1%	2.98
Medical services	4.05	9%	3.76
Women's health care	2.45	6%	3.25
Help with medication	3.78	3%	3.44
Drop-in center or day program	3.27	0%	2.98
AIDS/HIV testing/counseling	3.77	0%	3.50
TB testing	4.21	0%	3.68
TB treatment	3.59	0%	3.54
Hepatitis C testing	3.63	1%	3.60
Dental care	2.72	23%	2.64
Eye care	3.31	5%	2.93
Glasses	3.20	3%	2.92
VA disability/pension	2.92	17%	3.38
Welfare payments	2.36	1%	3.05
SSI/SSD process	2.37	5%	3.07
Guardianship (financial)	2.59	0%	2.83
Help managing money	3.11	8%	2.86
Job training	3.41	12%	3.09
Help with finding a job or getting employment	3.49	14%	3.20
Help getting needed documents or identification	3.51	3%	3.28
Help with transportation	3.61	3%	3.01
Education	3.00	9%	3.05
Child care	2.42	1%	2.47
Legal assistance	2.78	9%	2.78
Discharge upgrade	2.61	0%	3.01
Spiritual	3.58	6%	3.37
Re-entry services for incarcerated veterans	2.32	10%	2.71
Elder Healthcare	2.87	5%	3.07

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

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.35	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.86	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.89	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.	2.03	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.	1.54	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.55	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.	1.81	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.	2.00	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.03	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.	1.54	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.	1.52	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.	1.85	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?	3.43	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.15	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 16

Site: VAMC Jackson, MS - 586

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: 950

2. Estimated Number of Veterans who are Chronically Homeless: 303

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: 3

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	1,761	83
Transitional Housing Beds	902	230
Permanent Housing Beds	125	120

***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*

Welfare payments	Will refer clients to state agencies for applications for benefits, including food stamps.
Long-term, permanent housing	Two local HUD Continuums of Care have submitted grant applications for the develop of permanent housing projects specifically for veterans.
Re-entry services for incarcerated veterans	The I.S.I.A.H. Project is a VA Grant and Per Diem program that specializes in serving re-entering incarcerated veterans. We are trying to get a re-entry specialist for direct outreach to the penal 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: **96**
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	4.07	4%	3.42
Food	4.31	9%	3.73
Clothing	3.90	9%	3.59
Emergency (immediate) shelter	4.19	12%	3.25
Halfway house or transitional living facility	4.11	8%	3.02
Long-term, permanent housing	2.78	41%	2.46
Detoxification from substances	4.04	3%	3.32
Treatment for substance abuse	4.30	17%	3.50
Services for emotional or psychiatric problems	4.10	13%	3.43
Treatment for dual diagnosis	3.73	8%	3.25
Family counseling	3.33	1%	2.98
Medical services	4.29	8%	3.76
Women's health care	2.90	3%	3.25
Help with medication	4.04	3%	3.44
Drop-in center or day program	3.44	3%	2.98
AIDS/HIV testing/counseling	3.99	0%	3.50
TB testing	4.20	0%	3.68
TB treatment	3.72	1%	3.54
Hepatitis C testing	3.71	0%	3.60
Dental care	3.14	23%	2.64
Eye care	3.41	12%	2.93
Glasses	3.26	6%	2.92
VA disability/pension	3.06	16%	3.38
Welfare payments	2.54	6%	3.05
SSI/SSD process	3.03	9%	3.07
Guardianship (financial)	2.72	0%	2.83
Help managing money	3.14	8%	2.86
Job training	3.00	12%	3.09
Help with finding a job or getting employment	3.49	12%	3.20
Help getting needed documents or identification	3.51	5%	3.28
Help with transportation	3.88	9%	3.01
Education	3.45	16%	3.05
Child care	2.49	3%	2.47
Legal assistance	3.00	6%	2.78
Discharge upgrade	3.18	5%	3.01
Spiritual	4.05	8%	3.37
Re-entry services for incarcerated veterans	2.88	5%	2.71
Elder Healthcare	3.09	4%	3.07

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

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.46	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.50	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.29	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.	2.96	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.17	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.54	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.38	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.00	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.58	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.42	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.42	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.	2.50	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*

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?	4.42	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.31	3.58

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

4. Existing Agreements with Community Service Types:

Service Types	**VA has existing collaborative agreement with agencies?**
Correctional Facilities (Jails, prisons, courts)	No
Psychiatric/substance abuse inpatient (hospitals, wards	Yes
Nursing homes	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 16

Site: VAMC New Orleans, LA - 629

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: 2,800

2. Estimated Number of Veterans who are Chronically Homeless: 436

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	195	205
Transitional Housing Beds	205	150
Permanent Housing Beds	105	195

***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*

Emergency (immediate) shelter	Two shelters are re-opening with over 200 beds. We will be working closely with them in FY 2008.
Long-term, permanent housing	We have secured 25 housing vouchers through the Jefferson Housing Authority and will attempt to work with other parish housing authorities.
Halfway house or transitional living facility	We will help new VA Grant and Per Diem projects with their start-up, including Raven's Outreach Center in Baton Rouge, LA.

***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: **83**
Percentage of Participant Surveys from Homeless Veterans: **61%**

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	3.42	3%	3.42
Food	3.76	4%	3.73
Clothing	2.93	10%	3.59
Emergency (immediate) shelter	3.15	26%	3.25
Halfway house or transitional living facility	3.63	9%	3.02
Long-term, permanent housing	2.32	43%	2.46
Detoxification from substances	3.11	14%	3.32
Treatment for substance abuse	3.75	9%	3.50
Services for emotional or psychiatric problems	3.47	7%	3.43
Treatment for dual diagnosis	3.36	1%	3.25
Family counseling	3.29	1%	2.98
Medical services	3.77	10%	3.76
Women's health care	2.42	0%	3.25
Help with medication	3.67	4%	3.44
Drop-in center or day program	2.58	10%	2.98
AIDS/HIV testing/counseling	3.63	0%	3.50
TB testing	3.90	0%	3.68
TB treatment	3.27	1%	3.54
Hepatitis C testing	3.74	0%	3.60
Dental care	3.12	20%	2.64
Eye care	3.43	7%	2.93
Glasses	3.45	4%	2.92
VA disability/pension	2.75	21%	3.38
Welfare payments	2.23	3%	3.05
SSI/SSD process	2.93	9%	3.07
Guardianship (financial)	2.21	0%	2.83
Help managing money	2.70	6%	2.86
Job training	2.86	13%	3.09
Help with finding a job or getting employment	3.04	17%	3.20
Help getting needed documents or identification	3.17	1%	3.28
Help with transportation	3.40	16%	3.01
Education	2.99	4%	3.05
Child care	2.05	3%	2.47
Legal assistance	3.11	14%	2.78
Discharge upgrade	2.94	4%	3.01
Spiritual	3.83	0%	3.37
Re-entry services for incarcerated veterans	2.47	3%	2.71
Elder Healthcare	2.28	3%	3.07

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

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.19	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.59	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.72	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.	2.30	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.	1.50	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.59	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.	1.85	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.19	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.88	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.	1.62	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.	1.62	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.	2.04	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?	3.10	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.30	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 16

Site: VAMC Oklahoma City, OK - 635

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: 308

2. Estimated Number of Veterans who are Chronically Homeless: 119

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: 10

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	566	0
Transitional Housing Beds	340	0
Permanent Housing Beds	124	100

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

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

Long-term, permanent housing	Much HUD funding went to new builders for permanent housing in FY 2007. We will work closely with our HUD Continuum of Care.
Eye care	Will continue to work with local community agencies and try to make eye care services for homeless veterans a priority at our VA.
Help with transportation	Our staff coordinates with the Disabled American Veterans van system for patient VA appointments. In 2008, a new transportation system for community homeless will begin, thanks to funding received by our local homeless alliance.

***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: **54**
Percentage of Participant Surveys from Homeless Veterans: **56%**

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	3.65	2%	3.42
Food	3.99	11%	3.73
Clothing	3.36	7%	3.59
Emergency (immediate) shelter	3.38	2%	3.25
Halfway house or transitional living facility	3.31	7%	3.02
Long-term, permanent housing	2.19	52%	2.46
Detoxification from substances	3.48	6%	3.32
Treatment for substance abuse	3.62	4%	3.50
Services for emotional or psychiatric problems	3.19	9%	3.43
Treatment for dual diagnosis	2.82	2%	3.25
Family counseling	2.59	2%	2.98
Medical services	3.77	7%	3.76
Women's health care	2.80	0%	3.25
Help with medication	3.63	0%	3.44
Drop-in center or day program	2.34	7%	2.98
AIDS/HIV testing/counseling	3.56	2%	3.50
TB testing	4.18	0%	3.68
TB treatment	3.56	0%	3.54
Hepatitis C testing	3.63	0%	3.60
Dental care	3.06	19%	2.64
Eye care	2.11	33%	2.93
Glasses	2.04	24%	2.92
VA disability/pension	3.08	13%	3.38
Welfare payments	2.60	0%	3.05
SSI/SSD process	2.50	4%	3.07
Guardianship (financial)	2.60	4%	2.83
Help managing money	2.96	11%	2.86
Job training	2.71	9%	3.09
Help with finding a job or getting employment	3.10	9%	3.20
Help getting needed documents or identification	3.04	6%	3.28
Help with transportation	3.15	20%	3.01
Education	2.67	7%	3.05
Child care	1.98	2%	2.47
Legal assistance	2.27	7%	2.78
Discharge upgrade	2.76	2%	3.01
Spiritual	3.00	4%	3.37
Re-entry services for incarcerated veterans	2.20	4%	2.71
Elder Healthcare	2.64	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.	2.71	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.43	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.07	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.	2.14	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.	1.29	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.43	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.	1.86	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.	2.36	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.29	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.	1.57	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.	1.57	1.62
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.07	1.83

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

3. VA/Community Integration*

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score**	**VHA (nationwide) Mean Score****
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.00	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.71	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	Yes
Faith-based organizations	Yes

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

CHALENG 2007 Survey Results Summary

VISN 16

Site: VAMC Shreveport, LA - 667

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: 162

2. Estimated Number of Veterans who are Chronically Homeless: 60

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: 1

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	200	100
Transitional Housing Beds	97	60
Permanent Housing Beds	50	40

***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*

Halfway house or transitional living facility	Continue to work with community partners in applying for grants, and maintain current partnerships with transitional housing providers.
Long-term, permanent housing	Continue to increase the number of HUD Shelter Plus Care vouchers and maintain partnership with Housing Authority of Bossier City. Build relationships with HUD-subsidized properties.
Dental Care	All veterans in our VA homeless housing programs are receiving dental care. Other veterans have to go to Louisiana State University Medical Center. Individuals staying at the local rescue mission can take advantage of a new dental clinic.

***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: **89**
Percentage of Participant Surveys from Homeless Veterans: **57%**

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	3%	3.42
Food	4.00	7%	3.73
Clothing	3.93	5%	3.59
Emergency (immediate) shelter	3.89	22%	3.25
Halfway house or transitional living facility	4.03	22%	3.02
Long-term, permanent housing	3.35	45%	2.46
Detoxification from substances	4.14	5%	3.32
Treatment for substance abuse	4.22	11%	3.50
Services for emotional or psychiatric problems	3.94	5%	3.43
Treatment for dual diagnosis	3.61	7%	3.25
Family counseling	3.41	0%	2.98
Medical services	4.34	6%	3.76
Women's health care	3.57	3%	3.25
Help with medication	3.94	5%	3.44
Drop-in center or day program	3.32	11%	2.98
AIDS/HIV testing/counseling	3.96	1%	3.50
TB testing	4.00	0%	3.68
TB treatment	3.81	0%	3.54
Hepatitis C testing	3.90	1%	3.60
Dental care	3.37	22%	2.64
Eye care	3.62	6%	2.93
Glasses	3.63	5%	2.92
VA disability/pension	3.39	14%	3.38
Welfare payments	3.09	0%	3.05
SSI/SSD process	3.10	7%	3.07
Guardianship (financial)	3.06	5%	2.83
Help managing money	3.32	6%	2.86
Job training	3.34	10%	3.09
Help with finding a job or getting employment	3.34	18%	3.20
Help getting needed documents or identification	3.71	3%	3.28
Help with transportation	3.46	6%	3.01
Education	3.52	6%	3.05
Child care	2.92	2%	2.47
Legal assistance	2.97	4%	2.78
Discharge upgrade	3.39	2%	3.01
Spiritual	3.80	6%	3.37
Re-entry services for incarcerated veterans	3.15	19%	2.71
Elder Healthcare	3.44	3%	3.07

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

2. Level of Collaboration Activities Between VA and Community*

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score**	**VHA (nationwide) Mean Score****
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.47	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.85	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.21	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.	2.36	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.	1.82	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.	1.88	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.	2.00	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.94	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.	1.75	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.	1.75	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.	1.91	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?	3.93	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.83	3.58

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

4. Existing Agreements with Community Service Types:

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

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

CHALENG 2007 Survey Results Summary

VISN 16

Site: VAMC Muskogee, OK-623 (Tulsa, OK)

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: 250

2. Estimated Number of Veterans who are Chronically Homeless: 98

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	600	0
Transitional Housing Beds	41	10
Permanent Housing Beds	0	30

***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*

Halfway house or transitional living facility	We are encouraging local mental health association to apply for VA Grant and Per Diem funding.
Dental Care	One of our VA Grant and Per Diem programs is applying for VA dental funds. We will also attempt to develop a fee-basis arrangement with community dentists.
Help with transportation	We will strengthen our community relationships to help address transportation needs.

***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: **53**
Percentage of Participant Surveys from Homeless Veterans: **48%**

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	3.66	0%	3.42
Food	4.00	12%	3.73
Clothing	3.60	12%	3.59
Emergency (immediate) shelter	3.77	7%	3.25
Halfway house or transitional living facility	3.56	16%	3.02
Long-term, permanent housing	2.44	40%	2.46
Detoxification from substances	3.55	7%	3.32
Treatment for substance abuse	3.78	16%	3.50
Services for emotional or psychiatric problems	3.74	16%	3.43
Treatment for dual diagnosis	3.58	7%	3.25
Family counseling	3.35	2%	2.98
Medical services	3.88	19%	3.76
Women's health care	2.91	2%	3.25
Help with medication	3.60	0%	3.44
Drop-in center or day program	3.50	2%	2.98
AIDS/HIV testing/counseling	3.72	0%	3.50
TB testing	3.83	0%	3.68
TB treatment	3.62	0%	3.54
Hepatitis C testing	3.55	0%	3.60
Dental care	2.45	25%	2.64
Eye care	2.69	7%	2.93
Glasses	2.51	5%	2.92
VA disability/pension	3.20	19%	3.38
Welfare payments	2.90	0%	3.05
SSI/SSD process	2.84	16%	3.07
Guardianship (financial)	3.00	2%	2.83
Help managing money	2.82	9%	2.86
Job training	2.84	9%	3.09
Help with finding a job or getting employment	3.10	14%	3.20
Help getting needed documents or identification	3.31	0%	3.28
Help with transportation	3.29	9%	3.01
Education	3.12	5%	3.05
Child care	2.67	2%	2.47
Legal assistance	2.78	7%	2.78
Discharge upgrade	2.77	5%	3.01
Spiritual	3.37	0%	3.37
Re-entry services for incarcerated veterans	2.62	5%	2.71
Elder Healthcare	3.23	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.	2.07	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.46	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.46	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.	1.81	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.	1.78	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.30	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.	1.43	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.	1.68	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.64	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.	1.35	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.	1.42	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.	1.58	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?	3.32	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.36	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	Yes
Faith-based organizations	Yes