



Assessing Progress in the Five-Year Plan to End Veteran Homelessness

The Service Providers' Perspective

In June 2012, the Department of Veterans Affairs (VA) Advisory Committee on Homeless Veterans met with community-based service providers to discuss progress in the department's Five-Year Plan to End Veteran Homelessness. The forum was held at the National Coalition for Homeless Veterans (NCHV) Annual Conference in Washington, D.C., and attracted representatives from more than 60 organizations that provide housing and supportive services to homeless and at-risk veteran families.

The unprecedented dialogue was open and frank, and gave service providers the opportunity to express concerns about the development and implementation of the Five-Year Plan. Since its inception VA Secretary Eric Shinseki has called community-based organizations the “creative geniuses” of the homeless veteran assistance movement, and has consistently said the success of the campaign to end veteran homelessness depends on VA's collaboration with its community partners.

It was clear during the work session that the observations and information being offered by service providers should be reported back to VA leadership in the interest of strengthening this critical partnership.

NCHV staff, with the assistance of several service providers, compiled a list of the issues discussed during the session and distributed it to organizations that participated in the meeting. We asked them to identify their top seven concerns on the list and rank them in descending order of importance to their respective organizations. The consensus priority issues were then assigned to teams of veteran service providers to develop – separately – reports explaining the concerns and recommendations on how to address them.

At the same time, NCHV conducted a nationwide member survey to gauge the effectiveness of VA's efforts to include service providers in the planning and implementation phases of the Five-Year Plan to End Veteran Homelessness. Nearly half of NCHV member organizations providing services to homeless and at-risk veterans participated in the survey, underscoring its value as a representative customer satisfaction assessment.

Our prime objective was to present an insightful and balanced report to VA leadership on the progress of the Five-Year Plan to End Veteran Homelessness from the perspective of the Department's community-based partners. We believe the identification of service providers' priority concerns, coupled with their overall assessment of collaborative efforts to date, achieves that purpose.

Diversity

The member survey graphically illustrates the evolution of the homeless veteran assistance movement represented by NCHV since its founding in 1990. From a collective of community-based organizations serving homeless veterans primarily under two federal grant programs – the VA Grant and Per Diem Program (GPD) and the Department of Labor Homeless Veterans Reintegration Program (HVRP) – NCHV has grown into a diverse community of private and government assets working together to end veteran homelessness under a federal strategic plan with clearly articulated goals and objectives.

Nearly one-third of member survey participants do not receive funding under the GPD program. More than 20% receive no direct federal homeless program funding at all. Members responding to the survey include recipients of case management contracts, the full range of Department of Housing and Urban Development (HUD) grants, Continuum of Care funding, Department of Health and Human Services (HHS) grants, and organizations that receive funding under specialized local and state government programs only.

About 15% of survey participants have GPD programs with 125 or more beds, compared to 37% with 74 or fewer beds. More than a quarter of responding GPD programs have fewer than 50 beds. The representation of large GPD programs among survey participants was quite impressive, and their combined assessment of collaborative efforts between VA and its community partners is generally consistent with the ratings recorded across the board.

Responses by Region

There were a few surprises in the regional distribution of participants in the member survey. The **South** accounted for the largest number of responses, at 20.7% of the overall sampling. This region also represents the greatest diversity of participants, with only about 50% of respondents receiving funding under the GPD program.

Despite the considerable representation of programs that do not receive VA funding in this region, the South gave the VA its highest combined marks in effectively communicating the goals and objectives of the Five-Year Plan with community providers (78%) and responding to local needs of service providers (76%).

The **Northeast** – New York and New England – ranked second in responses at 18.9% of survey participants. About 75% of members in this region receive GPD funding, and the Northeast recorded the highest representation of VA-funded programs in the survey. This is significant because the mix of organizations responding to the survey in this region represents the extreme opposite of the South, and yet the overall customer satisfaction ratings are the same – 78% believe the VA has effectively communicated the goals and objectives of the Five-Year Plan, and 76% approve of the local VA responses to the needs of service providers.

The **Heartland** – the Great Lakes states, Kentucky and Missouri – produced the third highest number of responses (17.0%), even though none of the four states with the most homeless veterans is located in this region. Only 61.1% of respondents receive GPD funding, the second lowest in the survey. Yet the approval rating for VA's communication of the goals and objectives of the Five-Year Plan matched the survey high of 78%. The rating for local VA responses to service provider needs in the Heartland slips to 72%, which is still a solidly positive value.

The **Mid-Atlantic** region results show solid approval of both national and local VA engagement with service providers – 76% on both counts – and set the benchmark high among organizations that believe VA should cut funding to GPD programs that are not producing acceptable outcomes – advancement to permanent housing among them. In fact, the 82% agreement rating for that issue was the third highest mark in the entire survey. The Mid-Atlantic region ranked fourth in survey responses, and stands in the middle of the pack in program diversity with 68.7% of respondents receiving GPD funding.

California – the state with the most homeless veterans by far and some of the largest and most successful assistance programs in the nation – produced 11.3% of survey responses. About 75% of participants receive GPD funding. California recorded a 70% approval rating for VA’s effectiveness in communicating the goals and objectives of the Five-Year Plan, and a 72% favorable rating for local VA responses to service provider needs. More than 84% of respondents in California believe there needs to be a federal mediation or arbitration process to resolve disputes between service providers and local VA officials – the highest mark for this issue, and second highest overall in the survey.

The **Pacific Northwest** – which includes Alaska and Hawaii for this report – produced 6.6% of survey responses, with a relatively high 72.7% of participants receiving GPD funding. This region gave the VA national office a survey low approval rating of 60% for effectively communicating goals and objectives of the Five-Year Plan, but a superior 92% approval rating for local VA responses to service provider needs. When those values are combined, the Pacific Northwest comes to within 1 percentage point of the survey high for overall customer satisfaction with the VA.

Despite the extreme variance in approval ratings for local and national VA efforts, respondents in the Pacific Northwest are relatively cool to the idea of instituting a federal mediation or arbitration process to resolve disputes between service providers and local VA leadership – perhaps an affirmation of the cooperative climate nurtured by community organizations and local VA officials in this region.

The **West** is perhaps the most challenging region in the nation in terms of integrated service delivery, availability of resources, employment opportunities, and access to VA facilities. Three distinct geographic divisions – the Great Plains, Rocky Mountains and Desert Southwest – are characterized by vast stretches of rugged territory, low population densities and transportation challenges. While the region gave the VA national office a high approval rating of 76% for communicating the goals and objectives of the Five-Year Plan, the local VA response to service provider needs received a 66% approval rating. Respondents in the West – 72.7% of whom receive GPD funding – were the least likely to agree that VA should cut funding for Grant and Per Diem recipient organizations that are underperforming based on national performance standards for the program.

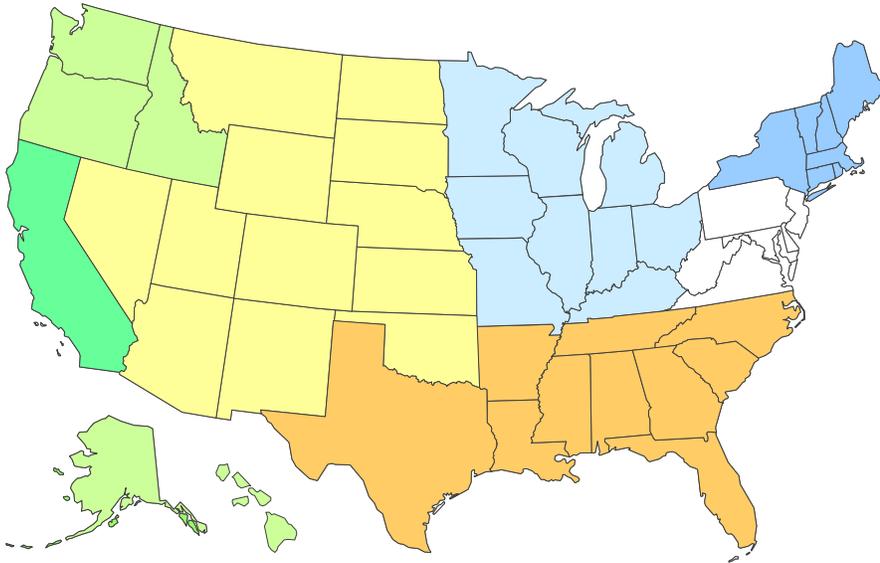
National and Regional Ratings

The national ratings in the following summary are percentages that appear in the overall computer results, and are calculated based on equal value for all submitted survey files. About 10% of surveys were 50% to 100% incomplete, however, and another 15% were “non-responsive” on various questions. Points were assigned to responses on each question according to the following scale:

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree
- 0 = N/A – respondents gave reasons for not answering the question.

Surveys that included N/A responses were counted in calculating the percentages of the agreement ratings for each question reported in the regional breakdowns below. Survey questions that had no choice marked, and offered no reason, were tagged as “non-responsive” and were excluded from the calculations to determine regional agreement ratings.

National Results



74.6%
agree
12.3%
disagree

Question 4

VA at the NATIONAL level has effectively communicated its plan for achieving the objectives of the Five-Year Plan to End Veteran Homelessness to service providers.

This is the most important question in the NCHV Member Survey. Without a clear understanding of the plan, it would be impossible for VA officials and community-based partners to develop and implement effective local action plans. National results presented here are not adjusted to eliminate “non-responsive” replies, so the 74.6% overall agreement rating on this statement is commendable. Only the Pacific Northwest region recorded an agreement rating below 70% on this issue.

Perhaps even more significant is the extremely low percentage of respondents who disagree with the statement. Only 12.3% feel the VA has not adequately communicated its objectives under the plan, and only 3.8% strongly disagree. That is the widest range between positive and negative responses in the survey, and indicates strong approval of national VA efforts to date.

National

Survey Respondents:

– **100%**

Grant & Per Diem:

– **67.6%**

VA National Office has effectively communicated its plan to end veteran homelessness:

– **74.6% agree**

Local VAMC is responsive to requests of my organization:

– **66% agree**

Providers need a federal arbitration process to resolve disputes with local VA officials:

– **55.6% agree**

VA programs incorporate input of service providers:

– **38.6% agree**

VA needs to determine which GPD programs are underperforming and their funding should be cut:

– **61.3% agree**

Survey participant comments are included in the NCHV Member Survey Results and Tables section.

Regional responses, which are adjusted to exclude “non-responsive” but include “neutral” replies, are solidly positive.

- Heartland 78% agree
- Northeast 78% agree
- South 78% agree
- Mid-Atlantic 76% agree
- West 76% agree
- California 70% agree
- Pacific Northwest 60% agree

66.0%
agree

Question 5

The staff at the LOCAL VA Medical Center is responsive to requests from my organization.

17.0%
disagree

The ultimate success of the Five-Year Plan to End Veteran Homelessness wholly depends on the effective implementation of local action plans, which have been in development since 2010. In some regions the collaboration between community assets and VA officials has been exemplary, and in other areas it has been characterized as less than ideal by service providers. Overall, 66% of survey respondents agree with this statement.

About 15% of respondents checked “neutral” on this issue. Interestingly, the agreement rating on the statement climbs to a high 75.7% when the “non-responsive” replies are discounted. Only 17% disagree with the statement, including 4.7% who strongly disagree.

Service providers in the Pacific Northwest gave local VA authorities the strongest endorsement in the survey – 92% of them say local VA officials are responsive to their needs. Agreement marks greater than 70% were recorded in the Heartland, the Northeast, the South, the Mid-Atlantic and California. Regional ratings, adjusted to exclude “non-responsive” replies, serve to heighten expectations that collaborative efforts should improve as further development and implementation of local Five-Year Plans move forward.

- Pacific Northwest 92% agree
- Mid-Atlantic 76% agree
- Northeast 76% agree
- South 76% agree
- California 72% agree
- Heartland 72% agree
- West 66% agree

55.6%
agree

Question 6

Service providers need an arbitration process at the federal level to respond to issues with local VA officials.

12.3%
disagree

In written comments, some respondents said they checked neutral on this statement because arbitration seems too extreme an intervention for conflict resolution in most cases.

However, only 12.3% of survey participants said they disagree with this statement. Most respondents

believe there needs to be at least a mediator or authority in the VA national office who can facilitate rapid resolution of disputes that cannot be resolved at the local level.

There is widespread concern that policies and program guidelines established by national VA leadership are interpreted differently on the local level. Service providers regularly network with each other at regional and national training conferences and share their experiences and challenges. Often the differences they cite reflect variances in community services and resources that are available, but occasionally their concerns reflect the belief that local VA officials and community partners need better guidance to ensure more uniform responses to departmental directives.

This question is significant because it is a barometer of service provider confidence in local VA officials to cooperatively work through issues arising from fundamental and comprehensive changes in the homeless veteran services community. The low agreement rating in the national result on this question reflects relatively strong overall satisfaction with local VA authorities, represented in the responses to Question 5. But there is solidarity in the belief that a formal and expeditious process to resolve local disputes under the direction of the VA national office is necessary across most regions in the nation, particularly those with higher population densities and high homeless veteran counts:

- California 84% agree
- Heartland 82% agree
- Mid-Atlantic 76% agree
- South 72% agree
- West 68% agree
- Pacific Northwest 62% agree
- Northeast 60% agree

38.6%
agree
28.3%
neutral
26.4%
disagree

Question 7

VA homeless veteran assistance programs adequately incorporate the inputs of service providers and grantees.

Ironically, the national survey result for this statement illustrates one of the most unifying concerns expressed by community-based service providers – national data does not truly reflect the effectiveness and efficiencies of homeless programs that are greatly impacted by local economic and political influences. The low 38.6% agreement rating in the national results on this statement indicates a strong perception the VA is not sufficiently collaborating with its community-based partners, many of which represent several decades of program development expertise and proven success in helping homeless veterans achieve employment and permanent housing.

This concern came to a flashpoint at the NCHV Annual Conference with respect to VA data that shows only 53% of clients who enter the Grant and Per Diem (GPD) Program advance to permanent housing. This issue is discussed in Question 9, but service providers contend there are many organizations with successful outcomes that clearly attest to the value of the GPD program for the great majority of homeless veterans who do not need permanent supportive housing.

A closer look at all survey responses to this question shows that 28.3% checked “neutral,” and another 8.5% were “non-responsive.” Nearly 20% of all survey participants avoided the question. Omitting the “non-responsive” replies from the overall sampling produces a decidedly different reality:

- Mid-Atlantic 66% agree
- South 66% agree
- Northeast 64% agree
- Heartland 58% agree
- California 56% agree
- West 56% agree
- Pacific Northwest 48% agree

Responses to this statement clearly suggest there is room for improvement with respect to VA collaboration with its community partners. Written comments lean more heavily toward the need for better consultation on the national level in evaluating program performance and developing recommendations to make existing and new programs more responsive to the goals and objectives of the Five-Year Plan.

36.8%
agree

Question 8

The “Housing First” model is NOT compatible with HUD-VASH.

28.3%
neutral

26.4%
disagree

This statement received the largest number of written comments in the survey, and the responses represent the most evenly divided sampling in the poll. Slightly more than one-third agree with the statement, and nearly one-third are neutral. Most of the comments focus on the access to and quality of case management for chronically homeless veterans who are fast-tracked into the HUD-VASH program. The comments reveal the strong representation of clinical staff and social workers among survey respondents, some of whom have been associated with the VA-community partnership for some time.

For many, this is not a discussion about program design or philosophy. It is an opportunity to voice caregivers’ view that the focus on housing should not relegate therapeutic supports for veterans with mental illness, chronic substance abuse and other disabilities to secondary status. If you read through the comments selected for inclusion in this report (NCHV Member Survey: Results and Tables), it is apparent that even respondents who say “Housing First” is compatible with HUD-VASH believe the program is not measuring up with respect to provision of intensive and comprehensive supportive services.

Veteran service providers’ concerns on this issue have been further stoked by recent reports circulating in the non-veteran homeless assistance community declaring there is now evidence that access to health services greatly improves the stability of homeless clients placed in housing. This reality has been the foundation of the VA-community partnership for a quarter century.

Regional results, adjusted to exclude “non-responsive” replies:

- Heartland 70% agree
- Mid-Atlantic 68% agree
- Pacific Northwest 68% agree
- California 64% agree
- Northeast 64% agree
- South 60% agree
- West 48% agree

61.3%
agree

Question 9

VA needs to determine which of its Grant and Per Diem programs are underperforming and discontinue their funding.

14.2%
disagree

The Grant and Per Diem Program is the traditional cornerstone of the VA’s community-based partnership to end veteran homelessness. The program was designed to provide transitional housing with a wide range of supportive services through local service providers linked to VA Medical Centers. The program has grown to include about 700 grant-funded partners with the capacity to serve about 25,000 to 30,000 homeless veterans each year. It remains a vital component in VA’s Five-Year Plan to End Veteran Homelessness.

There has been growing concern among service providers since the launch of the Five-Year Plan that this program is being threatened by non-VA interests who claim transitional programs are not the most effective, efficient pathway out of homelessness. In the non-veteran service community, this may be true. But in the VA Healthcare System of integrated service delivery networks, where clients in transitional programs necessarily have access to stable housing, high quality health care services, job preparation and placement assistance, and a wide range of other services, that position is arguable. There are many GPD programs with outstanding performance records, and there are no comparable national, health-based homeless service delivery systems in the non-veteran community.

VA data on GPD outcomes that show only 53% of program participants nationally advance to permanent housing adds fuel to the fire. There are many reasons clients do not move into permanent housing that have little to do with program performance – relapses, voluntary exits, extreme low income, and lack of affordable housing. In their comments, service providers generally agree “underperforming” programs should be evaluated and given the opportunity to address deficiencies before losing funding. However, there is strong consensus that poorly performing programs should lose their GPD grants if mandated corrective action plans are not successful.

- Mid-Atlantic 82% agree
- Heartland 76% agree
- Northeast 72% agree
- Pacific Northwest 72% agree
- South 72% agree
- California 70% agree
- West 52% agree

38.7%
agree

Question 10

I am satisfied with the Technical Assistance provided for VA homeless programs.

16.1%
disagree

Regional results, adjusted to exclude “non-responsive” replies:

- Mid-Atlantic 70% agree
- South 68% agree
- Northeast 66% agree
- West 60% agree
- California 58% agree
- Heartland 58% agree
- Pacific Northwest 46% agree

NCHV Member Survey: Results and Tables

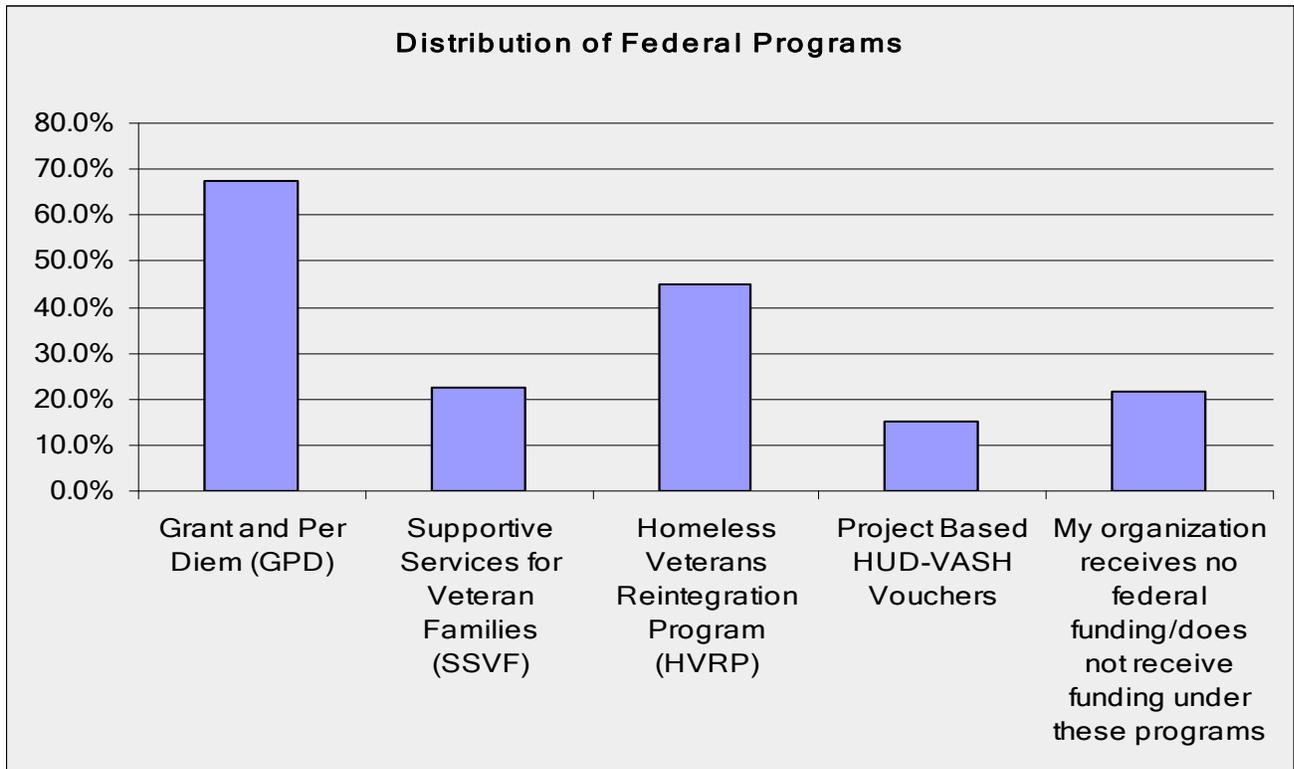
Basic Demographics: Questions 1 through 3:

Summary: Questions one through three covered basic demographic and program data about the member organizations. Survey responses to these questions show members' location, current Federal grants, and number of Grant and Per Diem beds.

Question #2: “My organization is a grantee or subgrantee in the following programs”

NOTE: respondents were allowed to check more than one option and provide additional programs in the “Other” category.

| Answer Options | Response Percent |
|-------------------------------------------------------------------------------------------|------------------|
| Grant and Per Diem (GPD) | 67.6% |
| Supportive Services for Veteran Families (SSVF) | 22.5% |
| Homeless Veterans Reintegration Program (HVRP) | 45.0% |
| Project Based HUD-VASH Vouchers | 15.3% |
| My organization receives no federal funding/does not receive funding under these programs | 21.6% |
| Other (listed below) | |

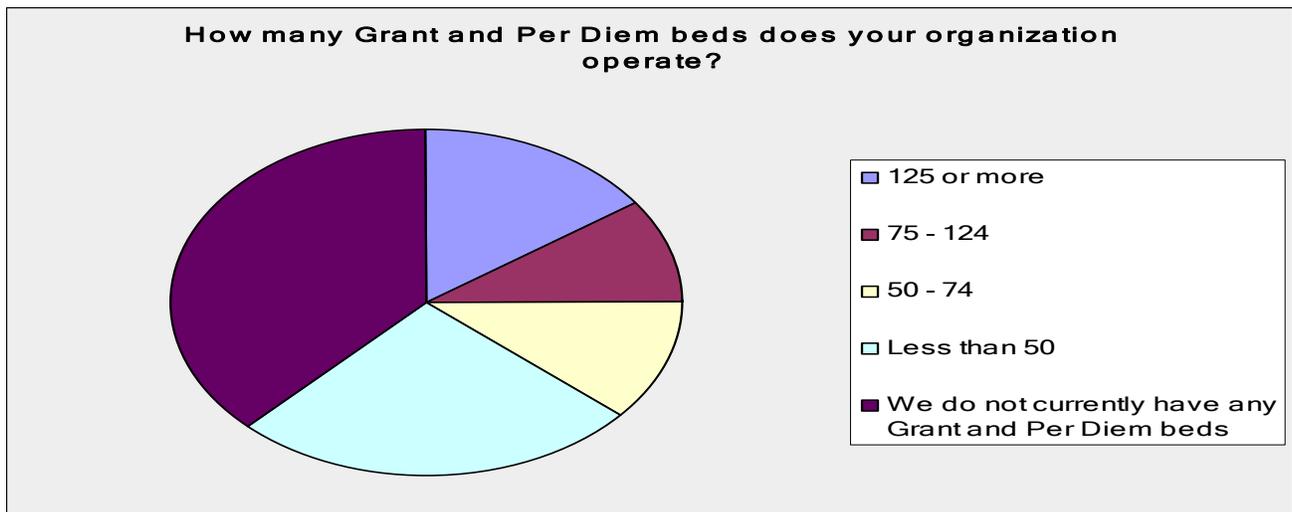


Programs listed in the “Other” Category include:

- Homeless Residential Care Bed contractor
- VWIP
- HUD Shelter + Care Program
- HUD-VASH Case Management
- HUD funded program
- HOME and CDBG
- DOL and VA Stand Down grants
- HUD Continuum of Care funding
- City of Detroit Grant
- HUD/McKinney grant for two Veteran only projects
- GPD Special Needs and Multi-Service Center and Per Diem Only
- ESG
- HHG
- HCHV
- HUD-SSO
- SAMHSA
- HUD/SHP
- Landlord of VASH recipients
- US Dept Veterans Affairs HVOC

Question 3: “How many Grant and Per Diem beds does your organization operate?”

| Answer Options | Response Percent |
|------------------------------------------------------|------------------|
| 125 or more | 15.3% |
| 75 - 124 | 9.7% |
| 50 - 74 | 11.3% |
| Less than 50 | 25.8% |
| We do not currently have any Grant and Per Diem beds | 37.9% |



Opinion Poll Questions: Questions 4 through 10:

Question #4: “VA at the NATIONAL level has effectively communicated its plan for achieving the objectives of the VA Secretary's five year plan to end veteran homelessness to service providers.”

| Answer Options | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|----------------|----------------|---------------|---------|----------|-------------------|
| Percentage | 18.90% | 55.70% | 13.20% | 8.50% | 3.80% |

Comments:

- National needs to do more regional training that involves all of community. Not training local and hope that they can convey the goals and methods. Not enough local people can afford to travel to DC for NCHV conferences.
- The Secretary has said, I think, that the last 50,000 homeless will be the most difficult. but I'm not sure he has said why this is, nor what he has in mind to address this.
- Unfortunately, you have to attend a conference for this information or search online. It would be nice to get information directly.
- The plan is great but the problem is if the veterans do not get help for their problems they will be back on the streets again.
- VA at the National level has not conveyed how the plan will be implemented.
- Encourage more participation and communication at community provider organized events.
- Plan has shifted from original concept.
- Sometimes the interpretation from the National Level to the Local VA appears to be different. This causes confusion for Service Providers.
- We receive notices from the VA national and local offices.
- The plan is unachievable within the time frame allowed.
- The overall plan has been communicated. Programmatic segments of the plan, notably recent changes in the Grant and Per Diem (GPD) Program, were not only not communicated, but were not discussed: a very top-down and arrogant feeling process. If “community partners” are truly valued, this process was a very poor example.
- If a provider is not directly connected to the VA, they receive nothing from the VA. A great deal of these community providers can be of outstanding assistance in ending homelessness.

Question #5: “The staff at the LOCAL VA Medical Center is responsive to requests from my organization.”

| Answer Options | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A |
|----------------|----------------|---------------|---------|----------|-------------------|-------|
| Percentage | 30.20% | 35.80% | 15.10% | 12.30% | 4.70% | 1.90% |

Comments:

- Our GPD liaison is contracted so does not have vital info we need and the management of our local CBOC shows no interest in our program. VISN staffs do not return emails or phone calls.
- It is sometimes hard to get assistance.
- Depends on the request.
- Experience inconsistent responsiveness from local VAMC.
- VAMC and our organization think of each other as mission essential partners.
- Many of the providers seem too busy to respond to timely requests for information.
- For the most part.
- Boise VA is excellent!
- Our liaison with the Homeless Program at the Local VA is extremely helpful. The restrictions and the interpretation are sometimes confusing.
- We have daily communication with local VA.
- The staff does nothing but refer. The case management is not effective for a vulnerable population that needs more service coordination. The staff is not user friendly and not well received by the veterans and the community providers. Staff defers the problem, refers the veteran and has lack of follow-up with providers to ensure concerns are addressed.
- Our agency has a wonderful relationship with both our local Clinic and Reintegration Center.
- It is not that they are not responsive to me; it's putting more barriers in front of the veteran.
- There is real inconsistency between VAMCs, some are very responsive, some are not at all.

Question #6: “Service providers need an arbitration process at the Federal level to respond to issues with the local VA Medical Center.”

| Answer Options | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A |
|----------------|----------------|---------------|---------|----------|-------------------|-------|
| Percentages | 24.50% | 31.10% | 27.40% | 5.70% | 6.60% | 4.70% |

Comments:

- Mixed bag. One local medical director worried about doing it "wrong" so delayed project opening. Needed more pressure. Works best with Medical Director who allows Mental Health and Homeless staff to work with community.
- A mediation process where retribution is not tolerated.
- I would always recommend a mediator or ombudsman process, followed by arbitration if necessary. Or a neutral evaluation as used in the federal courts.
- It should really come from the community level as well, possibly the Mayor acting as arbitrator and communicating with the Continuum of Care (CoC) and federal systems.
- Need more information.
- Need counterbalance for a liaison who may be capricious.

- The local VAMC displaces responsibility for decisions that impact our agency in a negative way to an inability to change them because of the Federal mandates.
- Communication not arbitration.
- Decrease the time frame to resolve the problem, don't add to it
- Some VAMCs have interpreted grant requirements differently, which in some cases, have put us at risk of being non-compliant.

Question #7: VA programs adequately incorporate the input of service providers/grantees.”

| Answer Options | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A |
|----------------|----------------|--------|---------------|----------|-------------------|-------|
| Percentages | 14.20% | 22.60% | 28.30% | 15.10% | 11.30% | 8.50% |

Comments:

- Not flexible enough to blend with local initiatives. Our local homeless coordinator does not have authority to combine VA and local resources to maximize the benefits to veterans. Allow more VA staff time and complete full-time employees (FTEs) to coordinate with the community.
- Resolution of GPD issues does not incorporate input of service providers.
- Improvement would be appreciated
- Except through the Advisory Committee via NCHV there has not been a vehicle for Service Providers to provide input into VA Program development or implementation. This applies to all VA programs.
- There is some (collaboration) on a local level, but not nationally.
- VA programs, or the definition that has been provided to the grantees/providers, lack "flexibility" dealing with the homeless population, and the VA staff is not flexible.
- GPD: I recently gave back over \$750,000 in awarded non-federal funds for a planned GPD project serving homeless female veterans. It was not for lack of trying to obtain information about up-coming GPD NOFA. VA NEVER responded to queries. 2. SSVF is only now addressing the HUD-VASH/SSVF interface. We had all been hopeful SSVF reporting would moderate a bit ... it has gone the opposite direction!
- It would be nice if the VA at least listened to its service providers. How can someone write rules and regulations for a program when they have never organized or operated and worked within that program to know whether those rules and regulations work?

Question #8: “The Housing First model is NOT compatible with HUD-VASH.”

| Answer Options | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A |
|----------------|----------------|--------|---------------|----------|-------------------|-------|
| Percentages | 14.20% | 22.60% | 28.30% | 15.10% | 11.30% | 8.50% |

Comments:

- Needs to be flexible and not highly regulated by VA. Either pay for VA employees or offer more flexible local responses to outsourced VASH case management.

- I think HUD-VASH is "fool's gold." ... but then, I also think, unlike the Secretary, that substance abuse is a direct cause of homelessness, and that treatment should be #1 selection before housing... so I'm a Luddite in the brave new world of the Five-Year Plan.
- The VASH coordinator in our area cannot handle the demands of Housing-First clients. There are two very new social workers trying to manage 110 vouchers.
- There are not enough services for a very challenged HUD-VASH veteran population.
- Some veterans we work with do not qualify for HUD-VASH, and the Housing First model (which we use) brings in the most chronic homeless that are still active substance abusers and have a very hard time following the rules.
- VASH is a great vouchers system, but more project-based VASH should be available. Housing First allows for placement, but with the VASH it allows the voucher holder more time to prolong deciding his or her choice in housing.
- VASH needs better case management delivery.
- Continued sobriety should be an ongoing requirement for HUD-VASH.
- Case management services must be adequate.
- Housing First is compatible with HUD-VASH provided it includes extensive wrap-around services and community provider involvement.
- The two work well together but both have shortcomings.
- I am seeing too many veterans in HUD-VASH relapse and become unable to pay their portion of the rent. Several veterans have subsequently lost housing because of ongoing substance use and no money to pay their bills.
- Operation of HUD-VASH does not lend itself to timely placement of a veteran into housing.
- The Housing First does not adequately assure that clients will be able to maintain a drug- and alcohol-free existence. Services to this population need to be mandated rather than left to the choice of the client.
- Most of the veterans need substance abuse/mental health recovery to remain in independent living situations. Recovery first, housing second.
- With the Grant Per Diem and the HUD-VASH programs, coordination of supportive services is key for the success of the programs and for the veterans they serve.
- It does not provide adequate support for these individuals to be successful.
- The Housing First model IS compatible with HUD-VASH!!!!
- Housing without appropriate supervision and services sets up veterans to fail.
- HUD-VASH requires certain federal guidelines, as well as agreeable landlords, dealing with the varied populations. The case management is imperative for success to be achieved. Hands-on case management, not just referring or deferring the veteran to another agency, but actually assisting the veteran to be sure issues are resolved, and there is effective communication and follow through. The Housing First is dealing more with a diverse population and there is cause to be concerned that integration with mainstream may not be appropriate.
- I think it can be, but the case loads are far too high for a Housing First model to be effective.
- As I understand the Housing First model, it brings in resources with it. HUD-VASH does not, only a case manager. The case manager is supposed to help the veteran find resources once in the home or apartment. I think that is the difference. Housing First

also has more direct, hands-on case mgmt whereas HUD-VASH is much less frequent contact – once a month if that.

- Long waiting list, no communication with providers or potential providers.
- Placing veterans into HUD-VASH at the beginning of their entry into a GPD program, or in early stages of any recovery program, is setting a veteran up for failure.
- There are sometimes conflicts with a veteran keeping his voucher when his behavior is contrary to Housing Authority regulations.
- The supportive housing model used by HUD-VASH is not rigorous enough. The expectation of monthly case management will only work with those who are ready for housing. In a Housing First model the level of case management should be increased to weekly until stability has been achieved.
- HUD-VASH does not follow the evidence-based Housing First model so the most vulnerable veterans will be underserved using the current HUD-VASH model.

Question #9: “VA needs to determine which of its Grant and Per Diem programs are underperforming and discontinue their funding.”

| Answer Options | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A |
|----------------|----------------|---------------|---------|----------|-------------------|-------|
| Percentages | 17.00% | 44.30% | 20.80% | 10.40% | 3.80% | 3.80% |

Comments:

- Need to work to find flexibility when services are good but time frames are longer than desired. Offer assistance to improve rather than cutting them off without opportunity to improve or opt out of GPD.
- How do you define "underperforming" ? With this focus on outcomes there are unintended consequences, such as turning away the seriously mentally ill (SMI) and chronic relapse because of low probability of successful outcomes.
- I believe those programs need to be evaluated, a corrective action plan with a timeline given and if they don't pass, discontinue funding.
- Underperformance can be the result of many things. With inputs only from the VA or VA staff allows too much opportunity for corruption.
- Accepting confidential feedback from program residents needs to be performed at the end of each quarter.
- Agreed, but keep GPD programs that are working. There is way too much emphasis on HUD-VASH, which is not always the answer despite what the statistics might seem to say.
- Weed out the ineffective programs now
- I think if programs are underperforming, they should be allowed to make improvements before funding is cut.
- Performance of each must be examined and weighed in the context of the local community's needs and resources. Also other options besides immediate de-funding and reallocation should be considered such as a probation period or a partial decrease/reallocation. Resources should, if at all possible, remain in the local community.

- VA should help underperforming GPDs achieve success.
- You need a fair process to determine underperforming programs, and discontinued GPD beds should be made available to more successful agencies.
- I think the VA should provide TA to those underperforming Grant and Per Diem Programs before discontinuing their funding.
- I can't agree with this statement unless I know the cause of the underperformance.
- First VA needs to try to upgrade the programs.
- Before discontinuing funding, there needs to be communication to work with providers to fix issues. If after an evaluation period the program is still not performing well, then discontinue.
- Make more funding available for successful programs or new programs.
- Our agency has a GPD program that has maintained 100% occupancy since opening in 2008. We have consistently maintained a 93-98% permanent housing placement, an equally high rating in employment and assistance in obtaining benefits. By all annual evaluation measures, we have an incredibly effective program. Former GPD participants maintain contact, serve as mentors, volunteer at Stand Down, and at our community's cold weather emergency shelter. At the last NCHV conference, we were told GPD programs had only a 52-53% permanent housing placement, and the implication was the Program itself was outdated and ineffective. I can prove just about anything using carefully selected statistics. I do know that for many veterans, the issues causing their homelessness are complex and often require a period of time greater than 90 days to work through. This is particularly true for women veterans. Women have always served voluntarily, often with past experiences with domestic violence, dysfunctional relationships, and other issues prior to enlistment. Many then experience military sexual trauma. Unwinding these issues may best be done in a safe, supportive community of female veterans that some GPD programs provide. Altering the GPD program to a 'transition in place' model, not allowing for further development of additional beds for special populations, and tarring the entire GPD program with the less successful program brush is supremely arrogant...although easier than systematically weeding out non-performing programs.
- Rules are written to be followed. If not, they should not be in the program. What is so hard about that? The GPD standards should be high not low.
- When dealing with this issue, you want to award programs that are operating at a highly efficient level. There is no room for underperforming when dealing with homeless veterans.
- This depends on how VA assesses performance.
- If a program is underperforming measures should be taken to improve performance before discontinuing.
- Example: If a private provider has a per diem grant but is not providing everything they said they would, then they should be brought task. This would better distribute funding and strengthen the overall program.
- GPD is a highly structured system and the level of support we have through our medical center is very hands on. I am not familiar with many other programs, but believe any program that is underperforming should be looked at for either improvements or discontinuing their funding.

- Successful programs provide much needed services to the at-risk veterans who need intensive case management.

Question #10: “I am satisfied with the Technical Assistance provided for VA programs (Note: NCHV is NOT a Technical Assistance provider for VA)”

| Answer Options | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A |
|----------------|----------------|--------|---------------|----------|-------------------|--------|
| Percentages | 5.70% | 33.00% | 34.00% | 12.30% | 3.80% | 11.30% |

Comments:

- GPD TA is not useful. SSVF in Seattle by CSH was pretty good. More interesting user-friendly financial TA would be helpful. TA from VA does not feel neutral. Don't want to generate an audit or to hear "read the OMB" as the answer.
- I am not familiar with technical assistance.
- VA needs to learn how to partner effectively with community partners.
- Other than pre-grant TA, not sure what other TA is provided for VA programs.
- Often their response is unclear or is too technical for a lay person. I am still awaiting a response from SSVF regarding the question of counting CWT as income; since it is temporary, untaxed, and not even counted as income at the State level.
- We provide 19 SROs and about 10 additional beds specifically for Veterans in the program at our mission. I did not check any beds for the second question, as we do not "participate in any federal funded program. We do however work with Boise VA/Hospital, and have an excellent relationship with them, and excellent outcomes of our transitional living program.
- We have not used VA technical assistance.