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

CHALENG 2007 Survey Results Summary

VISN 9

Site: VAMC Huntington, WV - 581

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: 110

2. Estimated Number of Veterans who are Chronically Homeless: 15

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: 5

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	240	0
Transitional Housing Beds	60	25
Permanent Housing Beds	50	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*

Long-term, permanent housing	Our staff will actively participate in the HUD Continuum of Care planning process. Permanent housing will continue to be emphasized as a priority planning consideration.
Halfway house or transitional living facility	The Roark-Sullivan Lifeway Center, Charleston, WV received funding approval for a 27- bed GPD transitional housing program. Matching funds have been obtained and construction is now in progress.
Detoxification from substances	VA staff will make referrals to VA and/or non-VA detoxification programs. We will continue to advocate for the expansion of existing program bed capacity and the creation of new detoxification program 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: **21**
Percentage of Participant Surveys from Homeless Veterans: **10%**

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	0%	3.42
Food	4.05	5%	3.73
Clothing	4.05	5%	3.59
Emergency (immediate) shelter	4.24	0%	3.25
Halfway house or transitional living facility	2.67	35%	3.02
Long-term, permanent housing	2.43	60%	2.46
Detoxification from substances	3.00	25%	3.32
Treatment for substance abuse	3.15	20%	3.50
Services for emotional or psychiatric problems	3.20	15%	3.43
Treatment for dual diagnosis	2.95	15%	3.25
Family counseling	3.10	0%	2.98
Medical services	3.67	0%	3.76
Women's health care	3.32	0%	3.25
Help with medication	3.62	0%	3.44
Drop-in center or day program	3.19	0%	2.98
AIDS/HIV testing/counseling	3.14	5%	3.50
TB testing	3.62	0%	3.68
TB treatment	3.20	0%	3.54
Hepatitis C testing	3.47	0%	3.60
Dental care	2.35	20%	2.64
Eye care	2.50	0%	2.93
Glasses	2.30	0%	2.92
VA disability/pension	3.32	10%	3.38
Welfare payments	3.10	0%	3.05
SSI/SSD process	3.20	5%	3.07
Guardianship (financial)	2.53	5%	2.83
Help managing money	2.70	20%	2.86
Job training	3.10	15%	3.09
Help with finding a job or getting employment	3.20	20%	3.20
Help getting needed documents or identification	3.50	0%	3.28
Help with transportation	3.05	0%	3.01
Education	3.10	0%	3.05
Child care	2.33	0%	2.47
Legal assistance	2.55	0%	2.78
Discharge upgrade	2.78	5%	3.01
Spiritual	3.75	0%	3.37
Re-entry services for incarcerated veterans	2.33	15%	2.71
Elder Healthcare	2.79	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.	2.63	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.00	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.60	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.	2.13	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.	1.56	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.63	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.	1.53	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.	1.94	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.81	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.	1.53	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.	1.40	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.	1.44	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?	3.53	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.56	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 9

Site: VAMC Lexington, KY - 596

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: 70

2. Estimated Number of Veterans who are Chronically Homeless: 25

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	170	0
Transitional Housing Beds	140	25
Permanent Housing Beds	35	15

***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*

Services for emotional or psychiatric problems	We are discussing with our VAMC leadership establishing a mental health intensive case management (MHICM) team to serve veterans with chronic mental illness.
Long-term, permanent housing	No actions planned at this time.
Emergency (immediate) shelter	No actions planned at this time.

***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: **14**
Percentage of Participant Surveys from Homeless Veterans: **43%**

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	4.22	17%	3.42
Food	4.36	17%	3.73
Clothing	4.50	8%	3.59
Emergency (immediate) shelter	4.15	8%	3.25
Halfway house or transitional living facility	3.70	8%	3.02
Long-term, permanent housing	2.85	42%	2.46
Detoxification from substances	4.08	8%	3.32
Treatment for substance abuse	4.15	0%	3.50
Services for emotional or psychiatric problems	3.65	8%	3.43
Treatment for dual diagnosis	3.36	8%	3.25
Family counseling	3.00	0%	2.98
Medical services	4.14	0%	3.76
Women's health care	3.20	8%	3.25
Help with medication	3.69	8%	3.44
Drop-in center or day program	3.08	0%	2.98
AIDS/HIV testing/counseling	3.64	0%	3.50
TB testing	4.36	0%	3.68
TB treatment	4.23	0%	3.54
Hepatitis C testing	4.07	0%	3.60
Dental care	3.57	0%	2.64
Eye care	4.00	0%	2.93
Glasses	3.71	0%	2.92
VA disability/pension	3.00	42%	3.38
Welfare payments	3.00	0%	3.05
SSI/SSD process	3.15	17%	3.07
Guardianship (financial)	3.00	0%	2.83
Help managing money	3.00	17%	2.86
Job training	2.93	8%	3.09
Help with finding a job or getting employment	3.07	8%	3.20
Help getting needed documents or identification	3.50	0%	3.28
Help with transportation	3.21	8%	3.01
Education	3.21	17%	3.05
Child care	2.64	0%	2.47
Legal assistance	3.07	0%	2.78
Discharge upgrade	2.77	0%	3.01
Spiritual	3.64	8%	3.37
Re-entry services for incarcerated veterans	3.17	17%	2.71
Elder Healthcare	3.00	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.	3.00	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.17	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.	3.17	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.	2.00	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.50	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.	2.50	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.17	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.83	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.	1.67	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?	4.00	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.33	3.58

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

4. Existing Agreements with Community Service Types:

Service Types	**VA has existing collaborative agreement with agencies?**
Correctional Facilities (Jails, prisons, courts)	Yes
Psychiatric/substance abuse inpatient (hospitals, wards	Yes
Nursing homes	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 9

Site: VAMC Louisville, KY - 603

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: 450

2. Estimated Number of Veterans who are Chronically Homeless: 153

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	599	100
Transitional Housing Beds	1,008	75
Permanent Housing Beds	715	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*

Long-term, permanent housing	Continue to work with local area housing agencies to assist veterans in obtaining permanent housing. Use Internet to locate affordable apartments for veterans.
Emergency (immediate) shelter	Formal and informal discussion with local shelter providers regarding need for regular emergency beds (non-transitional, medical holdover, etc.).
Help with finding a job or getting employment	Increased communication with local providers of employment services (particularly Goodwill Industries and Department of Labor). Increase knowledge of Social Security "Ticket to Work" program. Update our list of potential employers for ex-offenders.

***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: 69
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	3.53	0%	3.42
Food	4.12	8%	3.73
Clothing	3.70	3%	3.59
Emergency (immediate) shelter	3.80	16%	3.25
Halfway house or transitional living facility	3.55	6%	3.02
Long-term, permanent housing	2.81	28%	2.46
Detoxification from substances	3.62	8%	3.32
Treatment for substance abuse	4.00	16%	3.50
Services for emotional or psychiatric problems	3.61	6%	3.43
Treatment for dual diagnosis	3.24	8%	3.25
Family counseling	3.03	5%	2.98
Medical services	3.96	14%	3.76
Women's health care	3.37	2%	3.25
Help with medication	3.59	3%	3.44
Drop-in center or day program	3.65	3%	2.98
AIDS/HIV testing/counseling	3.79	0%	3.50
TB testing	4.20	0%	3.68
TB treatment	3.97	2%	3.54
Hepatitis C testing	3.79	2%	3.60
Dental care	2.85	16%	2.64
Eye care	3.05	10%	2.93
Glasses	3.08	3%	2.92
VA disability/pension	3.51	14%	3.38
Welfare payments	3.18	2%	3.05
SSI/SSD process	3.03	8%	3.07
Guardianship (financial)	2.84	8%	2.83
Help managing money	2.83	8%	2.86
Job training	3.03	11%	3.09
Help with finding a job or getting employment	3.19	24%	3.20
Help getting needed documents or identification	3.09	8%	3.28
Help with transportation	2.94	10%	3.01
Education	3.09	6%	3.05
Child care	2.65	10%	2.47
Legal assistance	2.78	11%	2.78
Discharge upgrade	2.94	6%	3.01
Spiritual	3.49	6%	3.37
Re-entry services for incarcerated veterans	2.90	2%	2.71
Elder Healthcare	3.06	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.	2.67	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	2.00	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.06	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.	2.61	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.06	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.82	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.	2.39	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.28	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.	1.72	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.	1.61	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.	2.11	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?	3.89	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	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 9

Site: VAMC Memphis, TN - 614

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: 208

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: 7

2. Housing Inventory

Housing Inventory	Beds*	# of additional beds site could use
Emergency Beds	271	10
Transitional Housing Beds	380	10
Permanent Housing Beds	249	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*

Halfway house or transitional living facility	New 10-bed VA Grant and Per Diem program for hospice care will open in December 2007. We still need more beds for veterans with mental health and dual diagnosis issues.
Glasses	Will continue to look for resources. Still no assistance available for veterans purchasing glasses.
Long-term, permanent housing	Long-term permanent housing is needed for veterans who complete transitional housing. Some have to go back to their old environment or to housing that is not sober living.

***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: **81%**

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	4.46	2%	3.42
Food	4.62	5%	3.73
Clothing	4.05	5%	3.59
Emergency (immediate) shelter	4.26	10%	3.25
Halfway house or transitional living facility	4.42	5%	3.02
Long-term, permanent housing	2.76	57%	2.46
Detoxification from substances	4.24	2%	3.32
Treatment for substance abuse	4.32	7%	3.50
Services for emotional or psychiatric problems	3.75	10%	3.43
Treatment for dual diagnosis	3.53	12%	3.25
Family counseling	3.48	10%	2.98
Medical services	4.31	2%	3.76
Women's health care	3.44	0%	3.25
Help with medication	4.07	12%	3.44
Drop-in center or day program	3.57	0%	2.98
AIDS/HIV testing/counseling	4.07	2%	3.50
TB testing	4.49	0%	3.68
TB treatment	4.15	0%	3.54
Hepatitis C testing	4.43	0%	3.60
Dental care	3.81	19%	2.64
Eye care	4.27	5%	2.93
Glasses	4.17	2%	2.92
VA disability/pension	3.05	22%	3.38
Welfare payments	2.67	0%	3.05
SSI/SSD process	2.88	10%	3.07
Guardianship (financial)	3.00	0%	2.83
Help managing money	3.38	5%	2.86
Job training	3.30	22%	3.09
Help with finding a job or getting employment	3.49	17%	3.20
Help getting needed documents or identification	4.04	2%	3.28
Help with transportation	3.81	5%	3.01
Education	3.70	22%	3.05
Child care	2.92	2%	2.47
Legal assistance	3.27	7%	2.78
Discharge upgrade	3.31	5%	3.01
Spiritual	4.21	7%	3.37
Re-entry services for incarcerated veterans	3.11	7%	2.71
Elder Healthcare	3.31	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.	2.00	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.40	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.67	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.	1.17	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.	1.25	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33	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.	1.00	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.	1.40	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.40	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.33	1.61
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.80	1.62
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.83	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?	3.56	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.14	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 9

Site: VAMC Mountain Home, TN - 621

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: 254

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	196	75
Transitional Housing Beds	104	10
Permanent Housing Beds	50	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*

Long-term, permanent housing	Continue use of Shelter Plus Care program to maximum benefit. Explore other permanent housing options in the area.
Help with finding a job or getting employment	Working with a local employment task force exploring opportunities for job finding.
Dental Care	Community partners looking for to find funding and to provide services through the Johnson City Dental Clinic. We will be looking for national, state, and county grants to apply for.

***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: 42
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	3.98	0%	3.42
Food	4.20	0%	3.73
Clothing	3.93	0%	3.59
Emergency (immediate) shelter	3.69	19%	3.25
Halfway house or transitional living facility	3.66	28%	3.02
Long-term, permanent housing	2.98	58%	2.46
Detoxification from substances	3.74	3%	3.32
Treatment for substance abuse	3.81	3%	3.50
Services for emotional or psychiatric problems	3.77	17%	3.43
Treatment for dual diagnosis	3.53	8%	3.25
Family counseling	3.24	3%	2.98
Medical services	4.05	11%	3.76
Women's health care	3.29	0%	3.25
Help with medication	3.90	8%	3.44
Drop-in center or day program	3.32	6%	2.98
AIDS/HIV testing/counseling	3.83	0%	3.50
TB testing	4.10	0%	3.68
TB treatment	3.57	0%	3.54
Hepatitis C testing	3.82	0%	3.60
Dental care	2.62	28%	2.64
Eye care	3.23	3%	2.93
Glasses	3.37	6%	2.92
VA disability/pension	3.25	14%	3.38
Welfare payments	3.03	0%	3.05
SSI/SSD process	3.00	14%	3.07
Guardianship (financial)	2.66	0%	2.83
Help managing money	3.03	11%	2.86
Job training	2.88	19%	3.09
Help with finding a job or getting employment	3.33	8%	3.20
Help getting needed documents or identification	3.72	3%	3.28
Help with transportation	3.20	8%	3.01
Education	3.68	6%	3.05
Child care	2.79	3%	2.47
Legal assistance	3.10	3%	2.78
Discharge upgrade	3.03	3%	3.01
Spiritual	3.90	6%	3.37
Re-entry services for incarcerated veterans	2.68	6%	2.71
Elder Healthcare	3.00	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.	2.33	2.56
Co-location of Services - Services from the VA and your agency provided in one location.	1.44	1.89
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.06	1.86
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.22	2.26
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.83	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.56	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.	1.94	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.61	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.	1.47	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.	1.72	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?	4.44	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.39	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 9

Site: VAMC Nashville, TN - 626 (Nashville and Murfreesboro)

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: 225

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	636	90
Transitional Housing Beds	159	26
Permanent Housing Beds	70	140

***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*

Treatment for substance abuse	We will continue to build relationship with community programs that serve veterans who are ineligible for VA services or have exhausted their benefit under VA Substance Abuse Treatment Program guidelines.
VA disability/pension	We are looking for a consistent point of contact to expedite claims for VA service-connected and non-service-connected benefits.
SSI/SSD process	We will continue to develop closer relationship with local SOARS contact to expedite SSI/SSD process.

***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: **78**
Percentage of Participant Surveys from Homeless Veterans: **65%**

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

Need	Site Mean Score	% want to work on this need now*	VHA Mean Score (nationwide)**
Personal hygiene	3.95	2%	3.42
Food	4.04	6%	3.73
Clothing	3.79	9%	3.59
Emergency (immediate) shelter	4.14	11%	3.25
Halfway house or transitional living facility	4.18	12%	3.02
Long-term, permanent housing	3.10	33%	2.46
Detoxification from substances	3.92	6%	3.32
Treatment for substance abuse	4.00	17%	3.50
Services for emotional or psychiatric problems	3.66	17%	3.43
Treatment for dual diagnosis	3.25	9%	3.25
Family counseling	2.85	8%	2.98
Medical services	4.00	14%	3.76
Women's health care	2.80	5%	3.25
Help with medication	3.85	0%	3.44
Drop-in center or day program	3.27	9%	2.98
AIDS/HIV testing/counseling	3.71	2%	3.50
TB testing	3.80	0%	3.68
TB treatment	3.48	0%	3.54
Hepatitis C testing	3.87	0%	3.60
Dental care	2.88	20%	2.64
Eye care	3.16	2%	2.93
Glasses	3.01	3%	2.92
VA disability/pension	3.04	20%	3.38
Welfare payments	2.67	0%	3.05
SSI/SSD process	2.84	6%	3.07
Guardianship (financial)	2.77	0%	2.83
Help managing money	3.57	12%	2.86
Job training	3.51	17%	3.09
Help with finding a job or getting employment	3.92	8%	3.20
Help getting needed documents or identification	4.14	2%	3.28
Help with transportation	3.97	8%	3.01
Education	3.31	11%	3.05
Child care	2.51	2%	2.47
Legal assistance	2.96	18%	2.78
Discharge upgrade	2.97	3%	3.01
Spiritual	3.76	6%	3.37
Re-entry services for incarcerated veterans	2.88	3%	2.71
Elder Healthcare	2.70	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.	2.86	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.	2.14	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.	2.71	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.	2.39	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.29	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.	2.57	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.	2.63	2.15
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.57	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.	2.07	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.	2.18	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.	2.18	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?	3.97	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.72	3.58

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

4. Existing Agreements with Community Service Types:

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