



**July 2003**

**2003 ANNUAL REPORT  
OF THE ADVISORY COMMITTEE  
ON HOMELESS VETERANS**

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## **ADVISORY COMMITTEE ON HOMELESS VETERANS ANNUAL REPORT**

### **History**

On December 21, 2001, President George W. Bush signed Public Law 107-95, the Homeless Veterans Comprehensive Assistance Act of 2001. The Act's intent is to revise, improve and consolidate provisions of law providing benefits and services for homeless veterans. In response to its provisions, the Advisory Committee on Homeless Veterans (ACHV) was established on March 1, 2002, pursuant to section 2066 of Title 38, United States Code. The mission of the Advisory Committee on Homeless Veterans is to provide advice and make recommendations to the Secretary on issues and problems affecting homeless veterans, assess the needs of homeless veterans and determining if the Department of Veterans Affairs and other programs and services are meeting those needs.

The Law required that the committee consist of no more than 15 members appointed by the Secretary, from specific areas of expertise or affiliations as well as other organizations or groups deemed appropriate by the Secretary. The committee also includes ex-officio members from the Departments of Labor, Defense, Health and Human Services, and Housing and Urban Development. While not among the committee's 15 members, the Chair of the Advisory Committee on Women's Veterans, sits with this committee to ensure that the needs of women veterans are reflected in the committee's actions. The Secretary determines the length of service for each committee member whose tenure may not exceed three years. Members are eligible for reappointment.

### **Members:**

The members of the Advisory Committee on Homeless Veterans were selected by the Secretary of Veterans Affairs from knowledgeable candidates who are experts in the treatment of individuals with mental illness, experts in the treatment of substance abuse disorders, experts in the development of permanent housing alternatives for lower income populations, state veterans' affairs officials, community-based service providers, advocates of homeless veterans and other homeless individuals. The law also specified that the committee include a previously homeless veteran as a member. The members serve without pay; and in accordance with the committee's charter, may meet annually up to four times but not less than twice at the call of the Chair. Approximately half the members were appointed for two years and the remainder for three years.

Below is a list of the committee members and a brief biographical summary:

**Michael Blecker** Executive Director of the Swords to Plowshares. Mr. Blecker operates programs for homeless veterans in the San Francisco Bay area. Swords to Plowshares is a direct service provider, and a VA grantee under VA's Homeless Grant and Per Diem Program. Mr. Blecker is a founding board member of the National Coalition for Homeless Veterans. Mr. Blecker, a veteran, was appointed for a three-year term.

**Raymond Boland** Secretary, Wisconsin Department of Veterans Affairs. Mr. Boland serves as the State Secretary of Veterans Affairs. The Wisconsin Department of Veterans Affairs is a direct service provider and a VA grantee. Mr. Boland is a former board member of the National Coalition for Homeless Veterans. Mr. Boland, a veteran, was appointed for a three-year term.

**Ralph D. Cooper** Executive Director, Veterans Benefits Clearinghouse, Inc. Roxbury, MA. His organization is a direct service provider operating a number of programs for homeless veterans and is also a VA grantee. Mr. Cooper is a former charter member of the National Coalition for Homeless Veterans. Mr. Cooper, a veteran, was appointed for a three-year term.

**Thomas Cray** President, Veterans Outreach Center, Inc., Rochester, New York. The Veterans Outreach Center is a VA grantee that provides transitional housing and employment services to veterans in upstate New York. Mr. Cray was elected in July 2001 as the President of the Board of National Coalition for Homeless Veterans. Mr. Cray, a Vietnam Veteran, was appointed for a three-year term.

**Dominic DiFrancesco** Former National Commander, The American Legion. Mr. DiFrancesco is a past national commander of the American Legion. The American Legion is not a grantee or a service provider; however, Mr. DiFrancesco, a veteran, was appointed for a two-year term.

**Paul Errera, M.D.** Retired VA Physician. Dr. Errera served as VA's Director of Mental Health and Behavioral Sciences for nine years (1985-1994). Thereafter, he served as senior clinician at the VA Continuing Community Care Center and at the North East Program Evaluation Center. Dr. Errera was appointed for a two-year term.

**Marsha T. Four, RN** Chair, Advisory Committee on Women's Veterans; Director, Homeless Veterans Service, Philadelphia Veterans Multiservice Center. The Philadelphia Veterans Multiservice Center is a VA grantee that provides transitional housing and supportive services to veterans in Eastern Pennsylvania. Ms. Four is a National Board member of the Vietnam Veterans of America. Ms. Four, a veteran, sits with the committee in her role as Chair of the Advisory Committee on Women's Veterans.

**Samuel C. Galbreath Jr.** Principal, Sam Galbreath Associates; Housing & Community Development, Oregon. Mr. Galbreath is a developer in the Northwest whose organization develops low-income housing and community facilities. He has worked using VA's Enhanced Use Lease Program to develop 189 units of service enriched housing at VA's Vancouver and Roseburg Campuses. His company is not a direct services provider and is not a VA grantee. Mr. Galbreath served in the National Guard and was appointed for a two-year term.

**Carlos Martinez** President & CEO, American GI Forum, National Veterans Outreach Program Inc., San Antonio, Texas. The American GI Forum is a direct service provider and a VA grantee that operates transitional housing programs for homeless and employment services. Mr. Martinez served on the Department of Labor's Veterans Employment and Training Services (VETS) Advisory Committee and is currently on the VA's Advisory Committee on Veterans Readjustment. Mr. Martinez, a veteran, was appointed for a two-year term.

**James F. Mclsaac** CEO, Vietnam Veterans Workshop, doing business as New England Shelter for Homeless Veterans. Mr. Mclsaac served until March 2003 as CEO. The Vietnam Veterans Workshop is a direct service provider and a VA grantee. Mr. Mclsaac, a veteran, was appointed for a two-year term.

**Donald W. Moreau** Consultant, Hoosier Veterans Assistance Foundation (HVAF), Indianapolis, IN. Colonel Moreau is retired from the U.S. Army. His last assignment was Commander, U.S. Armor Agency, U.S. Army Combat Development Command. He was an active member of HVAF and has previously worked for three Governors of Indiana on veterans' issues, welfare to work programs and homeless projects. Mr. Moreau, a veteran, was appointed for a two-year term.

**Al Pavich** President & CEO, Vietnam Veterans of San Diego, San Diego, CA. Vietnam Veterans of San Diego provides transitional housing and employment services to successfully help homeless veterans and their children restore their lives and become productive citizens. Mr. Pavich, a retired Commander of the United States Navy, was appointed for a two-year term.

**Richard C. Schneider** National Director, Veterans and State Veterans Affairs, Non Commissioned Officers Association of the United States of America. Mr. Schneider is the current Chair of the Veterans Organization Homeless Council. This organization is a coalition of veterans' service organizations and military organizations that meets regularly to coordinate a united effort on legislative and administrative activities in support of homeless veterans. Mr. Schneider, an Air Force veteran, was appointed for a two-year term.

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<sup>β</sup> Mr. Mclsaac resigned from the advisory committee prior to the final submission of this report.

**Kathryn E. Spearman** President/CEO, Volunteers of America (VOA) of Florida, Inc., Tampa FL. Ms. Spearman is the CEO of Volunteers of America, Florida, a faith-based organization that operates a number of transitional housing programs in Florida for veterans and a one stop multi-service center as well as a full service mobile medical and benefits vehicle. VOA is a direct service provider and a VA grantee. Ms. Spearman was appointed for a three-year term.

**Roosevelt Thompson** Systems Account Associate, Council for Early Childhood Professional Recognition, Washington, D.C. Mr. Thompson enrolled and completed VA's Compensated Work Therapy Program. He has successfully transitioned into the workforce at the Xerox Corporation. He has previously testified before Congress on his experiences as a homeless veteran. Mr. Thompson, a veteran, was appointed for a three-year term.

**Robert Van Keuren** Homeless Veterans Program Coordinator, Veterans Integrated Systems Network 2, Behavioral VA Health Care Line. Mr. Van Keuren was appointed Chairman of the Advisory Committee on Homeless Veterans. He was a founding member of the National Coalition for Homeless Veterans and previously served as Executive Director of the Vietnam Veterans of San Diego. He was one of the creators of the Stand Down concept for reaching out to homeless veterans. Mr. Van Keuren, a Vietnam Veteran, was appointed for a three-year term.

**Peter H. Dougherty** Director of Homeless Veterans Programs, Department of Veterans Affairs, Washington D.C. Mr. Dougherty was appointed to serve as the Designated Federal Official for the Advisory Committee on Homeless Veterans.

## **MINUTES OF THE ADVISORY COMMITTEE ON HOMELESS VETERANS**

### **Meeting June 3-5, 2002**

The first meeting of the Advisory Committee on Homeless Veterans was held on June 3-5 2002 at the Ronald Reagan Building and International Trade Center, 1300 Pennsylvania Avenue, NW Washington D.C. All members including ex-officio members from the Departments of Housing & Urban Development, Labor, Defense and Health and Human Services and Mr. Pete Dougherty, the committee's Designated Federal Official, were in attendance.

The meeting was called to order at 8:30 a.m. by Chairman Robert Van Keuren and began with a prayer by Chaplain Clarence Cross from the VA Medical Center in Washington. Dr. Leo Mackay, Jr., Deputy Secretary of Veterans Affairs, welcomed the members of the committee on behalf of Secretary Principi and President Bush and presented Chairman Van Keuren with his Certificate of Appointment. Chairman Van Keuren and Mr. Dougherty presented each committee member with a Certificate of Appointment.

The following presentations were made during the committee's initial three-day meeting:

- Mr. Robert DiBella, Staff Attorney, VA's Office of General Counsel, conducted a review of required ethics training.
- Mr. Peter Dougherty, Director, Homeless Veterans Program Office, gave an overview of Public Law 107-95, the Homeless Veterans Comprehensive Assistance Act of 2001.
- Dr. Craig Burnette, Coordinator, Project Community Homeless Assessment Local Education and Networking Groups, discussed the CHALENG reporting process and reviewed the latest report.
- Ms. Gay Koerber, Associate Chief Consultant, VA Health Care for Homeless Veterans (HCHV), gave an overview of VA's Health Care for Homeless Veterans programs.
- Mr. Roger Casey, Director, Homeless Providers Grant & Per Diem Program, gave an overview of VA's Grant & Per Diem program.
- Dr. Robert Rosenheck, Director, Northeast Program Evaluation Center (NEPEC), outlined program monitoring and evaluation of VA's homeless programs.
- Dr. Laurent Lehmann, Chief Consultant, VA Mental Health Strategic Health Group, gave an overview of VA's Mental Health program.

- Dr. Scott Murray, Director, Veterans Integrated Service Network 2, Behavioral VA Health Care Line, outlined the Integration of Mental Health into Primary Care.
- Ms. Rita Reed, Deputy Assistant Secretary, Office of Management & Budget, outlined VA's Funding and Resources.
- Ms. Harriett Heywood, Associate Director, Center for Women Veterans – outlined and distributed an informational packet on Women Veterans.
- Dr. Alfonso R. Batres, Director, Readjustment Counseling Services, gave an overview of the readjustment counseling service often referred to as veteran centers.
- Anthony Campinell, Associate Chief Consultant Psychosocial Rehabilitation, outlined VA's Compensated Work Therapy program.
- Ronald J. Henke, Director, Compensation & Pension Service, Veterans Benefit Administration, and Ms. Jacqueline Bobo (VBA) Homeless Coordinator, outlined VA's compensation & pension programs.
- Peggy McGee, Director, Communications Management Services, outlined and distributed an informational packet regarding the National Cemetery Administration.
- Charles Ciccoella, Deputy Assistant Secretary, Veterans Employment & Training Service, Department of Labor, presented and gave handouts on the Department of Labor's programs that assist homeless veterans.
- Phil Mangano, Executive Director, US Interagency Council on Homelessness (ICH), gave an overview of the US Interagency Council on Homelessness.
- Ms. Barbara Broman, Deputy to the Deputy Assistant Secretary for Human Services Policy, gave an overview of the Department of Health and Human Services homeless program.
- Mr. James Breckenridge, Chief, Psychology Service, VA Medical Center, Palo Alto, outlined the Veterans Equitable Resource Allocation (VERA) funding system.
- Mr. John Garrity, Director, Special Needs Assistance Programs, gave an overview of the Department of Housing and Urban Development (HUD) homeless programs.

- Mr. George Basher, Director, New York State Division of Veterans Affairs, outlined the role and responsibility of the National Association of State Directors of Veterans Affairs.
- Ms. Sharon Hodge, gave an overview of Vietnam Veterans of America (VVA) homeless initiatives.
- Mr. Tony Island, gave an overview of Veterans of Foreign Wars (VFW) homeless initiatives.
- Mr. Donald Whitehead, Executive Director, National Coalition for the Homeless (NCH), gave an overview of NCH programs and mission.
- Ms. Linda Boone, Executive Director, National Coalition for Homeless Veterans (NCHV), gave an overview of NCHV's programs and mission.

On Wednesday, June 5, 2002, the Secretary of Veterans Affairs, Anthony J. Principi, visited the committee and expressed his thanks to each member for serving on this very important committee. He told the committee that its goal is to ultimately eradicate the homeless veterans population and, in the interim, make suggestions to reduce it as much as possible. He also highlighted that a significant amount of work needs to be done to end homelessness but that he was confident there are many dedicated people on this committee working to address the needs of homeless veterans. The Secretary told the committee that its work would be carefully studied and reviewed and, where possible, implemented.

Chairman Van Keuren thanked the Secretary for taking time to meet with the committee. He told the Secretary that the committee would work diligently to give the Department the best advice possible. The meeting was adjourned at noon on June 5, 2002.

### **Meeting September 18-20, 2002**

The second meeting of the Advisory Committee on Homeless Veterans began on September 18, 2002, at the Louis Stokes VA Medical Center in Brecksville, Ohio. Members began this opening day session by boarding a bus and touring the following facilities that provide services to homeless veterans in and around Cleveland, Ohio. Listed below is a brief summary of the programs and sites visited by the committee:

#### **Transitional Residence Program**

9401 Lorain Avenue,  
Cleveland, Ohio  
Robert Darby – Program Coordinator

In VA's Compensated Work Therapy/Transitional Residence (CWT/TR) also known as "Veterans Industries", disadvantaged, at-risk and homeless veterans live in a 25-bed community based supervised apartment building while working for pay. VA contracts with private industry and the public sector for work done by these veterans who learn new job skills, relearn successful work habits and regain a sense of self-esteem and self-worth. This Cleveland-based CWT/TR program provides a community based setting, 40 hours of therapeutic work assignments at Veterans Industries, weekly substance abuse counseling, vocational counseling, job placement services and case management services. All homeless veterans at the site are charged a monthly fee for upkeep and maintenance of the building.

**West Side Catholic Shelter – Health Care for Homeless Veterans Women's Outreach Initiative**

3135 Lorain Avenue

Cleveland, Ohio

Agnes Hoskin – Executive Director

This is a 30-bed women's shelter that sets aside beds for women veterans. The Health Care for Homeless Veterans (HCHV) Program provides outreach and intensive case management services to eligible homeless female veterans with or without children. The program is designed to encourage family preservation, connect women veterans to the full range of services available, and provide care to their children through collaborations with community providers who treat women and children.

**Mental Health Services, Inc.**

1701 Payne Avenue

Cleveland, Ohio

La Tonya Murray – Program Director

This is a 50-bed shelter for men with physical or psychiatric disabilities with approximately one-third of the clients being veterans. VA provides two health technicians to monitor the shelter. VA staff focuses on engaging homeless veterans in VA services, assessment and referral case management.

**Salvation Army Shelter**

2100 Lakeside Avenue

Cleveland, Ohio

Patricia Tomcho – Coordinator (VA Homeless Outreach Services)

This 300-bed shelter for homeless men comprises of approximately one-third veterans. Basic shelter services are provided, and VA provides two health technicians to monitor the shelter milieu. VA staff focuses on engaging homeless veterans in VA services, assessment and referral case management.

### **Veterans Industries of Northeast Ohio**

3500 St. Clair Street

Cleveland, Ohio

James Gambrell, Administrator

Veterans Industries is a Vocational Rehabilitation Program of the Louis Stokes VA Medical Center. Its goal is to help veterans return to work and uses paid work experience to assist veterans in reaching this goal. Services are CARF accredited. Hourly wages are up to \$5.40 per hours. Veterans Industries staff provides support and assistance through regular site visits.

### **Volunteers of America of Northeast & North Central Ohio (VOA)**

775 East 152nd Street

Cleveland Ohio

Patricia Tomcho – Coordinator (VA Homeless Outreach Services)

VOA offers 50 transitional housing residential beds for male and female veterans. Services include case management, transportation, nursing clinic, outreach, vocational services, employment assistance, and psychosocial rehabilitation. Additionally, the VOA was awarded the Homeless Veterans Reintegration Program grant that is offered to veterans in the Grant & Per Diem Program.

The Advisory Committee on Homeless Veterans tour of the programs ended at approximately 4:30 p.m.

On Thursday, September 19, 2002, the Advisory Committee on Homeless Veterans meeting continued at the Louis Stokes VA Medical Center. The committee heard presentations from the following presenters:

- Dr. Craig Burnette, Coordinator, Project Community Homelessness Assessment Local Education and Networking Groups, reviewed VA's Community Homelessness Assessment, Local Education and Networking Group 2001 (CHALENG) Report.
- Roger Casey, Director, VA Homeless Grant & Per Diem Program, gave an overview of VA's current activity regarding the Homeless Grant & Per Diem Program.
- Dr. Dick McCormick, who recently had retired as Veterans Integrated Service Network 10 Mental Health Service Director, gave a presentation of the capacity and funding, under the Veterans Equitable Resource Allocation (VERA) System.
- Fred Malphurs, Special Assistant to the Deputy Secretary – gave a presentation about the Capital Asset Realignment for Enhanced Services (CARES) process currently underway.

- Dr. Robert Rosenheck, Director, Northeast Program Evaluation Center (NEPEC), discussed the "Capacity Law" and the Under Secretary for Health's Committee on Seriously Mentally Ill (SMI) Veterans.
- Peter Dougherty, Gay Koerber, Richard Schneider & Robert Van Keuren, gave a report on the House Veterans Affairs Committee (HVAC) Hearing on Homeless Veterans including implementation of Public Law 107-95 held earlier in the month.
- Anthony Campinell, Associate Chief Consultant, Psychosocial Rehabilitation, Mental Health Strategic Health Care Group, gave a report on the Veterans Health Administration's Veterans' Construction Team program.

On Friday, September 20, 2002, Chairman Van Keuren called the committee meeting to order at 8:00 a.m. to continue its meetings at the Louis Stokes Medical Center.

Mr. William D. Montague, the Medical Center Director, welcomed the committee to the area and gave the committee his comments on the excellent community relationships in the area. Dr. Robert Roswell, Under Secretary for Health, Veterans Health Administration, spoke to the committee and let them know of his strong interest and support of the committee's work. He responded to several questions and expressed his strong interest in talking with the committee regarding the implementation of its recommendations. Mr. Peter Dougherty, the committee's Designated Federal Official, advised the committee that its next meeting was scheduled for December 12-13, 2002, at the Volunteers of America, Veterans Service Center, Miami, Florida, and that a veterans' town hall forum would be included at that meeting.

In his role as Director of Homeless Programs, Mr. Dougherty gave the committee an overview of issues involving case management and a review of Public Law 107-95.

The Advisory Committee on Homeless Veterans meeting was adjourned at noon.

### **Meeting December 12-13, 2002**

The Advisory Committee on Homeless Veterans met on Thursday, December 12, 2002, at the Volunteers of America's Veterans Service Center, Flagler Street, Miami, Florida. Nearly all committee members and ex-officio members from the Department of Labor and Housing and Urban Development were in attendance. Mr. Peter Dougherty, the Designated Federal Official, called the meeting to order at 8:35 a.m. and advised the committee that Chairman Van Keuren was unable to attend.

The following presentations and distribution of materials were made:

- Claude Hutchinson, Director, VA Office of Asset Enterprise Management, gave an overview of VA's Multifamily Housing Loan Guarantee Program.
- Ms. Maria Foscarinis, Executive Director, National Law Center on Homelessness and Poverty, gave an overview of the criminalization of homelessness.
- Roger Casey, Director, VA Homeless Grants & Per Diem program, gave an overview and a slide presentation of VA's Homeless Grants & Per Diem programs.
- Dr. Dennis Culhane, University of Pennsylvania, gave an overview of the research he has been pursuing since the mid 1990's on the dynamics of homelessness and the impact of supported housing on service use and costs.
- Steve Weiss partner in the law firm of Cannon, Heyman & Weiss Buffalo, New York – discussed the Low Income Housing Tax Credits (LIHTC) program and urged the committee to support efforts to get a ruling from the Department of Treasury that would allow per diem housing providers to use this financial tool.
- Dr. Robert Rosenheck, Director, VA Northeast Program Evaluation Center, distributed a handout and spoke about the Homeless Female Veterans Outreach Program, Critical Time Intervention Program, Transition and Employment and Support Program, homeless dental initiatives and discussed outcome and study of residential treatment.

The Advisory Committee on Homeless Veterans meeting recessed at 4:00 p.m; and re-assembled to conduct a veterans' town hall forum at the St. John Bosco's church in Miami. Homeless veterans were invited to voice their concerns to the committee regarding their own experiences, services that are being provided, needed services, and what they felt needed to be done by both the VA and the community to help improve their lives and the lives of their fellow veterans. Several dozen spoke at the forum that lasted more than two hours. Most praised VA's services being conducted in the community and many expressed concern about VA curtailing those services in the future.

On Friday, December 13, 2002, Mr. Dougherty called the meeting to order at 8:30 a.m. Mr. Dougherty gave announcements regarding the next advisory committee meeting to be held on February 20-21, 2003 in Washington D.C. He advised the committee that most of its work would be to finalize its recommendations for the first Annual Report to be submitted to Secretary Principi by the end of March 2003. He also noted that the next two meetings would be held on May 8-9, 2003 in Washington D.C.

Dr. John Vera, Chief of Staff, Miami VA Medical Center appeared before the committee on behalf of the Miami VA Medical Center and formally welcomed the committee to Miami. He told the committee, in response to concerns raised at the town hall forum, that while there was a group looking at the Outpatient Substance Abuse Clinic (OSAC) program and how best to utilize staff, there were no plans to close the OSAC program at its Volunteers of America (VOA) site. He also addressed various issues on homelessness.

The following presentations were received following Dr. Vera's welcome and discussion:

- Ron Henke and Ms. Betty Moseley-Brown, of Veterans Benefits Administration Compensation & Pension Service (VBA), gave an overview of the indigent veterans burial Issues and provided the committee with information on the full-time homeless coordinators.
- Anthony Campinell and Bernie Counoyer, Veterans Health Administration, made a presentation about what was necessary to implement Veterans Construction Team in Compensated Work Therapy programs.
- Ms. Linda Boone, Executive Director, National Coalition for Homeless Veterans (NCHV), distributed handouts and encouraged the committee to share with NCHV any issues they would like to see moved forward.
- Mr. Ciccolella, Deputy Assistant Secretary of Veterans Employment and Training Service and ex-officio member of the committee, reported that the Veterans Workforce Investment Act (VWIA) is funded at a little over \$7 million. The US Interagency Council on Homelessness is developing seven initiatives that focus on prevention; "Coming Home" a re-entry initiative that is led by the Department of Justice (DOJ) is underway; and pursuant to Public Law 107-95, the Department of Labor (DOL) is required to run six demonstration programs for incarcerated veterans with VA.
- Ms. Carlisle, Deputy Assistant Secretary for Department of Housing and Urban Development (HUD) and ex-officio member of the committee, reported that HUD established, a task force to look at improving internal programs and make them more accessible to homeless. Also told the committee that a joint HUD, HHS and VA NOFA will be coming out shortly to enhance services for the chronic homeless.

Mr. Dougherty declared the committee meeting adjourned at 3:20 p.m.

### **Meeting February 20-21, 2003**

The Advisory Committee on Homeless Veterans met on Thursday, February 20, 2003 at the Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, D.C. Nearly all Committee members and ex-officio members from Departments of Labor, Housing and Urban Development, Health and Human Services and a representative of the Department of Defense were in attendance. Chairman Robert Van Keuren called the meeting to order at 8:35 a.m. Mr. Peter Dougherty, Designated Federal Official, told the committee that Secretary Principi sent his regrets for not being able to attend. The purpose of the meeting was to draft and edit the committee's findings and recommendations for its first annual report to Secretary Principi. The committee members made numerous edits, revisions and additions to earlier draft findings and recommendations. The final editing will be completed by Mr. Dougherty to incorporate into the final report.

The following presentation and overview were made:

- History of VA's Homeless Program/Committee Advice - Ms. Julie Susman, President/CEO of the Jefferson Consulting Group, Washington D.C., who served in the 1980's on the staff of the Senate Committee on Veterans Affairs, provided a brief legislative history of the VA's Homeless Program to the committee. Ms. Susman stated that Dr. Errera was a great partner, beginning in 1979, working with the committee in efforts to assist chronically mentally ill veterans. From 1985–1987 the focus was on trying to get legislation passed for the chronically mentally ill veterans. Legislation was enacted twice that pertained to shelter supervision and oversight for chronically mentally ill, including homeless veterans. When the McKinney Act came out in 1987, an amendment was created, and the word "homeless" was inserted giving VA its first homeless specific mission. The law was changed from a drug and alcohol focus to a focus on outpatient, community based treatment, and a preventative approach.
- Ms. Susman gave the committee a few suggestions as it looked toward making its recommendations:
  - Look at what leads veterans into homelessness; the programs in place now, the projected need, and the entire continuum. Think of projection of trends as veterans' age, programs close, and balance of VA and community.
  - Focus on momentum for homelessness. Do not lose out from being a part of other programs and initiatives, i.e. HUD dollars for housing and long-term care for frail elderly.
  - Think about any new programs that are gathering data and statistics to have certain questions added to their process in order to track for homeless patients coming in. This will provide more accurate statistics.

At the end of the presentation, Chairman Van Keuren presented Ms. Susman with a special recognition for her leadership, commitment, and compassion to America's veterans.

- VA's Advisory Committees - Mr. Phil Riggan, VA's Committee Management Officer, provided an overview of the VA's advisory committees and the role of VA's Committee Management Office. He distributed a list of VA advisory committees and told the committee:
  - The Committee Management Office provides the overall coordination of the VA's 25 advisory committees.
  - Seventeen of the 25 advisory committees have been created and established by statute, which specifies who serves on the committees. In addition, to the 17 established by statute, one is a Presidential taskforce to create greater liaison between VA and DOD to improve delivery of health care for veterans. The other 7 advisory committees were created by the Secretary and are related to VA research and policy.
  - Five committees have been created in the past 12 months, the most active in recent VA history. They include: Advisory Committees on Homeless Veterans, Chiropractic Care within the VA, Gulf War Research, Nursing Commission and Capital Asset Realignment for Enhanced Services Commission.
  - VA's advisory committees date back to World War II. Many have been terminated and some are still active. These committees are making a significant impact on policy decisions.

At the conclusion of these presentations, the committee began revising and editing its findings and recommendations. Chairman Van Keuren adjourned the meeting at 4:15 p.m.

The meeting was continued on Friday, February 21, 2003 and called to order at 8:35 a.m. by Chairman Van Keuren. Mr. Phil Mangano, Director, US Interagency Council (ICH) on Homelessness gave a presentation on ICH. Mr. Mangano told the committee:

- The US Interagency Council on the Homelessness (ICH) brings together 20 different federal agencies to respond to the issues of homelessness. It defines strategies and advocates for resources necessary to reduce and end homelessness.
- The work of the ICH is to create collaborations as well as inter-agencies working together. HUD, HHS, VA, DOL and SSA already have internal working groups. A large portion of ICH's work is intergovernmental to ensure that federal effort is partnered with states and localities.

- The ICH has challenged the U.S. Conference of Mayors to end homelessness in 10 years and is working on involving governors, as well, to end homelessness in their states. The council is also working on inter-community relationships as well as those providing mental health, AIDS, and housing services.
- The 35 million dollar HUD, HHS, VA joint Notice of Funding Availability To End Chronic Homelessness has been published, which signifies a great start to ending homelessness.
- The Departments of Labor and Justice are also involved with ICH. The Department of Justice (DOJ) has a \$100 million initiative for people discharged from prisons or jails, and Department of Labor (DOL) is willing to step up with regards to a number of issues that address homelessness. DOL is looking at how their resources can be better accessed by homeless individuals.

Mr. Charles Ciccolella, Deputy Assistant Secretary, Veterans Employment and Training Service (VETS), Department of Labor gave an overview to the committee that included:

- DOL has a very keen interest in addressing homelessness.
- It is participating in Policy Academies to assure that individuals from their Workforce Investment Boards attend.
- Homelessness will be addressed in their legislative proposals to define a clear role for the labor and employment components.

The committee continued their work on the revision and editing of findings and recommendations for the annual report. A motion was made by Mr. Cooper and seconded by Mr. Pavich to approve the minutes of the committee meeting of December 12-13, 2002 as distributed.

It was noted that in the future, after being approved, minutes would be posted on the VA's publicly accessible web site. Chairman Van Keuren announced the next committee meeting would be held on May 7, 8 & 9, 2003 in Washington, D.C. The meeting of the Advisory Committee on Homeless Veterans was adjourned at 2:40 pm.

## 1. FUNDING LEVELS FOR MENTAL HEALTH SERVICES ARE INADEQUATE

### Finding:

For the past two years, VA's Seriously Mentally Ill (SMI) Committee has concluded the VA has failed to meet its obligation to maintain its capacity to provide specialized services to SMI veterans under Public Law 104-262. Hearings conducted by the Senate Committee on Veterans Affairs requested that the SMI together with VA's Mental Health Strategic Health Care Group, present a plan and a budget for restoring VA's capacity as required by the law.

The current capacity to treat veterans who suffer from mental illness and substance abuse disorders has declined and threatens the ability to partner with the community. VA needs to create a baseline funding level that ensures that the needs of homeless veterans can be adequately addressed to sustain and build upon community partnerships that offer transitional housing, treatment, employment and connections to other community services. This review needs to be done with a clear recognition that VA has lost capacity.

Present and future funding levels must ensure core VA services needed by veterans for their mental health problems are adequate. To address homeless and at-risk veterans, as well as the veterans' population in general, funding levels for mental health services nationally must be increased significantly to include behavioral health care in community-based outpatient clinics and primary care clinics; as well as sufficient substance abuse inpatient and residential treatment to adequately supply timely access and high quality services. These services are inextricably tied to the problems of homelessness and the ability of VHA to collaborate effectively in providing support services to community partners to meet veterans' needs.

### Recommendation:

The Advisory Committee on Homeless Veterans recommends:

- The Secretary and Under Secretary for Health ensure that national funding for mental health services is increased as called for by the Senate Committee on Veterans Affairs.

### Response:

VHA data shows that mental health workloads have increased steadily since 1996. From 1996 to 2002, the number of veterans receiving specialized mental health services increased from 581,625 individuals to 757,767. Further, utilization data show that 40 percent of those who receive specialized mental health services are considered seriously mentally ill.

According to the annual Capacity Reports published by VA in accordance with Public Law 104-262, the budget for mental health services declined fiscal year 1996 to fiscal year 1999. VA data indicates that the mental health budget has increased every year since Fiscal year 1999 from \$1,865,811,000 to \$2,282,109,000 in fiscal year 2002.

Decreasing costs generally reflect decreases in staffing as more treatment services shifted to outpatient and residential care, which are less staff-intensive but just as effective for most patients. VA estimates mental health care costs for fiscal year 2003 to be \$2,456,901, 000 and \$2,612,828,000 for fiscal year 2004, thus reflecting a \$155 million increase.

- VA measures these changes nationally and uses them as a performance measure for Network Directors at the VISN level. Measures should be consistent as a percent of spending in each network.

**Response:**

Capacity to serve veterans with serious mental disorders is a performance measure for Network Directors. Networks determine the demand for services and the service enhancements required to meet those demands on a local basis as a part of the strategic planning process. There is variation across Networks in terms of the nature and volume of services required in order to meet legal capacity requirements, as well as variation in the nature and volume of medical care required to meet all other health care demand, so a consistent percentage of spending for mental health needs for all Networks would not be a viable option. Rather, Networks strive to meet their increasing mental health needs equitably with the other health care needs of their veteran populations. In fiscal year 2002, only two Networks saw fewer seriously mentally ill patients, and in those Networks the decrease was less than 2 percent (a total of 577 patients out of almost 34,000 served in those Networks.)

## **2. INCREASED APPROPRIATION FOR GRANT + PER DIEM PROGRAMS**

### **Finding:**

Funding for VA's Homeless Grants & Per Diem has been vital to build and maintain a healthy system of services at the community level to assist homeless veterans. In less than a decade, more than 7,000 high quality transitional beds, service centers and vans for transportation and outreach are on line or are being developed. The long-term commitment to funding this program is vital to homeless veterans service providers.

VA discontinued contract residential care and shifted those funds to increase transitional housing under the Per Diem only program. While this determination was well reasoned, it has resulted in significant disruption of services at some locations.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- Funding for the Grant and Per Diem Program should be separated from VA's medical care appropriation and be a separate line item in the Department's appropriation each year to ensure its uniqueness and that its complex needs are not in competition with other healthcare needs.

### **Response:**

VA does not support the Committee's recommendation to separate funding for the Homeless Providers Grant and Per Diem Program from VA's medical care appropriation. Funding for the Homeless Providers Grant and Per Diem Program should continue to be made available from within VA's medical care appropriation as VA's medical care appropriation covers a wide range of health related services for eligible veterans. Provision of supported housing and supportive service centers for homeless veterans under the Homeless Providers Grant and Per Diem Program includes assuring the availability of social services, employment services, other support services and, in some cases, direct treatment or referral to medical, mental health and substance abuse treatment. Given the therapeutic nature of these services, it seems most appropriate for these community-based programs to be funded by medical care appropriations and to be overseen by VA medical center employees who are knowledgeable about the service delivery needs of homeless veterans. To date, there has been no difficulty in securing adequate medical care funding for the existing Homeless Providers Grant and Per Diem Program. Funding for the program increased from \$22.4 million in fiscal year 2002 to approximately \$50 million in fiscal year 2003. The projected budget for the Homeless Providers Grant and Per Diem Program is \$69.4 million in fiscal year 2004. This represents more than a 200 percent funding increase over a two-year period.

- The current authorization of appropriations for this program should be increased to \$100 million.

**Response:**

VA agrees with the Advisory Committee's recommendation to increase the authorized spending level for the Homeless Providers Grant and Per Diem Program to \$100 million. The current statutory limit set by Public Law 107-95 is \$75 million for each of fiscal years 2003, 2004 and 2005. The Advisory Committee should be aware that increasing the authorized spending level to \$100 million does not mean that VHA will budget for, or spend to, that limit.

- Centrally controlled funding for contract residential care should be re-established at a funding level of at least \$20 million in FY 2004 and FY2005. This funding would provide the Department with flexibility to provide services in areas where adequate homeless per diem programs do not exist and where the capacity to provide residential care is inadequate.

VA does not support re-establishing centrally controlled funding for contract residential care for homeless veterans. VA's decision to consolidate funding for the contract residential treatment component of the Health Care for Homeless Veterans (HCHV) Program and the Grant and Per Diem Program was based on fiscal year 2001 data available from extensive monitoring and evaluation of both programs. Data from VA's Northeast Program Evaluation Center's (NEPEC's) monitoring and evaluation showed that homeless veterans served in both programs were similar in terms of demographic and clinical characteristics. In addition, housing and employment outcomes for veterans who successfully completed both types of programs were virtually identical.

On average, the length of stay for veterans in contract residential care was 73 days and the average cost for an episode of care was \$2,880. In contrast, the average length of stay for veterans in grant and per diem funded programs was 93 days and the average cost for an episode of care was \$1,674. During fiscal year 2002, there were 4,611 episodes of residential care provided for homeless veterans in HCHV contract programs and 11,013 episodes of care provided for homeless veterans in grant and per diem funded programs.

Given the comparability of outcomes, shifting HCHV Program resources from contract residential treatment to the grant and per diem program is allowing VA to support an even greater number of homeless veterans in community-based transitional housing programs.

VA believes there is sufficient flexibility within its interim regulation governing the administration of the Homeless Providers Grant and Per Diem Program to assure adequate distribution of programs across the nation. VA has established funding priorities in the most recent "Per Diem Only" Notice of Funding Availability (NOFA) that targets: 1) States that currently do not have any grant or per diem funded beds; and 2) Indian Tribal Governments.

In the supplementary section of the current NOFA, VA have also encouraged applications from organizations and localities that may have lost residential service capacity as a result of the merging of funding for contract residential treatment with funding for the Homeless Providers Grant and Per Diem Program. Through these priorities, VA believes that it will be able to expand residential services for homeless veterans both in rural and urban areas throughout the country. A return to contracting for residential services using centrally directed funding is not necessary. However, Networks and VA medical centers may choose to continue to contract for residential treatment for homeless veterans using their own general medical care funds. Several Networks and VA medical centers have chosen to do so for the remainder of fiscal year 2003.

### **3. HOMELESS COORDINATORS NEED TIME TO WORK WITH COMMUNITY PARTNERS**

#### **Finding:**

VHA Homeless Coordinators at the VISN and facility level have experienced significant challenges in the performance of their ever-expanding responsibilities. These include not only outreach to individual homeless veterans, but also helping to establish and oversee community providers and partnerships that assist homeless veterans, participating in local and regional systems of care, and their administrative liaison assignments, as required by the Homeless Grant and Per Diem program.

#### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- VHA Directive 2002-072, 4.b(1) should be revised to include the appointment of full-time positions of VISN Homeless Veterans Program Coordinators and include all aspects of their duties as homeless coordinators into their performance evaluations.

#### **Response:**

Most Network Homeless Veterans Program Coordinators carry these duties as ancillary responsibilities. Two of the 21 Networks have appointed full-time Homeless Veterans Program Coordinators and five Networks have designated facility Homeless Veterans Program Directors to coordinate activities throughout their Networks. Thirteen Networks have appointed individuals who hold a variety of positions at VA Medical Center (VAMCs) within their jurisdictions. One Network has appointed a member of the Network Director's immediate staff to serve as the Network Homeless Veterans Program Coordinator. The vast majority of the Network Homeless Veterans Program Coordinators previously held positions with direct clinical and programmatic responsibility for serving homeless veterans. The value of these Network Homeless Veterans Program Coordinators is that they understand the clinical and supportive service needs of homeless veterans and can assist in developing a continuum of care within their Network to address those needs. The disadvantage is that all but two of the Coordinators have significant responsibilities for other programs and services at either the medical center or VISN level.

It is true that the responsibilities of Network Homeless Veterans Coordinators are increasing, particularly as the number of Homeless Providers Grant and Per Diem-funded programs increase and the responsibility for network-wide oversight of these programs is becoming more demanding and time consuming.

Establishing additional full-time Network Homeless Veterans Program Coordinators may enhance the oversight and coordination in some Networks; however, this may not be the best approach in all Networks. VHA will conduct a survey of the Network Homeless Veterans Program Coordinators to determine what percentage of their time is dedicated to network-wide homeless veterans program activities and whether network level

activities are incorporated into their performance plans. At the same time, VHA will survey the Networks to determine if different models are in use for comparable programs that support network-wide coordination of services. Results of these surveys will be used to identify current approaches to care coordination and will be distributed to the Networks to encourage development and pilot testing of best practices models. Results of these surveys will be provided to the Advisory Committee on Homeless Veterans in August 2003.

- VHA should increase homeless veterans program staffing where need is identified to accomplish the actual workload performed and activities expected.

**Response:**

VA supports the Advisory Committee's recommendation to increase homeless veterans program staffing when the facility or the Network identifies such a need. VA's Homeless Veterans Programs are undergoing a major transition as it shifts from contracting for community-based residential treatment for homeless veterans to partnerships with community-based organizations that have successfully competed for funding under VA's Homeless Providers Grant and Per Diem Program. VA staff responsibilities for outreach, case management and oversight may vary greatly from medical center to medical center depending on the range of services offered by successful grant and per diem recipients in different locations. Given the great variability in VA staff responsibilities from location to location, VA medical centers and Networks are in the best position to determine where increases in staffing for homeless veterans programs are needed. VA's Northeast Program Evaluation Center (NEPEC) provides workload information on a quarterly and annual basis, and identifies national workload averages that each VA medical center can use for comparison purposes. This information can help assess where additional staffing may be needed.

- Request current homeless staffing level by VISN and facility.

**Response:**

Current staffing levels for VHA's Health Care for Homeless Veterans Programs are identified by each VA medical center and each Network in Tables 2-2, 2-2V, and 8-1 of NEPEC's Sixteenth Annual Report of the Health Care for Homeless Veterans Programs. A copy of these tables is attached.

#### **4. PER DIEM ONLY FUNDING**

##### **Finding:**

VA's "Per Diem Only" funding is an excellent approach to creating new beds with supportive services for homeless veterans. Its time limited funding makes it a funding approach consistent with other Federal homeless funding sources. There is real concern that previously funded veteran-specific services providers are having difficulty in getting projects refunded.

##### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Department of Veterans Affairs develop a strong system of goals and objectives so that program quality based upon actual performance will be considered in future "per diem only" funding awards.

##### **Response:**

NEPEC is now developing risk-adjusted performance goals for the Grant and Per Diem funded programs so that differences in veteran characteristics and program operations can be taken into consideration when evaluating program effectiveness. NEPEC expects to complete this assignment by October 2003. Results can be made available to VA reviewers who review applications for "Per Diem Only" funding in the future.

- The Department provide grant reviewers with veteran-specific service provider histories to be recognized and appropriately rewarded in future funding decisions.

##### **Response:**

VA does not support the Advisory Committee's recommendation to provide veteran-specific service provider histories to VA reviewers who review applications for grant or "Per Diem Only" funding. Applicants have opportunities throughout the application to identify their organizations as veteran-specific organizations. All previously funded grant or "Per Diem Only" awardees can be considered "veteran specific" since they have received VA funding to develop programs specifically for homeless veterans. Finally, applications for VA funding are reviewed and scored on the criteria identified in the regulations that govern the application process for the Homeless Providers Grant and Per Diem Program. Among other considerations, applications are reviewed and scored on the basis of need for the program in the community, ability of the applicant to develop and maintain a program to address that need and quality of the program proposal. These are appropriate criteria for selecting programs for grant and "Per Diem Only" funding.

## **5. CARES PROCESS NEEDS TO CONSIDER HOMELESS NEEDS**

### **Finding:**

The Department of Veterans Affairs is embarking upon its most significant review of facilities, commonly referred to as Capital Asset Realignment for Enhanced Services (CARES). This is an unprecedented effort to realign services into areas needed. To date, there has been little information shown that indicates that the potential realignment of assets will enhance services for homeless veterans. There is a strong need to ensure that homeless veterans are fully afforded a benefit from this process. Homeless veterans' programs that provide little direct revenue, but provide considerable benefits in direct services to veterans, need to be adequately considered as this review process proceeds.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The immediate inclusion of homeless veterans service providers at CARES VISN-level hearings.

### **Response:**

VA agrees with the Advisory Committee's recommendation to include community-based homeless veterans service providers at CARES hearings. The CARES Commission hearings will be open to the public. A listing of the locations, dates and times of the CARES Commission hearings will be posted on the CARES Commission Web Site: <http://www.carescommission.vagov/default.asp>.

- That, as VISN plans are presented for review by VHA headquarters staff, staff from the Office of Homeless Veterans Programs (075) and Mental Health Strategic Health Care Group (116) should be involved in that review and respond to this committee regarding how mental health, substance abuse and homeless services will be provided for in each of those plans.

### **Response:**

Network plans have been through multiple levels of review by the National CARES Program Office (NCPO), the Clinical CARES Advisory Group (CCAG) and CARES Senior Resource Group. These review groups included representation from mental health program officials. The draft National CARES Plan is being developed and will be presented to the CARES Commission later this summer. When the plan is publicly released, it will be available for review during a sixty-day comment period. The Advisory Committee on Homeless Veterans is encouraged to review and comment on the draft National CARES Plan.

The Advisory Committee is also welcome to provide copies of these documents to the Homeless Veterans Program Office and the Mental Health Strategic Health Care Group on issues related to the provision of mental health, substance abuse and homeless services within the draft National Plan.

- The CARES Commission reject VISN plans and call for their reconsideration unless at least 10% of the physical or financial assets achieved in the realignment are considered for use by homeless service providers. All plans approved must demonstrate adequate mental health and substance abuse treatment opportunities with inpatient and outpatient capabilities or the very survival of community based service provider partnerships are at risk.

**Response:**

VA does not agree with the Advisory Committee's recommendation to reject Networks CARES marketing plans unless at least 10 percent of the physical or financial assets are considered for use by homeless service providers. Each Network was asked to consider homeless initiatives as part of their overall space planning process. Until the draft National CARES Plan becomes available, it is not known how much space was identified and to what extent that space would be suitable for homeless initiatives. The CARES process used projection models to forecast health care needs, which were then used to identify planning initiatives to address "gaps" between the current workload and supply of services compared to projected utilization. No arbitrary quotas were established for determining asset allocations.

## **6. VA NEEDS TO STANDARDIZE RENTAL CHARGES TO HOMELESS PROVIDERS**

### **Finding:**

Nearly two-dozen local agreements have been made to allow homeless veteran-specific transitional housing service providers with space on VA grounds to offer transitional housing. Most of these organizations are supported by VA Grant & Per Diem funding. An internal review of these agreements shows space agreements that range from little or no charges to charges that reflect a very expensive "fair market value" for the space occupied.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Under Secretary for Health conduct a review for space and establish a minimal charge for use of space. A standardized charge is needed to encourage homeless veteran service providers to use their limited funding to ensure that needed services are provided.

### **Response:**

VA supports the Advisory Committee's recommendation to conduct a survey to determine how much VA medical centers are charging homeless veteran service providers to use space for transitional housing in buildings on the grounds of VA medical centers. Our plan is to solicit detailed information about the use of VA space, the cost for comparable space in the community and any additional VA charges for services the medical centers may provide to these organizations, such as meals, laundry services and utilities. The survey is being conducted by the Mental Health Strategic Health Care Group and will be completed by August 1, 2003.

Following a review of the survey findings, VA will review related VA program policy, including VHA Handbook 1660.1, which implements 38 U.S.C., § 8153, Enhanced Sharing Authority. The Handbook provides policy guidance to VHA facilities for selling (renting) the use of VHA health care resources that are not being fully maximized by veterans enrolled in the VA health care system. These health care resources include space in VHA buildings. Sharing authority is the most common mechanism for the use of VA space by a transitional housing program.

- The Committee specifically wishes to review this matter prior to the Under Secretary developing a national policy on use of space charges.

### **Response:**

The review will focus on determining whether current policy should be modified to separately address the use of space agreements with State or local governments or non-profit organizations that would like to develop or maintain transitional housing for homeless veterans. Survey findings and policy recommendations will be shared with the Advisory Committee.

## **7. SPECIAL PROJECTS – WOMEN, TEPS & CTI**

### **Finding:**

Three years ago, VA began several initiatives to assist homeless veterans with a variety of demonstration programs such as, Critical Time Intervention, Therapeutic Employment Programs and an eleven site women's demonstration program. While each of these initiatives has an interesting concept, each seems to have a significant merit in establishing and testing new models for treating homeless veterans. One significant concern has been that these programs, since their inception, have been riddled with a lack of long-term commitment to staffing and funding the activities.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- A full review of these programs, their benefits, accomplishments and efficiency, be conducted by the Under Secretary for Health and the Secretary prior to any determination to discontinue any of them. Given the weak support shown to these programs to date, they should continue in force until a new total review can be conducted.

### **Response:**

VA supports the Advisory Committee's recommendation to conduct a full review of these demonstration programs at the end of the three-year period during which Networks and VA medical centers were expected to maintain these programs at original funding levels. While funding to activate these programs was initially distributed in fiscal year 2000, many facilities experienced significant delays in hiring staff and obtaining IRB approvals so that new models of care could be introduced and evaluated. The recognized activation date for these demonstration programs is February 1, 2001 and Networks are expected to maintain the programs, at a minimum, through February 2004. NEPEC is preparing an interim report that will provide preliminary information on the benefits, accomplishments and efficiency of these demonstration programs for the first 18 months of operation. The interim report will be sent to Network Directors and VA Medical Center directors and will be reviewed by the Deputy Under Secretary for Health for Management and Operations, the Deputy Under Secretary for Health and the Under Secretary for Health.

- The review of the women's program needs to include the Center for Women's Veterans (00W), the Women's Veterans Health Program Office (133), the Office of Homeless Veterans Programs (075D) and the Mental Health Strategic Health Care Group (116E).

### **Response:**

Any decisions concerning the continuation of these programs will not be made in isolation. VA expects Networks and VA medical centers to continue support for these programs for the minimum three-year period as specified in the original memoranda from the Under Secretary for Health that announced the selection of sites and

distribution of funds for program activations. Following review of information presented in NEPEC's interim report and discussions with the Health Services Committee of VHA's National Leadership Board, VA may issue a request to extend the demonstration period for one additional year. VA supports the development and evaluations of new models of care that have potential to better serve homeless veterans. If these programs are found to be effective and cost efficient, current demonstration programs should be maintained and the models should be exported to other Networks and VA medical centers.

NEPEC expects to complete the interim report by September 1, 2003, and it will be provided to the Advisory Committee, the Women Veterans Health Program Office and the Office of Homeless Veterans Programs.

## **8. DOMICILIARY CARE STUDY**

### **Finding:**

Domiciliary care for veterans, and specifically Domiciliary Care for Homeless Veterans (DCHV), is a valuable tool to assist many of the nation's sickest veterans who need significant access to VA health care services. Approximately 5,500 veterans benefit from this program annually and it is a valuable tool for returning veterans to community living.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- VA review its current alignment of domiciliary care to ensure there is at least one facility in each VISN without any diminishment of existing services.

### **Response:**

VA supports the Advisory Committee's recommendation concerning the review of VHA's the domiciliary care program. A national level task force (TF) has been appointed by the Deputy Under Secretary for Health to review all facets of the domiciliary care program including the issues raised here and to make recommendations to assure quality of care based on the needs of the veterans served. The interim report from the task force is due June 30, 2003 and the final report is due August 2003.

- The domiciliary care review should include a determination if the proper level of care is being provided at current program sites to achieve high quality care.

### **Response:     *See response above.***

- VA should review the cost of domiciliary care charged to homeless veterans and also review to see whether this function should be contracted out to qualified veteran specific transitional housing service providers.

### **Response:**

The \$5.00 per day co-payment for domiciliary patients does not affect homeless veterans since it is based on annual income that exceeds the income of virtually all homeless veterans. Chiefs of Domiciliary Care Programs responded to a query about this issue and there were no reported instances where homeless veteran in Domiciliary Care were charged a copayment.

DCHV programs provide a wide range of on-site rehabilitation services within a therapeutic milieu for homeless veterans that cannot be replicated in a transitional housing program. DCHV programs are an important component in the continuum of care for homeless veterans as evidenced by the successful housing and employment outcomes of homeless veterans who are treated in DCHV programs. The availability of both DCHV programs and transitional housing programs assure that appropriate levels of treatment and support services are available to homeless veterans with medical, mental health and substance abuse disorders.

## **9. DENTAL CARE FOR HOMELESS VETERANS**

### **Finding:**

Dental care is one of the most difficult problems faced by homeless veterans. Diseased teeth are both a physical problem and a significant hindrance to economic reintegration. This Committee endorses and supports the requirement that eligibility of veterans to participate in this program be tied to their participation in an approved residential program and finds this approach is both an encouragement and a reward for veterans to complete a therapeutic residential treatment program. Dental care is very important and needs to be implemented if VA's effort to provide health care and supportive transitional housing is to help improve the health and well being of homeless veterans.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Under Secretary for Health develop a plan to fully implement this program for all veterans eligible under Public Law 107-95.

### **Response:**

VHA Directive 2002-080, Eligibility Guidelines for One-Time Course of Treatment for Certain Homeless and Other Enrolled Veterans, dated December 9, 2002, was issued to all VA medical care facilities to provide guidelines on the provision of dental care for this new category of veterans. These eligibility guidelines were discussed on the nationwide conference call for Homeless Veterans Program Coordinators in March 2003 and the nationwide conference call for Chiefs of VA Dental Services in April 2003.

The Associate Chief Consultant, Health Care for Homeless Veterans has asked VA's Northeast Program Evaluation Center (NEPEC) to summarize dental services received by all homeless veterans who were housed in eligible residential treatment programs during fiscal year 2003. The study will identify the number of homeless veterans considered eligible for dental care under the authority provided by Public Law 107-95, the percentage of those veterans who reported need for dental care at the time of admission to the program, and the percentage of those with reported need who actually received dental care. NEPEC expects to complete the study by the end of April 2004 and the results will be forwarded to VA's Advisory Committee on Homeless Veterans.

## 10. NEPEC A HIGHLY EFFECTIVE PARTNER

### Finding:

The Northeast Program Evaluation Center (NEPEC) is a unique resource and makes VA the best equipped Federal agency to account for expenditures, staffing, community collaborations, characteristics of homeless veterans served and effectiveness of both internal and external operated programs that assist persons who are homeless, mentally ill or substance abusers. NEPEC is a valuable resource to VA clinical staff, community service providers and others.

### Recommendation:

The Advisory Committee on Homeless Veterans recommends:

- NEPEC remain VA's program monitoring and evaluation center for all of its specialized programs and that it be adequately funded to continue its vital mission of program monitoring and evaluation.

### Response:

VA supports the Advisory Committee's finding that NEPEC is a valuable resource for monitoring and evaluating VA and community-based programs that specifically serve homeless veterans as well as other VA programs that treat veterans with mental illnesses and substance abuse disorders. NEPEC has been responsible for monitoring and evaluating all of the specialized programs for homeless veterans since these programs began in 1987. Data from these evaluations provide important and timely feedback to local VA program managers, VAMC Directors and Network Directors and the information has been used to expand and modify programs to better serve homeless veterans.

NEPEC will remain VA's primary monitoring and evaluation center for all of its specialized homeless veterans programs and will continue to monitor and evaluate general mental health services and other specialized programs such as Post-traumatic Stress Disorder (PTSD) programs. VHA is committed to program monitoring and evaluation as a means to assuring that veterans receive quality care. It is anticipated that adequate resources will be available to allow NEPEC to continue these activities.

- VA should expand efforts to get this vital information out to wider internal and external audiences.

### Response:

NEPEC is developing its own web page so that program monitoring and evaluation information will be available to internal and external audiences. The NEPEC web site will be fully operational by October 1, 2003. The web site can be accessed at <http://www.nepec.org>.

## **11. MULTIFAMILY HOUSING LOAN PROGRAM**

### **Finding:**

The concept of providing formerly homeless veterans with cost-effective and cost-efficient housing while they return to work, through the Multifamily Transitional Housing Loan Guarantee for veterans program, is an excellent approach to allowing veterans returning to gainful employment to live in a below-market cost sober residence.

### **Recommendation:**

The Advisory Committee on Homeless Veterans has been pleased with the approach taken in moving this concept forward. The committee recommends:

- This program be implemented and tested with actual experience.

### **Response:**

VA supports the Advisory Committee's recommendation to implement this program to test its feasibility and is committed to implementing this program at three to five pilot sites. Identification of sites for the pilot phase of this demonstration program is well underway. In order to expedite the implementation of this pilot program with the goal of having three to five projects approved for financing before the end of the current fiscal year, VA decided to use sole-source negotiation with organizations having a proven track record for developing and operating housing for homeless veterans or other low income individuals. As of May 2003, site visits have been made to Portland, OR; San Diego, CA; Los Angeles, CA; Houston, TX; Chicago, IL; New York, NY; Boston, MA; Baltimore, MD; and Miami, FL.

- The Committee requests it be kept informed about the program's implementation. The Committee further requests the Secretary explore the possibility of using this model in a cost-effective manner in smaller cities after successful pilots have been achieved.

### **Response:**

VA will provide regular updates to the Advisory Committee on the status of this program. While this program appears most promising for successful implementation in large urban areas, we will consider the possibility of using this model in smaller cities, after the pilot programs have been established.

## **12. CWT NEEDS TO EXPAND COMMUNITY PARTNERSHIPS**

### **Finding:**

VA's Compensated Work Therapy (CWT) sometimes called "Veterans Industries" is of real assistance in bringing many unemployed veterans back into community employment. Many CWT programs are working under their potential and each needs a strong component of community collaboration. This program has strong potential for enhancing veterans' reintegration into community employment. However, in many locations, it fails to do so.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Under Secretary for Health review CWT's current programs and practices and develop a plan to actively expand collaborations with community partners.

### **Response:**

VA supports the Advisory Committee's recommendation to review current Compensated Work Therapy (CWT) programs and practices and develop a plan to actively expand collaborations with community partners. VHA's CWT programs provide therapeutic vocational rehabilitation services to seriously disabled veterans who need assistance to recover their full potential for employment. Currently, there are 107 CWT programs nationally that provide vocational rehabilitation services to more than 13,000 seriously disabled veterans in fiscal year 2002 and assisted 42 percent of those discharged from CWT programs to obtain competitive employment.

VHA's existing authority permits VA's CWT programs to enter into agreements with private contractors, other Federal agencies and VA entities such as Engineering Service to make CWT participants available to perform labor on construction projects in VA and in other Federal agencies. Additional legislative authority for supported work models is also being reviewed that would allow CWT to implement the latest evidenced based practices shown to improve rehabilitation outcomes for severely disabled individuals. The requested legislative authority will allow CWT to expand employment opportunities in the community, integrated with community based social support networks.

### **13. NATIVE AND RURAL VETERANS**

#### **Finding:**

Native American veterans and many rural veterans have been unable to effectively access programs and services provided by this Department. Distance and lack of cultural sensitivity contribute to this problem. While there may be no lack of interest, systems of information and services often make this lack of access far too difficult to achieve for small and often unsophisticated providers of service. VA should embark on an effort to provide technical assistance to homeless veterans service providers. The Committee finds no area more in need than Native American and rural veteran homeless service providers.

#### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- VA uses its new technical assistance service to target, among others, Native American and rural service providers.

#### **Response:**

VA agrees with the Advisory Committee's recommendation to assure that technical assistance is made available to Native American and rural service providers.

Organizations that are awarded VA's technical assistance grant under the Notice of Fund Availability (NOFA) published in the Federal Register on May 5, 2003, will be provided with the names and locations of Tribal Veterans Representatives who serve as liaisons to VA so that they will be aware of technical assistance and training opportunities.

- VA should target these groups under future Notices of Funding Availability to ensure that proper services are made available to rural and Native American Veterans.

#### **Response:**

VA has identified funding priorities in the NOFA for "Per Diem Only" funding that was announced in the Federal Register on May 5, 2003. These funding priorities target: 1) States that currently do not have any grant or per diem funded beds, and 2) Indian Tribal Governments. The seven States that currently do have any grant or per-diem funded beds are primarily rural in nature and include Alaska, Idaho, Kansas, Montana, North Dakota, New Hampshire and Wyoming. By establishing these funding priorities, VHA expects to award funding to assist with the development of transitional housing for Native American homeless veterans on Indian reservations and homeless veterans in rural areas.

#### **14. VBA HOMELESS COORDINATORS NEED TRAINING**

##### **Finding:**

Pursuant to Public Law 107-95, VBA has made strong efforts to increase its efforts to assist homeless veterans. While placing full-time coordinators in the twenty largest offices and part-time coordinators in the smaller offices is a step in the right direction, VBA needs to fully link these coordinators into the VHA healthcare system and into the larger systems of care in the country. In addition, VBA must develop clear and concise training on all of the expectations required by these coordinators under Public Law 107-95.

##### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Under Secretary for Benefits develops a coordinated and on-going training program for homeless veterans program coordinators. Any training developed at a minimum needs to be coordinated with the Director of Homeless Veterans Programs and the Associate Chief Consultant, Health Care for Homeless Veterans.

##### **Response**

VBA has begun to provide training for its coordinators. First, Compensation and Pension Service sponsored the attendance of the 20 full-time homeless veterans outreach coordinators (HVOCs), designated by Public Law 107-95, at the National Coalition for Homeless Veterans conference. This was coordinated with the Director of Homeless Veterans Programs and the Associate Chief consultant, Health Care for Homeless Veterans, who assisted in arranging for guest speakers. The conference was held May 5-7, 2003. Ten other regional offices were represented as well. In the afternoon of May 6, the HVOCs were briefed on issues specific to their work, were given the opportunity to ask questions, express their concerns, and promote their best practices. Guest speakers represented the Departments of Justice and Labor, HUD, and VA's Project CHALENG director. The audience was briefed on the following topics with focus on homeless veterans: HUD's Special Needs Assistance Programs, Justice's Serious and Violent Offender Reentry Initiative, employment assistance available through Labor, and CHALENG. VBA officials also briefed the audience on mission and administrative matters. From two to five HVOCs attended each of the conference's 19 workshops. They will submit reports on these workshops to the VBA program coordinator who will post them on VBA internal web site for the benefit of all regional office HVOCs. Conference information will also be covered on a future HVOC telephone conference.

VA's Compensation and Pension Service devised a reference resource document for HVOC use. It contains electronic document resources pertaining to legislative and VA materials related to homeless veterans.

It also contains links to numerous web sites containing information on homelessness; i.e., VA, HHS, HUD, DOJ, DOL, state, NCHV and ICH. The document was sent to all HVOCs and is posted on the service's Intranet web site. It will be improved and updated as needed.

Monthly national HVOC telephone conferences are held, sponsored by the Compensation and Pension Service. During these 50-minute conferences, HVOCs are updated on homeless veteran issues and are given the opportunity to pose questions and comments. In addition a special training topic is covered. The Director of Homeless Veterans Programs and the Associate Chief Consultant, Health Care for Homeless Veterans, have been invited to participate in these conference calls.

HVOCs were asked to submit their ideas and suggestions for the content of an HVOC training curriculum. The VBA program manager will consolidate the information that will be considered by a working group to finalize and distribute to all regional offices. The Director of Homeless Veterans Programs and the Associate Chief Consultant, Health Care for Homeless Veterans, will be consulted in formulating the training program.

## **15. SLOW BACK PAYMENTS - NEED TO IMPROVE TIMELINESS**

### **Finding:**

Long delays in determining benefits are unacceptable. Homeless veterans are often in desperate need of benefits but the manner in which these benefits are received needs to be reviewed. A large long-delayed influx of money that some veterans receive is sometimes more detrimental to both their physical and economic health.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- VA reviews its payment policy and study how payment modifications for large awards may be made. This review should include discussion with the Social Security Administration and others with significant experience to ascertain if their approach can be duplicated.

### **Response:**

In 1991, VBA established procedures for regional office processing of claims for veteran claims. The procedure requires special identification, control, handling, and expedited processing with the objective of completion within 30 calendar days. Every effort is made to assist claimants in the development of their claims. There are occasional situations that prevent expedient processing; e.g., difficulty in verifying military service, non-receipt of medical records and delays in having the beneficiary examined at a VA medical facility. Generally, the longer it takes to adjudicate a claim, the greater the initial payment because of the effect of retroactivity of benefits.

Despite a large amount of payment due a beneficiary, VA is not legally able to delay or parcel out benefits due. When a benefit award is made, payment must be issued immediately to the beneficiary, or to a fiduciary/payee selected under VA's Fiduciary Program when there is evidence that the beneficiary is incompetent; i.e., unable to manage his or her personal funds. VA's Fiduciary Program is similar to that of the Social Security Administration's Representative Payment Program in which a third party administers the beneficiary's funds. VA's and SSA's third party payee programs help to assure that the funds of incompetent beneficiaries are used to the advantage of the beneficiaries.

- VA reviews the process by which veterans are placed with fiduciaries to ensure that the payment system effectively serves homeless veterans.

### **Response:**

As mentioned in the previous response, VA's Fiduciary Program helps to assure that the funds of incompetent beneficiaries are used to their advantage. The primary objective of the program is to protect the beneficiary. Fiduciaries are required to (a) receive the beneficiary's benefits, (b) pay for the costs of the beneficiary's needs (shelter, food, clothing, household necessities, utilities, transportation, etc.) within the limits of the beneficiary's income and resources, (c) conserve excess funds to the extent

possible for future needs, and (d) account for all of the beneficiary's funds and assets. VA's Fiduciary Program is effective, and more so for incompetent homeless veterans and incompetent veterans at risk of homelessness..

- VBA do what is required under Public Law 107-95 to aggressively reach out to homeless veterans to expedite the processing of their claims so that large back payments that some homeless veterans receive may be eliminated.

**Response:**

(VBA's special procedures for homeless veteran claims are addressed in the first response above.)

The VBA program of outreach to homeless veterans began in 1987. Each regional office has a designated HVOC. Their functions vary depending on many factors, among them the size of the office's jurisdiction in terms of demographics and geography. They routinely visit sites where the homeless congregate or are provided services. Networking is a key element to their effectiveness.

They are accessible to those in the community who assist the homeless so that they can intervene and assist in VA benefits matters. VBA's special procedures for homeless veteran claims assure that those cases are specially tagged for priority and expedited to the extent possible. That process not only results in delivery of benefits as quickly as possible, but also helps to prevent large retroactive payments.

Regional offices began to maintain a log of homeless veteran Compensation and Pension claims received on or after October 1, 2002. The log serves as a control for pending claims, a record of outcome, and report to Compensation and Pension Service for data analysis. For the six-month period ending on March 31, 2003, 1,502 claims were received nationwide. 25% of them were original claims for Compensation, 35% for reopened Compensation, 21% for original Pension, and 19% for reopened Pension. Compensation and Pension Service is working with the regional offices to correct the claims disposition entries, and to report the disposition information more timely. For that reason, we are unable to provide valid data on claims disposition at this time. Regional offices have been directed to correct data entries and update disposition information in time for Compensation and Pension Service roll-up of data for the period ending June 30, 2003. That will result in the additional data needed on the number of pending claims, average pending days, average processing time on completed claims, number of grants and denials, and general reasons for denial – all by type of claim. The data will be derived from claims received from October 1, 2002, through June 30, 2003. The data should be available by August 1, 2003. VBA will provide the Committee with that data.

## **16. BURIAL FOR HOMELESS NEEDS BETTER COORDINATION**

### **Finding:**

VA offers an array of services to living homeless veterans. However, many veterans who are not in contact with family or service providers die without notice by officials and are buried without recognition of their honorable military service. VBA and VHA have, in a variety of places, made efforts to see that a proper final resting place is secured, but those efforts are sporadic and often miss those who deserve and most need our Nation's final veterans benefit.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- VA develop a comprehensive strategy to work with local officials, homeless veterans service providers and VHA health care providers to ensure that all homeless veterans are treated in death with dignity.

### **Response:**

The key to preventing inappropriate veteran burials is the verification process for veteran status of the unclaimed remains of indigent decedents. The unclaimed remains of a homeless veteran may not be buried in a VA or other veteran cemetery if it is not known that the decedent was a veteran. Each regional office has a coordinator for this program who performs outreach to coroners, medical examiners, government agencies, funeral homes, etc., who deal with unclaimed remains. Those parties are reminded of the need to contact VA to verify the veteran status of unclaimed remains. To assure that the remains of unclaimed, indigent veterans, including those of homeless veterans, are provided a proper veteran burial; the coordinator assures that verification as to veteran status is made on all inquiries concerning unclaimed remains. VA's Compensation and Pension Service is current.

The Compensation and Pension Service has established ties to the National Funeral Directors Association (NFDA), and the Center for Disease Control's Medical Examiner and Coroner Information Sharing Program (MECISP). NFDA has linked VA's web information on this subject to its web site. VA has linked both organizations' web sites to its web site. MECISP has posted information on VA's Homeless Veterans Outreach program on its web bulletin board.

## **17. BENEFITS DELIVERED TO INCARCERATED VETERANS**

### **Finding:**

Increased involvement with both male and female veterans coming out of jails/prisons needs to be improved in order to improve recidivism and enhance the lives of veterans. Under current law, if a service-disabled veteran is incarcerated for a felony, he or she automatically loses approximately half of their benefits while incarcerated after the 61<sup>st</sup> day. These benefits are lost forever. Full benefits are resumed upon release if the VA is notified within one year of release. Depending on the nature of the disability, the VA may schedule a medical examination to determine the current extent of the disability. This lack of benefits significantly contributes to veterans' becoming homeless.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Veterans Benefits Administration (VBA) should be more proactive and work with prisons to assure that service-connected veterans who are scheduled for release from prison are aware of their obligation to notify the VA of their release so that benefits will be restored. This proactive approach must be done in coordination with the Veterans Health Administration. If an examination is scheduled, the case should be tagged for priority consideration. This would help mitigate against recidivism since the veteran would have some income stream upon release.

### **Response:**

The Secretary signed a Memorandum of Understanding with the Departments of Justice, Health and Human Services, Labor, Housing and Urban Development, and Education on December 4, 2002, to become a non-funding participating partner in the Serious and Violent Offender Reentry Initiative. The goal of the initiative is to reduce recidivism of offenders released from prison. VA's participation in this initiative is to provide technical services, outreach, and coordination services, as VA deems necessary and appropriate, for the benefit of veterans participating in the Serious and Violent Offender Reentry Initiative. Technical services include, among other things, the provision of technical or specialized consultative services that are tailored to the specific needs of requesting. VBA and VHA will coordinate on this matter. Generally, medical examinations are not required to resume Compensation or Pension benefits that were reduced or terminated because of incarceration.

- This process begins at some time prior to release with a presumptive approval that would allow sufficient time for restoration of benefits to coincide with release.

### **Response:**

The Compensation and Pension Service is investigating the feasibility of incorporating additional information in the computer-generated letters sent to incarcerated veterans when their benefits are reduced or terminated. The information would advise the veteran of what will be necessary for VA to increase or resume benefits as expeditiously as possible upon the veteran's release

## **18. COORDINATION OF VA'S HOMELESS EFFORTS NEEDS TO BE ENHANCED**

### **Finding:**

The issues involved with homelessness are complex and multifaceted. VA must approach this problem with a system-wide coordinated effort to ensure that VA programs and services are effective and coordinated with other activities or programs, assisting homeless persons. This comprehensive approach to VA's internal as well as external relationships is important particularly as Federal efforts to expand and coordinate relationships at the national, state and local levels are aimed at being both horizontally and vertically integrated.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Office of Homeless Veterans Programs be established at a senior-level and charged with direct accountability over all homeless veterans programs.
- The Director of that office should serve as the principal advisor to the Secretary and other senior leaders on issues of homelessness, without direct control over hiring, evaluation and personnel actions of department staff but as the lead on development and coordination of funding, programmatic direction and evaluation of department-wide homeless efforts.
- The Director should have principal responsibility for inter- and intra-agency collaborations including overall coordination of all VHA and VBA homeless efforts, serve as the primary link to the U.S. Federal Interagency on Homelessness, other federal agencies, state, local and tribal governments, veteran service organizations and national service providers on homelessness.
- The office should report directly to the Secretary and have overall coordination of all national and department-wide programs and initiatives.

### **Response:**

VA's efforts to assist homeless veterans are coordinated through the Director of Homeless Veteran Programs. This effort is led by Mr. Peter Dougherty who organizationally coordinates and oversees all of VA's efforts to assist homeless veterans including all internal and external relationships. As such, Mr. Dougherty has the direct relationship of advising and reporting to the Secretary and all other key departmental officials who have programmatic responsibility over homeless efforts.

A memorandum that outlines the above will be provided to the Advisory Committee on Homeless Veterans and this matter will be reviewed by the committee at the request of the chair.

## **19. COMPREHENSIVE TEN-YEAR PLAN TO END CHRONIC HOMELESSNESS**

### **Finding:**

Both the Congress and the Administration have called for a ten-year plan to end chronic homelessness. VA needs a plan to provide adequate beds and services to eliminate chronic homelessness. To be effective, the plan developed should be consistent with other related recommendations made by this Committee including "front-end loading" of transitional housing beds to ensure sufficient services to end chronic homelessness.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Secretary direct that a ten-year plan to end chronic homelessness be developed in coordination with the US Federal Interagency on Homelessness and requests that this committee review such plan, including draft proposals, prior to the development of the Department's FY 05 budget. The plan developed should have measurable outcomes to determine its effectiveness.

### **Response:**

VA has aggressively developed and enhanced both internal and external relationships to improve both the access and availability of both community and VA services.

VA has begun to review its service delivery options and needs. This issue will be reviewed with the Advisory Committee on Homeless Veterans and VA will seek the advice and counsel of the Committee as it proceeds to establish a coordinated plan to end chronic homelessness among veterans. The outline of this effort will be shared with the Committee; however, VA cannot present specific budget proposals prior to the public release of the Administration's budget.

## **20. INTERAGENCY COUNCIL ON HOMELESSNESS**

### **Finding:**

The U.S. Interagency Council on Homelessness (ICH) is a valuable resource and the Committee is pleased that Secretary Principi and other VA officials have been active participants. The Committee applauds the Secretary on taking an active leadership role. The strong development of multiple partners at the Federal level provides the best hope of resolving the issue of homelessness at the local level.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends the following:

- VA Homeless Coordinators need to participate with ICH on the Homeless Regional Homeless Coordinators and the State Homeless Coordinators in regional meetings.

### **Response:**

The ICH has been very active with three Cabinet- Secretary- Level meetings and a fourth scheduled in October 2003. In addition, since May 2003, the ICH has been meeting every Monday with senior managers of the various agencies that have significant programs and services for homeless people. VA's director of Homeless Programs regularly attends those meeting. ICH has appointed one of its regional coordinators, Ms. Debbie Jackson to serve as a liaison to VA. Ms. Jackson has more than 20 years of experience working for VA culminating in her working as the Compensated Work Therapy Manager for VA Medical Center, Washington, D.C. ICH has already been working with re-establishing a viable network of state level homeless coordinators and VA has already furnished ICH with contact information for VA field-based and central office staff who can assist with homeless issues. This matter will be reviewed with the Advisory Committee on Homeless Veterans at the request of the Chair.

- Federal inter-agency training workshops for grantees and sub-recipients (PHA's, states, local governments and non profits) need to be conducted at the regional level to inform all interested parties on:
  - how to get grants and build capacity
  - how to obtain other non-grant funding
  - how agency grants are integrated
  - issues identified by recipients of grants and those interested in serving the homeless.

This recommendation has been referred to ICH and ICH will, at the request of the Committee Chairman, discuss this recommendation and ICH actions.

- Regionally ICH should establish a veteran's "footprint" in the homeless strategies of governors and mayors.

This recommendation has been referred to ICH and ICH will, at the request of the Committee Chairman, discuss this recommendation and ICH actions.

- Nationally ICH needs to coordinate its Federal Strategic Plan with all ICH members.

This recommendation has been referred to ICH and ICH will, at the request of the Committee Chairman, discuss this recommendation and ICH actions.

- The ICH office should become an ex-officio member of this Advisory Committee.

This recommendation will require a change in law since ex-officio members are established by statute (see Public Law 107-95). In the future, ICH will be notified of all full Advisory Committee on Homeless Veterans meetings and will be asked to have a representative in attendance.

## **21. VETERAN EMPHASIS NEEDED UNDER HUD'S CONTINUUM OF CARE FUNDING**

### **Finding:**

The lack of veteran-specific data among the homeless has been a significant barrier to local and National efforts to gain resources to assist homeless veterans. Many communities have little veteran-specific information; and many veteran-specific service providers complain that little attention is paid to the needs of homeless veterans. While there have been National calls for veteran specific data for more than a decade, there appears to be no reliable National data and only sporadic reliable local data that clearly identifies homeless veterans outside the Department of Veterans Affairs.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- Veteran-specific data must be collected through the Department of Housing and Urban Development's Homeless Management Information System (HMIS) and be reported under HUD's Annual Progress Reports.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Housing and Urban Development. The data collection efforts by HUD will be addressed by that Department at the next Advisory Committee meeting (Fall 2003).

- Veterans be identified as a special-needs population for McKinney-Vento funding.

This recommendation has been forwarded to the ex-officio representative from the Department of Housing and Urban Development. Veterans are identified as a population to be served. HUD representatives will provide further information to the Committee upon the request of the Chairman.

- Veteran specific representation needs to be included on local Continuum of Care boards.

This recommendation has been forwarded to the ex-officio representative from the Department of Housing and Urban Development. In informal discussions with HUD, it appears that this recommendation may need further clarification. HUD's ex-officio member would be available at the Chairman's request to review this issue with the Committee.

## **22. VA CHALENG DATA NEEDS TO BE LINKED WITH HUD'S CONTINUUM OF CARE PLANS**

### **Finding:**

VA has invested significant efforts into the Community Homelessness Assessment Local Education and Networking Groups (CHALENG) for veterans needs, resources and local planning efforts. While this effort is far from comprehensive, it is clearly the best and most significant National effort to increase knowledge about the needs and numbers of homeless veterans. The Committee has found a significant undercounting of homeless veterans and lack of acknowledgement that there is a homeless veterans problem. HUD has an excellent model of addressing homeless needs but many jurisdictions by omission fail to address the needs of homeless veterans.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Department of Housing and Urban Development and VA establish a working group to determine the feasibility of incorporating VA's CHALENG information in HUD's local continuum-of-care planning process. While we recognize that these efforts may have many technical problems, each Department is urged to resolve those technical difficulties and improve the information about homeless veterans.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Housing and Urban Development. Appropriate staff from the VA and HUD are to meet to discuss the methods used to establish data collections; to review the catchments areas each department collects from and reports to, and to review ways this information could be used to enhance information under the continuum of care. This issue will be addressed at the Advisory Committee's Fall 2003 meeting.

## **23. POLICY ACADEMY**

### **Finding:**

The Departments of Housing and Urban Development, Health and Human Services, Labor and Veterans Affairs have co-sponsored State-level decision maker Policy Academies. VA, while not originally invited into this process, has taken strong action to become a full partner in the planning and coordination of those academies that focus on chronic homelessness - the segment of greatest relevance to homeless veterans.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- VA continues to participate in these academies to inform State-level decision makers of programs and benefits available to veterans and to ensure that the overarching federal strategy can clearly and consistently be applied.

### **Response:**

The Department of Veterans Affairs will continue to support this interagency effort to improve collaborative strategies to improve services to chronically homeless. The latest policy academy was held on May 20-22 in Chicago, IL. A detailed briefing of the policy academy program will be provided to the Advisory Committee upon the request of the Chairman.

- Veteran-specific representation should be included on each State team and senior-level state decision makers need to be encouraged to attend if this program is to be highly effective.

### **Response:**

The make-up of the State teams is, by design, determined by state-level decision makers. While we do not wish to alter this concept, VA has brought this issue to the attention of the policy academy planning committee. It should be noted that most State teams include one or more members knowledgeable of VA programs or veterans issues. Specific guidance to State teams will include a request that veteran-specific representation be included on State teams.

## **24. VA & DOD NEED TO IDENTIFY RISK FACTORS CURRENT/DEPARTING SERVICEMEMBERS**

### **Finding:**

The Departments of Veterans Affairs (VA) and Defense (DOD) have a high level of interest in the long-term health and vitality of person's who have served in the military. Both have significant health care resources and an interest in their physical and mental well-being. Males who have served in the military services are nearly twice as likely, and women four times as likely, to become homeless. An improved effort to reach active duty and departing servicemembers successfully transition back into society needs to be accomplished if the elimination of homelessness among veterans is to be achieved.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- VA join in an interagency prevention strategy with DOD to improve and to provide a proactive review of separating servicemembers to determine if those at risk of homelessness are being provided appropriate counseling and access to services prior to and following release.

### **Response:**

The Department of Defense informs VA of each servicemembers release from active duty. Through the Veterans Assistance at Discharge System (VADS), a "Welcome Home" letter is sent to all recently separated veterans. The letter includes "VA Benefits Timetable" that lists all potential benefits, contact telephone numbers and the VA Internet web site. Most servicemembers participate in the Transition Assistance Program, a joint effort of the Departments of Defense, Labor and Veterans Affairs. Three-day workshops are held, a substantial portion of which is dedicated to transition, employment, and career development.

- VA and DOD should participate in a research study to show if childhood risk factors and active duty experiences can be found to improve identification and treatment for active duty servicemembers and to enhance service delivery access once released from military service.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Defense. The ex-officio representative will provide the Committee with additional information at the Fall 2003 meeting. There is a legislative proposal H.R. 1906 108<sup>th</sup> Congress, which addresses this recommendation. This is an issue that DOD, through its ex-officio representative, will be prepared to address at the request of the Chairman.

## **25. DOD PROPERTY ENHANCE USE FOR HOMELESS VETERANS**

### **Finding:**

The Department of Defense (DOD) has vast physical resources and has a long history in some locations of linking those resources to homeless services. VA should be linked into information about excess and underutilized DOD property. DOD has a policy directive #4165.65 dated October 30, 1987 that allows DOD to provide significant assistance to homeless veterans' service providers. There appears to be no comprehensive review of these programs or level actively at DOD.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- That DOD determines if its policy directive #4165.65 is still active.

### **Response:**

DOD has advised that policy directive 4165.65 is still active. A copy of that policy is attached.

- That DOD conduct a search of all active installations to determine what levels of services are being provided for homeless veterans.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Defense. The ex-officio representative will provide the Committee with additional information at the Fall 2003 meeting. There is no single office within DOD that collects this information.

- That DOD develop an outreach plan to let homeless service providers, particularly homeless veterans service providers, become knowledgeable about how they may access these facilities to assist homeless veterans.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Defense. The ex-officio representative will provide the Committee with additional information at the Fall 2003 meeting. There is no office that currently has this responsibility within DOD.

## **26. WIA REAUTHORIZATION – INCLUDE SERVICES TO HOMELESS**

### **Finding:**

Under the Joint Training Partnership Act, employment assistance to homeless individuals was specifically authorized. However, under the Workforce Act of 1998, the references to homeless individuals were removed and replaced by assistance to “at risk” populations. Given the emphasis on performance outcomes, the states under WIA, job assistance for homeless people, is often overlooked.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- That employment assistance for homeless persons be written into the Reauthorization of the Workforce Investment Act, rewarding states that provide specific programs for assisting homeless people, including homeless veterans, with performance incentive monies.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Labor. H.R. 1261 108<sup>th</sup> Congress, which is pending before the Congress, relates to this topic. Department of Labor’s ex-officio will provide further information to the Committee at its Fall 2003 meeting.

## **27. INCARCERATED VETERANS TRANSITION PROGRAM PARTNERSHIP**

### **Finding:**

Under the Homeless Veterans Comprehensive Assistance Act, the Departments of Labor and Veterans Affairs are collaborating on six demonstration programs to provide assistance to incarcerated veterans who are transitioning from prison to civilian life.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Secretary of Veterans Affairs and the Secretary of Labor evaluate these demonstration programs; and, if successful, seek funding to establish such Incarcerated Veterans Transition Programs in all States where the need exists.

### **Response:**

The Departments of Labor and Veterans Affairs have been working collaboratively to initiate pilot projects by the end of fiscal year 2003. Three sites will be identified and selected next fiscal year. VA expects this joint effort to continue with effective communications and monitoring by both departments.

## **28. DVOP/LVER OUTREACH TO HOMELESS VETERANS**

### **Finding:**

The Department of Labor Veterans Employment and Training Service provides grants to fund Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representatives (LVER) at One Stop Job/Career centers in all the States. DVOP's in particular, are responsible for assisting disabled veterans and veterans with barriers to employment in finding good jobs and assist in placing homeless veterans who are enrolled in DOL's HVRP program.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Secretary of Veterans Affairs encourage the Secretary of Labor to use incentive award moneys in the grants to reward DVOP's and LVER's who actively outreach and assist homeless veterans in becoming job ready and in finding good jobs.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Labor. The ex-officio representative will provide the advisory committee with additional information at the Fall 2003 meeting.

## **29. DOL HVRP PROGRAM**

### **Finding:**

The Department of Labor's Homeless Veterans Reintegration Program (HVRP) is one of the most successful programs addressing the employment of homeless veterans. The entered employment rate for the HVRP approaches 54% and the job retention rate approach 70%. However, the funding for HVRP is at \$18.25 million for fiscal year 2002 and \$18.25 million for fiscal year 2003, even though the authorization under Public Law 107-95 is \$50 million.

### **Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Secretary of Veterans Affairs and the Secretary of Labor, seek congressional approval of the full \$50 million authorized for HVRP in FY 04.

### **Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Labor. The ex-officio representative will provide the Committee with information regarding DOD's funding level at the Fall 2003 meeting.

**30. HHS SHOULD OFFER PILOT FUNDING TO VETERAN SPECIFIC SERVICE PROVIDERS**

**Finding:**

VA and the Department of Health and Human Services (HHS) share a mission to assist many of our Nation's most vulnerable persons, including homeless veterans, with health care services. The Committee is unaware of any HHS project that specifically assists community-based service providers in veteran-specific programs.

**Recommendation:**

The Advisory Committee on Homeless Veterans recommends:

- The Department of Health & Human Services collect veteran specific data in all HHS funded programs.

**Response:**

***This recommendation has been forwarded to the ex-officio representative from the Department of Health and Human Services. The data collection efforts by HHS will be addressed at the next meeting of the Committee (Fall 2003).***

- HHS develop a number of pilot programs during fiscal year 2004 designed to enhance services for homeless veterans provided by veteran specific service providers.

**Response:**

This recommendation has been forwarded to the ex-officio representative from the Department of Health and Human Services. The Department of Health and Human Services will be prepared to discuss this recommendation at the next meeting of the Committee (Fall 2003).

## Attachment 1

### GLOSSARY

ACHV	-	Advisory Committee on Homeless Veterans
CHALENG	-	Community Homelessness Assessment Local Education and Networking Groups
CWT	-	Compensated Work Therapy
DCHV	-	Domiciliary Care Homeless Veterans Program
FTE	-	Full Time Employment
HCHV	-	Health Care for Homeless Veterans
HVAC	-	House Veterans Affairs Committee
ICH	-	Interagency Council on Homelessness
LIHTC	-	Low Income Housing Tax Credits
NCHV	-	National Coalition for Homeless Veterans
NEPEC	-	North East Program Evaluation Center
OSAC	-	Outpatient Substance Abuse Clinic
SMI	-	Seriously Mentally Ill
VBA	-	Veterans Benefit Administration
VERA	-	Veterans Equitable Resource Allocation
VETS	-	Veterans Employment & Training Service
VFW	-	Veterans of Foreign Wars
VISN	-	Veteran Integrated System Network
VOA	-	Volunteers of America
VVA	-	Vietnam Veterans of America
VWIA	-	Veterans Workforce Investment Act

## Attachment 2

### Summary of VA's Specialized Homeless Programs, FY 2002

#### **Homelessness Among Veterans**

Homelessness among veterans is a persistent problem that demands a comprehensive set of coordinated services. Veterans have a somewhat higher risk for homelessness despite demographic characteristics that would seemingly reduce the risk of homelessness (surveys have shown that veterans have higher incomes, lower rates of poverty and unemployment, and are better educated than non-veteran men in similar age groups). Epidemiologic studies conducted by the Northeast Program Evaluation Center (NEPEC) have suggested, for example, that veterans serving during the era immediately following the Vietnam War and female veterans have significantly higher risk than their non-veteran peers.

#### **VA Specialized Programs**

Over the last 16 years, VA has systematically developed the largest integrated network of services and programs designed to address the treatment, rehabilitation and residential needs of our Nation's homeless veteran population. In FY 2002, VA specialized homeless programs provided services to approximately 75,000 homeless veterans. VA specialized homeless services programs include the Health Care for Homeless Veterans Program (HCHV) and its components (the Grant and Per Diem Program, the Supported Housing Program, and the Housing and Urban Development - Veteran Affairs Supported Housing Program (HUD-VASH)); the Domiciliary Care for Homeless Veterans Program (DCHV); and the Compensated Work Therapy/ Transitional Residence Program (CWT/TR).

VA homeless services programs are designed to provide a continuum of care for homeless veterans. Key elements of this continuum are:

- (i) *outreach* to identify veterans among homeless persons encountered in communities and *clinical assessment* to determine the needs of those veterans;
- (ii) *rehabilitation* in community-based contracted residential treatment (HCHV Program), VA domiciliary programs (DCHV Program) or transitional residences (CWT/TR Program);
- (iii) *supportive transitional housing* to facilitate community re-entry (for example, the Grant and Per Diem Program);
- (iv) *supportive case management* to maintain independent living in the community (for example, the Supported Housing and HUD-VASH Programs).

VA established the main organization for the evaluation of its homeless programs, the Northeast Program Evaluation Center (NEPEC), at the same time the first specialized clinical programs were initiated. NEPEC data, which document results of community outreach, residential treatment and case management services, insure accountability of these programs and have guided the development of new initiatives.

During the initial years of operation of the HCHV and DCHV programs, long-term studies of program effectiveness were conducted. These studies showed that program participation allowed substantial percentages of veterans to exit homelessness: 62 percent of HCHV veterans and 52 percent of DCHV veterans were housed at approximately one year following entry to the program. Increases in public support income and clinical improvement of mental health and substance abuse problems were also noted. The results from these studies compare favorably to those from non-VA homeless services programs such as the Center for Mental Health Services' ACCESS project.

Although it is not possible to conduct such long-term effectiveness studies on an ongoing basis, all VA specialized homeless programs participate in regular monitoring by NEPEC. The information in this summary comes from that monitoring data.

### ***Outreach Services***

**HCHV Program.** The first core component of VA homeless services is outreach services. The HCHV program operates at 135 medical centers providing outreach to, and clinical assessment of, homeless veterans living on the streets and in emergency shelters. The mission for this program is to locate homeless veterans who have serious psychiatric and substance abuse problems and connect them with needed mental health, medical, and rehabilitative services.

In FY 2002, there were 335 program clinicians (mostly social workers and nurses) dedicated to the HCHV outreach effort. These clinicians contacted 42,668 veterans (129 veterans per clinician). This represents a four percent decrease relative to the number of assessments conducted in FY 2001 (44,845), but a 43 percent increase over the number of assessments conducted in FY 1998 (29,722).

More than 97 percent of the veterans contacted in FY 2002 were male, and their average age was 48 years. Slightly less than one-half of the veterans assessed were African American. About 47 percent of these veterans served in the military during the Vietnam era. Nearly 65 percent of the veterans seen were living in shelters or in outdoor locations at the time of first contact, and 40 percent had been homeless for six months or more. Over half reported having serious medical problems at the time of outreach. Of the veterans contacted, approximately 81 percent had a serious psychiatric or substance abuse disorder and 33 percent had both psychiatric and substance abuse disorders. Almost three quarters of these veterans had not worked in

the 30 days just prior to assessment; about two-thirds had a monthly income of less than \$500.

A principal outcome of clinical outreach is to connect homeless veterans with needed services, especially mental health services. Linking of clinical assessment data with VA administrative databases shows that approximately 71 percent of the veterans contacted at outreach during FY 2002 received VA mental health services (including HCHV case management services) in the six months following outreach. The majority of veterans contacted at outreach (52%) had not used any VA mental health services in the six months prior to outreach.

### **Residential Treatment**

A second core component of VA homeless services is residential treatment. Residential treatment programs provide safe housing that has continuous staff supervision, are designed to reinforce abstinence from substances, and provide on-site psychosocial counseling and ongoing case management. In the HCHV Program, these services are contracted from non-VA providers; in the DCHV and CWT/TR Programs, VA staff provides these services. Residential treatment has been part of the HCHV and DCHV Programs since their initiation in 1987; the CWT/TR Program was started in 1990. While in residential treatment, veterans may participate in the Veterans Industries/Compensated Work Therapy (VI/CWT) Program, which offers a wide range of rehabilitation services, ranging from formal evaluation and counseling to remunerative work and training experiences.

**HCHV Contract Residential Treatment.** Contract residential treatment is offered at 127 of the 135 HCHV Programs. In FY 2002, over \$13 million was spent on these services. This is about 64 percent of the amount allocated by VA Central Office (VACO) and the networks for this purpose (\$20 million). For the second year in a row, many (21) new HCHV Programs that were started in FY 2000 as part of the HCHV expansion did not place any veterans into residential treatment in FY 2002. Some of these programs reported the availability of residential treatment funds, while others reported that residential treatment funds were no longer available. Overall there was a \$5 million decrease in the availability of residential treatment funds between FY 2001 and FY 2002.

The HCHV Program supported 4,611 episodes of residential treatment in community-based halfway houses during FY 2002; the number of episodes of treatment decreased by nine percent over the number in FY 2001. Virtually all of the veterans who stay in contract residential treatment come from the HCHV outreach population described in the previous section. Thus, the overwhelming majority of veterans placed in contract care during FY 2002 (88 percent) met all of the appropriate criteria for residential treatment (homelessness, low income, and clinical need). The average length of stay in the program was 73 days, and the average cost per episode was \$2,880.

About 55 percent of the veterans discharged during FY 2002 were judged to have successfully completed residential treatment. Forty-nine percent had an apartment, room, or house at discharge, and an additional 27 percent were discharged to another treatment setting (such as a halfway house). This is the highest percentage of veterans housed at discharge ever recorded in the HCHV program. Approximately 50 percent had part-time or full-time employment (including employment through the Veterans Industries program). Clinical gains were substantial: about 70 percent experienced improvement at the time of discharge. Monitoring of mental health outpatient encounters indicated that 69 percent of discharged veterans were followed up with some type of VA after-care services within 30 days of discharge.

**DCHV Residential Treatment.** Residential treatment is currently offered through DCHV Programs at 34 VA medical centers. There are 1,833 beds dedicated to the treatment of homeless veterans. There are 690 staff employed by the DCHV programs; total annual cost of the program is approximately \$38 million dollars.

During FY 2002, 5,145 veterans completed an episode of DCHV treatment. Veterans enter the DCHV program through different referral sources. About 39 percent of DCHV clients were referred by VA inpatient units; about 22 percent were self referred; about 14 percent were referred from VA outpatient clinicians and 17 percent were referred by community outreach. Age, gender and military service era characteristics of DCHV clients are very similar to those of the HCHV outreach population. The DCHV program serves a veteran population with a high prevalence of substance abuse disorders. About 92 percent were diagnosed with a substance abuse problem, half (49 percent) had a serious mental illness (e.g., schizophrenia, bipolar disorder, anxiety disorders and major affective disorders) and 44 percent were dually diagnosed. About half of the clients (48 percent) report having serious medical problems.

During FY 2002, the average length of stay was 110 days, a small increase from the previous two fiscal years. Lengths of stay had dropped by nearly 37 days between FY 1995 and FY 2000.

During FY 2002, 33 percent of veterans were discharged to their own apartment, room or house; an additional 24 percent were discharged to an apartment, room or house of a family member or friend. About 23 percent were discharged to an institution. Four out of ten veterans had arrangements to work in part- or full-time competitive employment, while an additional 15 percent had arrangements to participate in a VA work therapy program. Clinical improvement at discharge was substantial, with over 85 percent of veterans showing improvement on substance abuse and mental health problems. Over half of DCHV clients with mental health or substance abuse problems receive follow-up aftercare within 30 days of discharge from the program.

**CWT/TR Residential Treatment.** The CWT/TR program is currently in its thirteenth year of operation. From the program's inception in September 1990, to the end of FY 2002, there have been over 6,000 admissions and nearly 5,600 discharges. Originally implemented as a 14-site program with 236 beds, the CWT/TR Program has expanded to 35 sites with 26 operational programs and 432 operational beds in FY 2002. Currently, 15 of the 34 CWT/TR sites (43 percent) have a primary mission of treating veterans with substance abuse disorders, 12 of the 34 sites (34 percent) are designed to treat veterans who are homeless and mentally ill, 5 sites (14 percent) treat psychiatrically ill veterans with vocational deficits, while 3 sites (9 percent) are designed to treat veterans with Post Traumatic Stress Disorder (PTSD).

The program is reaching its intended target population. Virtually every veteran carries a clinical psychiatric diagnosis: 96 percent had a substance abuse disorder, 49 percent had a serious psychiatric diagnosis (schizophrenia, other psychotic disorder, anxiety disorder, PTSD or mood disorder) and 44 percent were diagnosed with both a substance abuse disorder and a serious psychiatric illness. During FY 2002, 86 percent of veterans reported being homeless at least once in their lifetime and 60 percent of veterans reported being homeless when they last lived in the community.

The CWT/TR program includes a supportive, low-pressured work setting that is task-oriented. Veterans earn, on average, \$213 per week - more than enough to cover the weekly rent of \$50. During FY 2002, a veteran's mean length of stay in the program was approximately 6 months.

About 52 percent of veterans successfully complete the program. At discharge, about 40 percent have arrangements to work in competitive employment and 75 percent have arrangements to live in an apartment, room or house. Clinical improvement was noted in virtually all outcome measures - most importantly in substance abuse (69 percent reduction in alcohol problems and a 84 percent in drug problems); psychiatric problems (17 percent reduction in psychiatric problems); employment (20-fold increase in days worked in competitive employment); income (86 percent in total monthly income); housing status (210 percent increase in days housed, 80 percent decrease in days institutionalized and a 51 percent decrease in days homeless), as well as social in contacts (17 percent increase).

These data are encouraging, although they may be biased due to the low overall follow-up rate of 27.2 percent in fiscal year 2002. Follow-up rates have declined over the years as a result of staff reductions.

### ***Transitional Housing***

**Homeless Providers Grant and Per Diem Program.** A third core component of VA homeless services is transitional housing. Under the Homeless Providers Grant and Per Diem Program (GPD), VA offers grants to non-VA organizations to help develop supported housing programs and supported service centers.

Since 1994, VA has offered eight rounds of grants awarding \$63 million to help create community-based beds for homeless veterans in 44 states and the District of Columbia. Additional funds provide per diem payments to existing service providers. Collectively the program funded 4,776 beds in FY 2002. The missions of the service providers varies widely, ranging from residential treatment to transitional housing with little or no clinical support services.

The main referral source to GPD housing is the HCHV Outreach Program. Therefore the characteristics of the veterans in the GPD Program are similar to the larger outreach population: high prevalence of poverty, unemployment, serious medical and mental health problems.

There were 11,013 discharges from GPD in FY 2002. The average length of stay overall was about 85 days; however there is considerable variability across sites. This is to be expected, as the missions of the programs are widely variable. Data indicate that 50 percent of the veterans in GPD stay 43 days or less, with five programs having a median length of stay of less than two weeks. In contrast, there are 17 programs that have median lengths of stay over six months. The average cost per episode in the GPD program was \$1,674 (median: \$737).

In the GPD Program, 38 percent of the veterans were discharged successfully. Successful discharge is defined as those where the veteran has actively participated in accordance with treatment goals. In the majority of cases (50 percent), veterans were discharged due to program rule violations, or the veteran left the program without consultation. This may be a result of the wide variety of program types funded by GPD that include large bed capacity projects, emergency housing program designs, and projects where outreach is conducted by non-VA staff. About 28 percent of veterans discharged from GPD move into independent housing; an additional 25 percent are discharged to another treatment setting. Approximately 36 percent of veterans discharged are employed full-time, part-time or through Veterans Industries. Between 40 and 50 percent of the veterans (on alcohol, drugs, or who have mental health and social-vocational problems) are rated as having improved clinical status at discharge.

### ***Long-term Supported Housing***

**Supported Housing Program.** The fourth component of VA homeless services is supported housing. In FY 1993, VA established the Supported Housing Program (SH). The impetus for this program was a finding from NEPEC's study of VA homeless programs that six-month outcomes for homeless veterans receiving case management were almost as good as for homeless veterans receiving residential treatment, and costs were substantially less. In the SH program, VA staff provide case management services and, as part of the ongoing clinical support, help homeless veterans secure long-term transitional or permanent housing and help them remain in housing through the development of daily living skills.

Supported Housing case managers work within the HCHV team. Therefore, virtually all of the veterans entering the SH program are initially contacted through HCHV outreach. In FY 2002, the SH program case managed 1,639 veterans at 23 program sites. The demographic and clinical characteristics of SH clients match those of the larger outreach group. They have a very high rate of substance abuse and psychiatric disorders, and over one-third have been homeless for over six months.

Veterans in the SH Program live in various types of housing. The program strives to settle veterans into independent community housing. The average length of stay in the program is over a year; however, a few programs that have extremely long lengths of stay influence this average. The median length of stay is about eight months. About a third of veterans in the SH program receive HUD Section 8 rental assistance. Overall, veterans paid an average rent of \$251 monthly while in the SH Program.

Over half of the veterans discharged from this program during FY 2002, had a mutually agreed-upon termination, and 59 percent moved to independent housing upon discharge. About 59 percent were employed full-time, part-time or were in Veterans Industries programs at the time of discharge from Supported Housing.

**HUD-VASH Program.** In 1992, VA joined with the Department of Housing and Urban Development to launch the HUD-VASH program. HUD-VASH was initiated to further the objectives of serving the homeless mentally ill veteran through two closely linked interventions: (1) a housing subsidy provided through HUD's Section 8 voucher program, and (2) a community-oriented clinical case management effort. The goal of the program is to offer the homeless veteran an opportunity to rejoin the mainstream of community life, to the fullest extent possible. The main features of HUD-VASH that distinguish it from the Supported Housing Program are the availability of rental assistance for every program veteran, a more formalized screening procedure, the emphasis on movement into independent community residences, and a somewhat more intensive, longer-term case management model. The program currently operates at 34 medical centers. HUD-VASH employs 78 clinical case managers; these case managers were allocated a total of 1,753 Section 8 vouchers.

The program has screened about 5,500 veterans and admitted 4,300 veterans since beginning operation in 1992. About 33 percent of the veterans entering the program are still actively case managed; the average tenure in the program for active cases is over four years.

The veterans admitted to the HUD-VASH Program share many of the same characteristics of the HCHV outreach population (which is the main referral source for HUD-VASH). HUD-VASH veterans tend to have spent more days homeless in the month before intake and the prevalence of serious psychiatric problems is somewhat higher in this group. Perhaps because of the flexible housing options available in HUD-VASH, the program admits more homeless women veterans than do other VA homeless programs.

The HUD-VASH Program excels at establishing veterans in their own apartments. Within 3 months of admission about two-thirds of HUD-VASH veterans are successfully housed. At the 18-month and 3-year intervals following admission to the program, the percentage of veterans housed is approximately 95 percent. Although conclusions about outcomes at the 18-month and 3-year intervals have to be tempered in recognition of the appreciable attrition that occurs, these housing percentages compare favorably to other supported housing programs using HUD Section 8 vouchers.

A rigorous clinical trial comparing HUD-VASH to intensive case management without rental subsidies and standard HCHV care reinforces the effectiveness of the program. Over a 3-year follow-up period HUD-VASH veterans had 19% more nights independently housed than the case management control group and 27% more than the standard care group. The HUD-VASH group also had 38% and 37% fewer nights homeless than each of the control groups, greater subjective satisfaction with housing, and among those housed, fewer housing problems (e.g. pests, broken windows, neighborhood crime). There were no differences on any measures of psychiatric or substance abuse status or community adjustment.

### **Summary**

Homelessness is a complex issue. Services to homeless individuals are integral to the care of those individuals who served our Nation in the military and now find themselves among the Nation's most disadvantaged. As the largest single provider of direct services to homeless veterans, VA will continue to address the problems of this particular group through its wide range of specialized programs.



# Department of Defense INSTRUCTION

NUMBER 4165.65

October 30, 1987

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ASD(P&L)

SUBJECT: Shelter for the Homeless Program

References: (a) Section 2546 of title 10, United States Code

(b) Memorandum for the Secretaries of the Military Departments from the Secretary of Defense, "Shelter For the Homeless," October 29, 1984

## 1. PURPOSE

This Instruction implements reference (a) as DoD policy.

## 2. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense (OSD), the Military Departments (including their National Guard and Reserve components), the Unified and Specified Commands, the Defense Agencies and DoD Field Activities (hereafter referred to collectively as the "DoD Components").

## 3. POLICY

3.1. Under reference (b), the Secretary of Defense stated it is DoD policy that shelters for the homeless may be established on military installations.

3.2. The Secretary of a Military Department, or designee, may make military installations under his or her jurisdiction available for the furnishing of shelter to persons without adequate shelter in accordance with 10 U.S.C. 2546 (reference (a)) and this Instruction if he or she, or designee, determines that such shelter will not interfere with military preparedness or ongoing military functions.

3.3. The Secretary of a Military Department, after determining that a shelter for the homeless may be established on a military installation, shall ensure that the plans for the shelter be developed in cooperation with appropriate State or local governmental entities and charitable organizations. The State or local government entity, either separately or in conjunction with the charitable organization, shall be responsible for operating and staffing any shelter established by this program.

3.4. Services that may be provided by a Military Department incident to the furnishing of shelter under reference (a) are the following:

3.4.1. Utilities.

3.4.2. Bedding.

3.4.3. Security.

3.4.4. Transportation.

3.4.5. Renovation of facilities.

3.4.6. Minor repairs undertaken specifically to make suitable space available for shelter to be provided in accordance with 10 U.S.C. 2546 (reference (a)).

3.4.7. Property liability insurance.

3.5. The Military Departments should be especially sensitive to establishing shelters in the following areas:

3.5.1. Family housing areas.

3.5.2. Troop billeting areas.

3.5.3. Service facilities, such as commissaries, exchanges, dining facilities, hospitals, clinics, recreation centers, etc.

3.5.4. Safety arcs formed by firing ranges and impact areas.

3.5.5. Frequently used training areas.

3.6. Shelters for the homeless shall normally be established in only those facilities where the homeless will have exclusive use at all times. Shelters for the homeless shall normally not be established in facilities "shared" with military functions.

3.7. In addition to providing shelter and incidental services, the DoD Components may provide bedding for support of shelters for the homeless that are located on other than DoD real property. Bedding may be provided without reimbursement, but may only be provided to the extent that the provision of such bedding will not interfere with military requirements.

3.8. Individuals or entities interested in establishing shelters on military installations shall:

3.8.1. Submit a request to the Installation Commander where the shelter is desired; and

3.8.2. Provide, at a minimum, the following data: the name and address of the organization that will operate the shelter, the name and address of the affiliated State or local governmental entity, numbers of people to be served, type of program, hours of operation, special needs of the people to be served, incidental services required, estimated date when the services are requested, estimate of when services will no longer be necessary, and what security provisions are to be provided (physical security).

#### 4. RESPONSIBILITIES

4.1. The Deputy Assistant Secretary of Defense (Installations) DASD(I) shall:

4.1.1. Administer the program and issue such supplemental guidance as is necessary.

4.1.2. Appoint an individual as Director, The Homeless Assistance Program, who shall be the DoD program manager responsible for monitoring the program and answering all inquiries.

4.2. The Assistant Secretary of Defense (Comptroller) ASD(C) shall provide guidance on the use of DoD funds to finance the items issued in support of the Shelter for the Homeless Program.

4.3. The Secretaries of the Military Departments shall:

4.3.1. Implement the Shelter for the Homeless Program.

4.3.2. Appoint a senior manager to monitor the program within that Department and to provide any assistance that may be required to the DASD(I). Such official, after consultation with the Director, The Homeless Assistance Program, Office of Deputy Assistant Secretary of Defense (Installations) (ODASD(I)), shall approve or disapprove all requests to establish a shelter in accordance with 10 U.S.C. 2546 (reference (a)) and this Instruction.

4.3.3. Upon receipt of a formal request for assistance, as defined in subsection 3.8., above, the Military Department concerned shall provide an appropriate response to the requester within 30 days.

4.3.4. Ensure that each Installation Commander is informed about the program and the types of assistance that they may provide as authorized by 10 U.S.C. 2546 (reference (a)).

4.4. Installation Commanders shall:

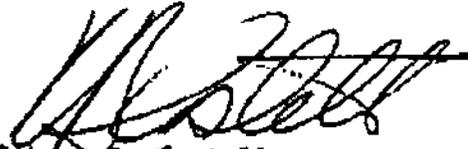
4.4.1. Acknowledge all requests for assistance.

4.4.2. Upon receipt of a request, initiate such action as is necessary to determine the availability of facilities at that installation for use as a shelter for the homeless.

4.4.3. Forward each request, through the chain of command, to the Service Senior Manager with a copy to DASD(I). The Installation Commander's recommendation shall accompany each request.

5. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward one copy of implementing documents to the Deputy Assistant Secretary of Defense (Installations) within 60 days.

A handwritten signature in black ink, appearing to read 'R. Costello', is written over a horizontal line.

**Robert S. Costello**  
**Assistant Secretary of Defense**  
**(Production & Logistics)**



THE SECRETARY OF VETERANS AFFAIRS  
WASHINGTON

June 19, 2003

**MEMORANDUM FOR UNDER SECRETARIES, ASSISTANT SECRETARIES, AND  
OTHER KEY OFFICIALS**

**SUBJECT: Homeless Program Coordination**

Homelessness among veterans is one of the most vexing problems our nation and this Department addresses. This issue requires highly sophisticated coordination of internal resources as well as the resources of other federal, state, local and tribal governments and organizations, veteran service organizations, and many others. VA's effort must be broad-based, multidimensional, and well executed.

Overall responsibility for the coordination of homeless issues and programs resides in VA's Homeless Veterans Programs Office (HVPO), Office of Public and Intergovernmental Affairs. As the director of the HVPO, Mr. Peter Dougherty serves as VA's principal advisor on homeless issues and has direct access to me, the Deputy Secretary, the Chief of Staff, and other key leaders within the Department. Mr. Dougherty serves as VA's lead in all matters related to homeless, including but not limited to serving as VA's senior policy member to the US Interagency Council on Homelessness, chairing the Secretary's Working Group on Homelessness, and serving as Department's lead for the joint initiatives with the Department of Health and Human Services and the Department of Housing and Urban Development. All internal and external actions to enhance or modify services for homeless veterans should be done in consultation and coordination with Mr. Dougherty.

Mr. Dougherty and the HVPO are responsible for insuring that VA's efforts remain focused, coordinated, and effective in meeting the goal of ending chronic homelessness. To this end, I have asked Mr. Dougherty to prepare a plan to achieve our goal to end chronic homelessness among veterans within a decade. Each administration and staff office is expected to assist with that effort. The Advisory Committee on Homeless Veterans will review and provide comments on the plan prior to its submission to me.

VA has a proud tradition of assisting those veterans who find themselves homeless. We have an excellent record of providing high quality services to homeless veterans directly and in partnership with others. I expect full cooperation with Mr. Dougherty and the HVPO so that we can continue this tradition in the future and meet our goal of ending chronic homelessness among veterans.

A handwritten signature in cursive script that reads "Anthony J. Principi".

Anthony J. Principi

TABLE 2-2. CLINICAL STAFFING OF HCHV PROGRAMS AS OF 9/30/02

VSN	Site Name	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active + Donated (FTEE)	% Total of Intended
1	BEDFORD	2.0	1.0	0.0	1.0	50.0%	1.0	2.0	100.0%
1	BOSTON	5.0	3.7	0.3	1.0	74.0%	0.1	3.8	75.0%
1	MANCHESTER	1.0	0.6	0.4	0.0	60.0%	0.0	0.6	60.0%
1	NORTHAMPTON	1.0	1.0	0.0	0.0	100.0%	1.0	2.0	200.0%
1	PROVIDENCE	3.0	3.0	0.0	0.0	100.0%	0.0	3.0	100.0%
1	TOGUS	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
1	WEST HAVEN	3.0	1.5	0.0	1.5	50.0%	3.5	5.0	166.7%
1	WHITE RIVER JCT	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
2	ALBANY	6.0	4.5	0.0	1.5	75.0%	0.0	4.5	75.0%
2	BUFFALO	4.0	3.0	0.0	1.0	75.0%	0.3	3.3	82.5%
2	CANANDAIGUA	1.0	1.0	0.0	0.0	100.0%	5.0	6.0	600.0%
2	SYRACUSE	4.0	4.0	0.0	0.0	100.0%	0.0	4.0	100.0%
3	BRONX	2.4	2.4	0.0	0.0	100.0%	0.5	2.9	120.8%
3	BROOKLYN	6.0	2.9	0.0	3.1	48.3%	2.0	4.9	81.7%
3	EAST ORANGE	4.0	2.6	0.4	1.0	65.0%	1.2	3.8	95.0%
3	MONROSE	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
3	NEW YORK	8.5	1.3	1.9	5.3	15.3%	1.5	2.8	32.9%
3	NORTHPORT	1.0	1.0	0.0	0.0	100.0%	0.5	1.5	150.0%
4	ALTOONA	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
4	BUTLER	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
4	CLARKSBURG	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
4	COATESVILLE	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
4	ERIE	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
4	LEBANON	3.0	2.0	0.0	1.0	66.7%	0.0	2.0	66.7%
4	PHILADELPHIA	3.5	3.5	0.0	0.0	100.0%	0.5	4.0	114.3%
4	PITTSBURGH	6.0	5.0	0.0	1.0	83.3%	0.0	5.0	83.3%
4	WILKES-BARRE	4.0	4.0	0.0	0.0	100.0%	0.2	4.2	105.0%
4	WILMINGTON	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
5	BALTIMORE	2.0	2.0	0.0	0.0	100.0%	0.5	2.5	125.0%
5	PERRY POINT	2.0	2.0	0.0	0.0	100.0%	0.3	2.3	112.5%
5	WASHINGTON DC	5.5	4.5	0.0	1.0	81.8%	0.0	4.5	81.8%

TABLE 2-2. CLINICAL STAFFING OF HCHV PROGRAMS AS OF 9/30/02, CONTINUED

VISN	Site Name	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active + Donated (FTEE)	% Total of Intended
6	ASHEVILLE	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
6	BECKLEY	0.5	0.0	0.0	0.5	0.0%	0.5	0.5	100.0%
6	DURHAM	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
6	FAYETTEVILLE NC	1.5	1.0	0.0	0.5	66.7%	0.5	1.5	100.0%
6	HAMPTON	3.0	3.0	0.0	0.0	100.0%	0.0	3.0	100.0%
6	RICHMOND	3.0	2.0	0.0	1.0	66.7%	0.0	2.0	66.7%
6	SALEM	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
6	SALISBURY	3.0	1.0	0.0	2.0	33.3%	1.0	2.0	66.7%
7	ATLANTA	3.5	1.5	0.0	2.0	42.9%	1.5	3.0	85.7%
7	AUGUSTA	2.0	2.0	0.0	0.0	100.0%	0.2	2.2	110.0%
7	BIRMINGHAM	4.0	3.5	0.0	0.5	87.5%	0.0	3.5	87.5%
7	CHARLESTON	2.0	0.0	0.0	2.0	0.0%	1.0	1.0	50.0%
7	COLUMBIA SC	1.0	1.0	0.0	0.0	100.0%	2.0	3.0	300.0%
7	TUSCALOOSA	0.5	0.5	0.0	0.0	100.0%	0.0	0.5	100.0%
7	TUSKEGEE	2.0	2.0	0.0	0.0	100.0%	1.0	3.0	150.0%
8	BAY PINES	2.0	2.0	0.0	0.0	100.0%	1.0	3.0	150.0%
8	GAINESVILLE	4.0	4.0	0.0	0.0	100.0%	1.0	5.0	125.0%
8	MIAMI	8.6	6.6	0.0	2.0	76.8%	0.0	6.6	76.8%
8	TAMPA	6.0	6.0	0.0	0.0	100.0%	0.7	6.7	111.7%
8	W PALM BEACH	2.0	2.0	0.0	0.0	100.0%	1.8	3.8	187.5%
9	HUNTINGTON	2.5	2.5	0.0	0.0	100.0%	0.0	2.5	100.0%
9	LEXINGTON	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
9	LOUISVILLE	3.0	3.0	0.0	0.0	100.0%	0.0	3.0	100.0%
9	MEMPHIS	2.0	1.0	0.0	1.0	50.0%	0.5	1.5	75.0%
9	MOUNTAIN HOME	2.0	2.0	0.0	0.0	100.0%	0.3	2.3	115.0%
9	NASHVILLE	3.0	2.0	0.0	1.0	66.7%	0.0	2.0	66.7%
10	CHILlicothe	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
10	CINCINNATI	3.0	2.0	1.0	0.0	66.7%	1.0	3.0	100.0%
10	CLEVELAND	3.7	2.7	0.0	1.0	73.0%	4.4	7.1	191.9%
10	COLUMBUS OPC	1.5	0.5	0.0	1.0	33.3%	0.3	0.8	56.0%
10	DAYTON	4.0	3.0	0.0	1.0	75.0%	1.0	4.0	100.0%
10	NORTHEAST OHIO	1.0	1.0	0.0	0.0	100.0%	1.3	2.3	230.0%

TABLE 2-2. CLINICAL STAFFING OF HCHV PROGRAMS AS OF 9/30/02, CONTINUED

VISN	Site Name	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active + Donated (FTEE)	% Total of Intended
11	ANN ARBOR	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
11	BATTLE CREEK	4.0	4.0	0.0	0.0	100.0%	0.7	4.7	117.5%
11	DANVILLE	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
11	DETROIT	4.7	4.5	0.0	0.2	95.7%	0.0	4.5	95.7%
11	INDIANAPOLIS	4.4	4.0	0.0	0.4	90.9%	0.4	4.4	100.0%
11	N. INDIANA	1.0	1.0	0.0	0.0	100.0%	0.2	1.2	120.0%
11	SAGINAW	1.0	0.6	0.4	0.0	60.0%	0.1	0.7	65.0%
11	TOLEDO	3.0	2.0	1.0	0.0	66.7%	1.0	3.0	100.0%
12	CHICAGO WS	5.5	5.5	0.0	0.0	100.0%	0.5	6.0	109.1%
12	HINES	5.0	5.0	0.0	0.0	100.0%	1.0	6.0	120.0%
12	IRON MOUNTAIN	0.5	0.5	0.0	0.0	100.0%	0.1	0.6	120.0%
12	MADISON	3.7	2.2	0.0	1.5	59.5%	0.0	2.2	59.5%
12	MILWAUKEE	4.0	3.1	0.0	0.9	77.5%	0.3	3.4	85.0%
12	TOMAH	2.0	1.0	0.0	1.0	50.0%	0.2	1.2	60.0%
15	COLUMBIA MO	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
15	KANSAS CITY	4.0	2.0	0.0	2.0	50.0%	0.1	2.1	52.5%
15	SAINT LOUIS	4.0	2.0	0.0	2.0	50.0%	1.0	3.0	75.0%
15	TOPEKA	1.0	1.0	0.0	0.0	100.0%	0.2	1.2	120.0%
15	WICHITA	0.5	0.0	0.0	0.5	0.0%	0.0	0.0	0.0%
16	ALEXANDRIA	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
16	FAYETTEVILLE AR	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
16	GULF COAST HCS	1.0	0.0	0.0	1.0	0.0%	0.0	0.0	0.0%
16	HOUSTON	5.0	5.0	0.0	0.0	100.0%	2.0	7.0	140.0%
16	JACKSON	3.0	2.0	0.0	1.0	66.7%	0.0	2.0	66.7%
16	LITTLE ROCK	8.3	8.3	0.0	0.0	100.0%	0.0	8.3	100.0%
16	MUSKOGEE	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
16	NEW ORLEANS	7.0	5.0	0.0	2.0	71.4%	0.0	5.0	71.4%
16	OKLAHOMA CITY	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
16	SHREVEPORT	2.0	1.0	0.0	1.0	50.0%	0.0	1.0	50.0%
17	CENT. TEXAS HCS	4.0	4.0	0.0	0.0	100.0%	0.0	4.0	100.0%
17	DALLAS	6.5	6.5	0.0	0.0	100.0%	1.0	7.5	115.4%
17	SAN ANTONIO	6.0	2.8	1.2	2.0	46.7%	0.0	2.8	46.7%

TABLE 2-2. CLINICAL STAFFING OF HCHV PROGRAMS AS OF 9/30/02, CONTINUED

VISN	Site Name	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active - Donated (FTEE)	% Total of Intended
18	EL PASO OPC	1.0	0.8	0.3	0.0	75.0%	0.0	0.8	75.0%
18	NEW MEXICO HCS	1.0	1.0	0.0	0.0	100.0%	4.2	5.2	515.0%
18	PHOENIX	4.0	4.0	0.0	0.0	100.0%	0.0	4.0	100.0%
18	TUCSON	4.0	4.0	0.0	0.0	100.0%	0.2	4.2	105.0%
18	W. TEXAS HCS	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
19	CHEYENNE	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
19	DENVER	2.0	1.0	0.0	1.0	50.0%	0.0	1.0	50.0%
19	GRAND JUNCTION	0.5	0.0	0.0	0.5	0.0%	0.0	0.0	0.0%
19	SALT LAKE CITY	4.5	2.5	0.0	2.0	55.6%	3.0	5.5	122.2%
19	SHERIDAN	0.5	0.5	0.0	0.0	100.0%	0.5	1.0	200.0%
19	SO COLORADO HCS	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
20	ANCHORAGE	2.3	1.3	0.0	1.0	56.5%	0.0	1.3	56.5%
20	BOISE	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
20	PORTLAND	4.0	4.0	0.0	0.0	100.0%	3.8	7.8	195.0%
20	ROSEBURG	4.5	4.0	0.0	0.5	88.9%	0.0	4.0	88.9%
20	SEATTLE	3.0	3.0	0.0	0.0	100.0%	0.0	3.0	100.0%
20	SPOKANE	2.0	0.5	0.5	1.0	25.0%	1.0	1.5	75.0%
20	WALLA WALLA	4.2	3.8	0.2	0.2	90.5%	0.0	3.8	90.5%
21	CENTRAL CA HCS	2.0	1.0	0.0	1.0	50.0%	0.0	1.0	50.0%
21	HONOLULU	1.5	1.5	0.0	0.0	100.0%	0.5	2.0	133.3%
21	NORTHERN CA HCS	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
21	PALO ALTO	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
21	SAN FRANCISCO	7.7	6.5	0.0	1.2	84.4%	0.0	6.5	84.4%
21	SIERRA NEV HCS	2.0	2.0	0.0	0.0	100.0%	0.2	2.2	110.0%
22	GREATER LA	23.5	20.7	0.0	2.8	88.1%	10.0	30.7	130.6%
22	LOMA LINDA	1.0	1.0	0.0	0.0	100.0%	0.3	1.3	130.0%
22	LONG BEACH	2.0	1.0	0.0	1.0	50.0%	2.0	3.0	150.0%
22	SAN DIEGO	3.0	2.8	0.2	0.0	93.3%	0.0	2.8	93.3%
22	SO NEVADA HCS	1.0	1.0	0.0	0.0	100.0%	1.0	2.0	200.0%

TABLE 2-2. CLINICAL STAFFING OF HCHV PROGRAMS AS OF 9/30/02, CONTINUED

VISN	Site Name	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active + Donated (FTEE)	% Total of Intended
23	CENTRAL IOWA	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
23	FARGO	4.5	4.0	0.0	0.5	88.9%	0.0	4.0	88.9%
23	GR. NEBRASKA	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
23	IOWA CITY	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
23	MINNEAPOLIS	3.0	3.0	0.0	0.0	100.0%	0.0	3.0	100.0%
23	OMAHA	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
	ALL SITES	373.1	303.2	7.8	62.1	81.3%	74.4	377.6	101.2%

\* Intended staffing is the number allocated by Central Office for HCHV Outreach plus Supported Housing (does not include HUD-VASH, CWT or CWT/TR)

\*\*Donated staff are FTEE detailed to the HCHV program from other services

TABLE 2-2V. CLINICAL STAFFING OF HCHV PROGRAMS AS OF 9/30/02, BY VISN

VISN	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active + Donated (FTEE)	% Total of Intended
1	17.0	12.8	0.7	3.5	75.3%	5.6	18.4	107.9%
2	15.0	12.5	0.0	2.5	83.3%	5.3	17.8	118.7%
3	23.9	12.2	2.3	9.4	51.0%	5.7	17.9	74.9%
4	22.5	20.5	0.0	2.0	91.1%	0.7	21.2	94.2%
5	9.5	8.5	0.0	1.0	89.5%	0.8	9.3	97.4%
6	15.0	11.0	0.0	4.0	73.3%	2.0	13.0	86.7%
7	15.0	10.5	0.0	4.5	70.1%	5.7	16.2	108.0%
8	22.6	20.6	0.0	2.0	91.2%	4.5	25.1	110.8%
9	13.5	11.5	0.0	2.0	85.2%	0.8	12.3	91.1%
10	14.2	10.2	1.0	3.0	71.8%	8.0	18.2	128.5%
11	21.1	19.1	1.4	0.6	90.5%	2.4	21.5	101.7%
12	20.7	17.3	0.0	3.4	83.6%	2.1	19.4	93.7%
15	10.5	6.0	0.0	4.5	57.1%	1.3	7.3	69.5%
16	32.3	27.3	0.0	5.0	84.5%	2.0	29.3	90.7%
17	16.5	13.3	1.2	2.0	80.6%	1.0	14.3	86.7%
18	11.0	10.8	0.3	0.0	97.7%	4.4	15.1	137.3%
19	11.5	8.0	0.0	3.5	69.6%	3.5	11.5	100.0%
20	21.0	17.6	0.7	2.7	83.8%	4.8	22.4	106.7%
21	17.2	15.0	0.0	2.2	87.2%	0.7	15.7	91.3%
22	30.5	26.5	0.2	3.8	86.9%	13.3	39.8	130.5%
23	12.5	12.0	0.0	0.5	96.0%	0.0	12.0	96.0%
	373.1	303.2	7.8	62.1	81.3%	74.4	377.6	101.2%

\* Intended staffing is the number allocated by Central Office for HCHV Outreach plus Supported Housing (does not include HUD-VASH, CWT or CWT/TR)

\*\*Donated staff are FTEE detailed to the HCHV program from other services

TABLE 8-1. CLINICAL STAFFING OF HUD-VASH PROGRAMS AS OF 9/30/02

VISN	Site Name	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active + Donated (FTEE)	% Total of Intended
1	BEDFORD	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
1	WEST HAVEN	2.0	0.0	2.0	0.0	0.0%	0.0	0.0	0.0%
2	ALBANY	0.5	0.5	0.0	0.0	100.0%	0.0	0.5	100.0%
2	BUFFALO	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
2	SYRACUSE	1.0	0.5	0.0	0.5	50.0%	0.5	1.0	100.0%
3	BROOKLYN	4.0	4.0	0.0	0.0	100.0%	0.0	4.0	100.0%
3	NEW YORK	4.0	2.0	0.0	2.0	50.0%	0.0	2.0	50.0%
5	WASHINGTON DC	2.5	2.0	0.5	0.0	80.0%	0.0	2.0	80.0%
6	HAMPTON	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
7	ATLANTA	2.0	1.0	0.0	1.0	50.0%	0.0	1.0	50.0%
8	BAY PINES	2.0	0.0	0.0	2.0	0.0%	0.5	0.5	25.0%
8	MIAMI	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
8	TAMPA	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
9	NASHVILLE	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
10	CINCINNATI	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
10	CLEVELAND	2.5	1.5	0.0	1.0	60.0%	0.8	2.3	90.0%
11	INDIANAPOLIS	1.6	1.6	0.0	0.0	100.0%	0.0	1.6	100.0%
12	HINES	2.0	1.0	0.0	1.0	50.0%	0.0	1.0	50.0%
16	HOUSTON	2.0	2.0	0.0	0.0	100.0%	0.0	2.0	100.0%
16	LITTLE ROCK	3.5	3.5	0.0	0.0	100.0%	0.0	3.5	100.0%
16	NEW ORLEANS	3.0	3.0	0.0	0.0	100.0%	0.0	3.0	100.0%
17	DALLAS	3.0	3.0	0.0	0.0	100.0%	0.0	3.0	100.0%
17	SAN ANTONIO	3.0	2.4	0.6	0.0	80.0%	0.0	2.4	80.0%
18	TUCSON	2.0	0.5	0.0	1.5	25.0%	0.0	0.5	25.0%
19	DENVER	2.0	1.5	0.0	0.5	75.0%	0.0	1.5	75.0%
19	SALT LAKE CITY	1.5	1.5	0.0	0.0	100.0%	0.0	1.5	100.0%

TABLE 8-1. CLINICAL STAFFING OF HUD-VASH PROGRAMS AS OF 9/30/02, CONTINUED

VISN	Site Name	Intended Staffing* (FTEE)	Active (FTEE)	Detailed Away (FTEE)	Vacant (FTEE)	% Active of Intended	Staff Donated** (FTEE)	Active + Donated (FTEE)	% Total of Intended
20	AMERICAN LAKE	4.0	3.8	0.1	0.1	95.0%	0.0	3.8	95.0%
20	ANCHORAGE	1.1	1.1	0.0	0.0	100.0%	0.0	1.1	100.0%
20	PORTLAND	1.0	1.0	0.0	0.0	100.0%	0.1	1.1	110.0%
20	ROSEBURG	1.0	1.0	0.0	0.0	100.0%	0.0	1.0	100.0%
21	SAN FRANCISCO	4.0	0.0	0.0	4.0	0.0%	0.0	0.0	0.0%
22	GREATER LA	5.0	3.0	0.0	2.0	60.0%	0.0	3.0	60.0%
22	LOMA LINDA	3.0	1.0	0.0	2.0	33.3%	0.0	1.0	33.3%
22	SAN DIEGO	3.0	1.0	0.0	2.0	33.3%	0.0	1.0	33.3%
	ALL SITES	76.2	53.4	3.2	19.6	70.1%	1.9	55.3	72.5%

\* Intended staffing is the number allocated by Central Office

\*\*Donated staff are FTEE detailed to the HUD-VASH program from other services