Housing and Housing Services Program Measure – Veterans Version (HHSPM-V)

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1. Introduction

In order to end homelessness for Veterans, the Department of Veteran Affairs established the Center for Homelessness amongst Veterans (the Center). The Center was established to combine research, policy, model implementation, and training towards reaching the goal of ending homelessness for all Veterans. Center research has sought to better count and describe Veterans who are homeless or at risk of homelessness and to evaluate the effectiveness of interventions aimed at reducing homelessness. A necessary component of this line of study is the description and accurate measurement of the housing and housing services portfolio in order to better match Veteran characteristics, needs and choices to available resources. This information can also be used to assess gaps in services, and plan model development. At the request of the Center staff, the University of South Florida undertook a series of studies to determine the aspects of Veterans housing programs that were most important to the Veterans, VA staff and community providers of Veterans housing; to determine the most accurate metrics of these aspects or domains, and to apply this measure to HUD VASH and Grant & Per Diem programs in two Veteran Affairs Medical Center locations. We then reviewed these measures to determine if particular types of housing or combinations of housing and housing services emerged.

Our goal was to develop a measure of all relevant domains of Veteran housing for homeless individuals. This can be distinguished from a fidelity measure or a measure of how closely the programs and services match a particular model. In order to describe different models, or elements of emerging models we focused instead on defining the characteristics that were deemed important from the literature and from our interviews.

a. Review of the literature on measurement of supported housing

Policy and care for persons with mental health issues have seen drastic changes in the last few decades. The deinstitutionalization of mental health patients gave rise to various residential services and models (Ogilvie, 1997; Ridgway & Zipple, 1990a, 1990b). Deinstitutionalization created a need for alternative sources for rehabilitation and treatment services for previously hospitalized mental health patients (Wright & Kloos, 2007). Many people were not successful in independent living situations because of obstacles such as lack of decent affordable housing, lack of community-based supports, and the cyclical nature of mental illness (Rog & Randolph, 2002). Various housing and service models were developed in order to address the gaps between the needs and choices of mental health consumers and the resources available to them.

Supportive housing models were introduced that addressed the recovery needs of mental health patients and addressed the desire of the patients to be an active and recognized member of their recovery planning team and their community. Patients’ opinions and goals were given more consideration in the planning of their treatment and in the definitions of success. Among the
various patient centered programs and models were the Community Support Systems (CSS), Supported Independent Living (SIL), and the Continuum of Care (CoC).

The Community Support Systems (CSS) model emphasized client identification, outreach, crisis response services, housing, and various supports (Stroul, 1989). Services were used in a manner that both maintained the individual’s dignity and recognized the existence of specific needs for each person (Stroul, 1989). The CSS was also seen as a model that advocated for strong involvement of consumers and family members in building the values of the programming and the support structure offered to the consumers (Ogilvie, 1997; Wilson, 1992). The CSS model also integrated State and County involvement, housing development, and creative financing strategies thus mainstreaming housing initiatives to the Housing Authority and taking away the stigma associated with mental health homes (Knisley & Fleming, 1993; Ogilvie, 1997).

Supported Independent Living is another mental health housing and services model that worked to produce services where the consumer regained some autonomy in their treatment plan. SIL is considered a treatment first model (Y.-L. Wong, Filoromo, & Tennille, 2007; Y.-L. I. Wong, Poulin, Lee, Davis, & Hadley, 2008). It combines housing and mental health services with other services such as money management and skills training. SIL can be found in cluster or scattered sites. SIL arrangements offer ongoing individualized services on an as-needed basis along with long-term housing subsidies for those who need continued care (Y.-L. Wong, et al., 2007; Y.-L. I. Wong, et al., 2008). Participation in SIL programs is usually contingent on a primary diagnosis of a major mental illness along with anywhere from 6 months to 1 year of sobriety prior to entering the program (Y.-L. Wong, et al., 2007; Y.-L. I. Wong, et al., 2008). Most SIL programs are also contingent on continuous compliance with their various program rules and regulations (Y.-L. Wong, et al., 2007; Y.-L. I. Wong, et al., 2008).

The Continuum of Care model is based on the concept of milestones in recovery and the individual tailored process of reduced symptoms and treatment. In the continuum concept of housing and treatment, patients move from more restrictive and heavily serviced living environments to less restrictive and less serviced independent living environments. Each stage is monitored by staff. Once specific milestones are reached the individual moves to the next living environment phase (Ogilvie, 1997; Parkinson & Nelson, 2003; Ridgway & Zipple, 1990a, 1990b). Residents move along this scale as they are placed into housing environments that can best accommodate their level of independence (Rog & Randolph, 2002). All residents housed together are assumed to be at the same readiness for independent living (Ogilvie, 1997; Ridgway & Zipple, 1990a, 1990b). The Continuum of Care typically includes emergency shelters, transitional housing, and permanent supportive housing (Y.-L. I. Wong, Park, & Nemon, 2006). Emergency shelters consist of short-term housing and services designed to meet the immediate needs of an individual or family (Y.-L. I. Wong, et al., 2006). Minimal services are available in terms of counseling, skills training, or day care and residents are usually on their own during the day (Letiecq, Anderson, & Koblinsky, 1998).

Transitional housing involves a greater availability of services and housing stability than emergency shelters but is time-limited, often up to 24 months, depending on the program. Transitional housing has a pre-designated length of stay policy with interim housing and support services (Casey, 2007; Letiecq, et al., 1998; Nakashima, McGuire, Berman, & Daniels, 2005). Transitional housing usually consists of 1 or 2 bedroom apartments within 20-40 multi-site
complexes where services and case management availability can be concentrated (Camasso, 2003; Letiecq, et al., 1998). Transitional housing is service intensive and promotes “housing readiness” through treatment, therapeutic services, housing assistance, case management, employment and training (Y.-L. I. Wong, et al., 2006). These services are all available in an effort to promote self-sufficiency within the consumers. Supportive services also aim at addressing the causes and effects of homelessness in an effort to move individuals toward independent living (Casey, 2007).

The final phase of the continuum of care model is permanent housing. Permanent supported housing is intended to provide services and housing to those individuals with functional disabilities who need continued support to stay housed (Y.-L. I. Wong, et al., 2006). It was intended to serve previously homeless persons with serious mental illness, substance abuse, and physical disabilities (Grant & Westhues, 2010; Y.-L. I. Wong, et al., 2006). The services may be provided within the residence or out in the established community agencies (Y.-L. I. Wong, et al., 2006). Supported housing is meant to facilitate independent living by incorporating financial aid, mental health services, case management, and ACT teams (Wright & Kloos, 2007).

Tabol, Drebing, and Rosenheck (2010) summarized previous work on supported housing reducing it to 10 themes. These include:

- Housing is a right to everyone and a requirement for rehabilitation. The individual owns or rents the housing under their own name. It is considered permanent housing.
- Housing is chosen and not assigned. Housing is also affordable to each client.
- The program sees each person in normal societal roles. They are seen as a tenant and citizen, not as a patient or consumer.
- The individual has control, not the provider.
- The housing is spread throughout the community and not grouped together with others with similar disabilities.
- Services, housing and supports are all separate and not contingent on each other. Housing and services are legally and physically separate.
- All services and training are done in the community or home where they will be utilized, not in an office or temporary location. There is no live in staff and services are community based.
- All services are individualized and specific to the needs of each individual. There are no one size fits all treatment plans. All services are voluntary.
- Programs and housing emphasize most facilitative approach rather than a least restrictive one. There is crisis support 24/7.
- Focus on natural supports not professional services.

Permanent supported housing has received such an abundance of support that in order to receive funds from HUD, HHS, DOJ, or VA, a community facility must show a plan that includes supported housing (Casey, 2007).

One model of permanent supported housing is Housing First. It was developed primarily for persons with long standing homelessness and mental illness (Casey, 2007; HUD final report, 2007). Housing First was developed to accommodate the hardest to house populations. The Interagency Council on the Homeless define chronically homeless persons as those disabled and
continuously homeless for a year or longer, or having had at least 4 episodes of homelessness during the last 3 years (HUD final report, 2007; Livingston, Srebnik, King, & Gordon, 1992; Nelson, Wiltshire, Hall, Peirson, & Walsh-Bowers, 1995). Initial housing placement may be transitional in nature but there is a commitment to keep that person permanently housed (HUD final report, 2007). The first priority is to get the person off the street and into services. However, sometimes housing availability is limited. Whenever possible programs following a Housing First model will try to skip transitional housing and place the individual directly or nearly directly into permanent housing (HUD final report, 2007).

Housing First follows a low demand approach (HUD final report, 2007). Supportive services are offered but not required to remain in housing (HUD final report, 2007). Assertive outreach is often part of the program model (HUD final report, 2007). Whether the individual accepts services or continues to use drugs and alcohol, every effort is made to continue to offer case management and to hold housing for clients who experience brief absences from housing no matter the reason (HUD final report, 2007). One such program to use the Housing First model was the Pathways to Housing program with New York State and New York City in 1992. They found that a low demand model coupled with permanent housing and services yielded high retention rates, even after 6 months (Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003).

American Veterans face a particularly hard time in the fight against homelessness. It has been shown that drug use/abuse, alcohol use and a diagnosis of schizophrenia were the three greatest predictors of Veteran homelessness (Edens, Mares, Tsai, & Rosenheck, 2011). Homeless Veterans tend to be white, older, higher educated, and married or once married when compared to homeless non-Veterans (Casey, 2007). Some risk factors for homelessness among Veterans include multiple deployments, extended deployments, substance abuse, unemployment, and Traumatic Brain Injury, combat exposure, unit transfers, disrupted family status, and injury or diminished functioning (Henderson et al., 2008; Fairweather, 2006 Iraq Veteran Project). Although, low socioeconomic status at the time of service entry, recent mental illness, and criminal justice involvement are better predictors of homelessness for vets than wartime service, combat exposure, or PTSD (Edens, et al., 2011). Veterans have been shown to differ from the general homeless population in terms of their use of social service system resources. They have been shown to have longer shelter stays, higher placement rates, and higher rates of previous residence in supported housing as when compared to homeless non-Veterans (Henderson, et al., 2008).

Just as Veterans can differ from the non-Veterans in terms of their risk factors, Veterans also can have unique protective factors against homelessness. Protective factors have included training success, choice of military (vs. draft or reserve/national guard), continuity of tours of duty, DOD housing and rehabilitation, employment assistance, transition assistance, rehabilitation, medical care, commensurate employment, compensation awards, and work therapy (Fairweather, 2006 Iraq Veteran Project). Other protective factors may include that Veterans tend to be older, have higher incomes than the general public, service-connected disability, and a diagnosis of PTSD or other anxiety disorder (Edens, et al., 2011). Although, others argue that PTSD may not have an independent effect on homelessness but instead be masking the effects of receiving combat benefits on preventing homelessness (Henderson, et al., 2008). For general homeless populations, strong social networks, strong ties to the community,
availability of social and economic resources and life satisfaction can mediate the environmental effects on homelessness (Casey, 2007; Letiecq, et al., 1998).

In order to accomplish an accurate measure of housing for Veterans, it is important to understand the domains that the literature suggests are important in the definition and actualization of supportive housing for vulnerable populations including Veterans with behavioral healthcare issues. Areas of focus identified by researchers, policy makers, consumers, and service providers were reviewed.

**Community Context.** Studies suggest that consumers consider independence, personal choice, convenient location, proximity to mental health services, safety, social and recreational activities, comfort and privacy as the most important characteristics to community housing (Kirsh, Gewurtz, & Bakewell, 2011; Massey & Wu, 1993). Case managers agreed that safety, comfort, stable housing and privacy were important, but did not rank other concerns as high (Kirsh, et al., 2011; Massey & Wu, 1993). Ogilvie (1997) found that support services were significantly related to measures of residential conditions. The worst the living conditions, the more service needs were reported as not being met when listed by the consumers. Overall, consumers preferred normal, integrated housing, and rejected SRO’s or program housing (Carling, 1990). They preferred not to live with other ex-patients, and wanted mental health staff available on a 24-hour basis but not living with them (Carling, 1990; Kirsh, et al., 2011).


In order for people to gain access to housing and to remain housed, the housing must be affordable. Most previous research has deferred to the HUD standard of 30% or less of the income of the tenant (Brown & Wheeler, 1990; Carling, 1990; Hatfield, 1992; Hopper & Barrow, 2003; Johnson & Rogers, 2009; Kasprow, Rosenheck, Frisman, & DiLella, 2000; Lipton, et al., 2000; Livingston, et al., 1992; Newman, et al., 1994; Ridgway & Zipple, 1990a, 1990b; Y.-L. Wong, et al., 2007). Affordable housing was correlated with fewer days admitted to a hospital per month (Brown, Ridgway, Anthony, & Rogers, 1991; Keck, 1990; Newman, et al., 1994). Reduction in housing problems was associated with reductions in service needs (Newman, et al., 1994). Housing must also include any additional special features that make it accommodating towards people with psychiatric disabilities (Parkinson & Nelson, 2003).
Various housing styles have been looked at to determine if they affect housing outcomes. In one study, residents in cluster-site housing dropped out at a higher rate than scattered-site housing (Y.-L. I. Wong, et al., 2008). For this study, cluster site housing may have created more stress for the residents because of more disruptions from other consumers. In another study, it was seen that board-and-care homes provided their residents with less control and power in decision-making, offered less privacy, were seen as less safe, less comfortable, and had more dense populations than non-for-profit facilities like supported apartments or group homes (Nelson, Hall, & Walsh-Bowers, 1997). It was also seen that members of supportive apartments and group homes were more likely than members of board-and-care homes to have their own room, spend less of their income on rent, and have more control in decision-making (Nelson, et al., 1997). Additionally, residents using section 8 vouchers reported improvements in living condition when measured using affordability, presence of rats, amount of space, furnishings, and conditions of the exterior of the property (Newman, et al., 1994). These improved housing conditions were correlated with improved outcomes for persons with chronic mental illness (Newman, et al., 1994). Residents reported that having private space reduced their stress levels, gave them stability, motivated them for self sufficiency, and gave them privacy to work on their personal priorities for recovery (Kirsh, et al., 2011).

The environment in which the housing is located can also affect housing outcomes or satisfaction. In one study, urban clients, compared to rural clients, were more likely to live in substandard dwellings and report aversive neighborhood conditions which in turn affected their housing outcomes (Davies, Bromet, Schulz, Dunn, & Morgenstern, 1989). In another study, neighborhood level conditions were found to be most influential on residential satisfaction and well-being outcomes (symptoms) (Wright & Kloos, 2007). Apartment and neighborhood variables explained most of the variance in recovery measures, while measures at the census tract level did not show an affect (Wright & Kloos, 2007). How residents see their environment means more to their housing stability and recovery than what the objective neighborhood dynamics are (Wright & Kloos, 2007).

Community characteristics can have an influence over the number and types of services offered as well as the consumer’s ability to access existing services. In a study published by Davies, et al. (1989), urban patients, compared to rural ones, were more likely to receive less practical support from staff, and reported more conflict with other consumers in their housing program. They also found that residents had reductions in symptoms when homes were centrally located within their service region and when the services fostered respect for residents, avoided overprotecting, and integrated community resources for social and recreational activities (Davies, et al., 1989).

**Measures of Community Context.** Some studies utilize existing standards as set forth by HUD or other established housing programs. Others develop housing measures they believe to be best in line with optimizing housing conditions for homeless, mental health, and substance abuse consumers. In most studies, scatter site housing is defined as having no more than 10% of the total units in any one building (Newman, et al., 1994; Tsemberis & Asmussen, 1999). For an apartment to be deemed affordable, rent should be no more than 30% of the tenant’s total income (Newman, et al., 1994; Siegel, et al., 2006; Tsemberis, 2010; Tsemberis & Asmussen, 1999). When studies have looked at the conditions of the dwellings, they have sometimes utilized the Environmental Assessment Questionnaire, Sheltered Care Environment Scale, the Multi-phasic...
Environmental Assessment Procedure (MEAP), the Robert Wood Johnson Foundation Program on Chronic Mental Illness (PCMI) Section 8 certificate program standards, the Housing Environment Survey (HES), the Housing Environment Rating Scale (HERS), the Community Oriented Program Environmental Scale (COPES) or even census tract information (Brunt & Rask, 2012; Davies, et al., 1989; Moos, Gauvain, Lemke, Max, & Mehren, 1979; Nelson, et al., 1997; Newman, et al., 1994; Raskin, Mghir, Peszke, & York, 1998; Wright & Kloos, 2007). When trying to measure the effects of elements of community context on rehabilitation or symptoms, previous studies have utilized the Patient’s Community Adjustment, which included measures of psychopathology, degree of social adjustment, quality of life, global functioning and the Robert Wood Johnson Program on Chronic Mental Illness which includes scales on addressing positive characteristics of the residence (Cheng, Lin, Kaspraw, & Rosenheck, 2007).


Some of the services included in support housing can be transportation to appointments, 24-7 crisis support, psychosocial services, employment/vocational skills, building social skills/social networks, money management, advocacy for entitlements, structuring time and leisure activities, medication management and independent living skills (Brown & Wheeler, 1990; Carling, 1990; Johnson & Rogers, 2009; Kaspraw, et al., 2000; Livingston, et al., 1992; Nelson, et al., 2005; Ridgway & Zipple, 1990a, 1990b; Rimmerman, Finn, Schnee, & Klein, 1992; Siegel, et al., 2006; Tsemberis, 1999; Tsemberis & Eisenberg, 2000). Service providers should be able to aid and enable consumers to build and maintain support networks with family, friends, and community members (Hatfield, 1992; Y.-L. Wong, et al., 2007). Services may be kept separate from housing where housing is not contingent on utilizing services or the resident’s progress (Keck, 1990; Livingston, et al., 1992; Siegel, et al., 2006; Witheridge, 1990).

Grant and Westhues (2010) looked at high versus low support models of supported housing to see how mental health clients rated their satisfaction and outcomes when they were allowed to chose the program type they preferred. The levels of support were classified based on how involved the staff were with everyday planned activities, how often staff were on site, involvement of peer support, and the number of services provided by the staff versus outside community members (Grant & Westhues, 2010). Over the course of a year they asked 27
consumers at 2 sites about their satisfaction with housing, social supports, mental health, physical health, and mastery (Grant & Westhues, 2010). After the year, they found no difference in the ratings between the high support program and the low support program (Grant & Westhues, 2010). They concluded that housing choice was the only predictor of housing satisfaction.

In a study by Rimmerman, Fin, Schnee & Klein (1992), psychosocial rehabilitation services were positively related to the outcome of symptoms, therapeutic goals, and social integration. In another study, social supports were seen to have a direct buffering effect on the health and well-being of the consumer (Ogilvie, 1997). Increases in the number of social supports led to decreases in symptoms, and shortened illnesses as reported by consumers (Ogilvie, 1997). Similarly, higher degrees of social stimulation (high vs. low expectation) were associated with lower re-hospitalization rates (Davies, et al., 1989). It was also seen that case managers who secured Supplemental Security Income for their Veteran clients were more likely to have those Veterans being housed at a 1 year follow-up (Kasprow, et al., 2000).

How consumers feel about the services is also important to the success of their housing stability. In a study by Ogilvie (1997), clients’ needs for community support services were significantly related to measures of residential conditions. The worst the living conditions, the greater the number of service needs that were not being met as reported by consumers (Ogilvie, 1997). This in turn can lower the quality of life for residents of these housing programs. Ogilvie (1997) also found that the reported quality of life was affected by housing type and program. They found that the influence of the program over quality of life diminishes as support and supervision are reduced (Ogilvie, 1997). In other studies, consumers reported that the areas in which they wanted the most help were in dealing with emotional upsets, financial matters, and making friends (Keck, 1990; Livingston, et al., 1992; Yeich, et al., 1994).

Services Measures. Within homelessness and housing research measures explore the frequency of services, some address the variety or consumer satisfaction. Wong, Park, and Nemon (2006) determined that there are 5 domains of services that should be offered; basic needs, treatment, services promoting self-sufficiency, services for women and children, other (legal or Veteran services) (Y.-L. I. Wong, et al., 2006). Many studies have presented some version of an ACT team as the preferred service model for supported housing (Rosenheck, Kasprow, Frisman, & Liu-Mares, 2003; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000). Thus an appropriate measure of services would incorporate elements of the Dartmouth Assertive Community Treatment Fidelity Scale (Teague, Bond, & Drake, 1998). In a study covering the topic of service and evaluation, a modified version of the Working Alliance Inventory was used to evaluate services/service providers (Rosenheck, et al., 2003). Consumers’ satisfaction with services was measured using questions aimed at determining the frequency of contact, if the coordinator was helpful (case manager helpfulness), the relationship between consumer and participant, and overall satisfaction with the housing program (Tsemberis, 1999).

Admission and Tenure. The requirements needed for homeless Veterans to get placed in supported housing are very important to their ability to be successful and remain housed. The supported housing model calls for low demand housing with no dismissal policies (Carling, 1990; Casey, 2007; Hopper & Barrow, 2003; Johnson & Rogers, 2009; Siegel, et al., 2006; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000; Y.-L. Wong, et al., 2007). Housing is seen as a right of all people and a necessary element to any treatment program.
The path by which consumers enter housing programs may affect their housing outcomes. It has previously been seen that residents who entered housing from the streets were more likely to leave housing within 12 months of entry and more likely to have temporary absences from the Housing First program (HUD final report, 2007). On the other hand, residents who entered Housing First programs from shelters, jail, crisis houses, living with friends or psychiatric hospitals had higher housing stability over 12 months of residency (HUD final report, 2007).

Most conceptual models of supported housing and Housing First emphasize the rapidity of housing placement. The time it takes for consumers to be placed in housing can also affect their tenancy. If individuals have a complicated or lengthy process to obtain housing or a voucher, they may have a harder time actually getting housed. Using a sample of 627 Veterans entering HUD VASH between 1992 and 2003, Tsai, et al. (2011) found that individual characteristics of Veterans, including conditions such as substance abuse and criminal history did not affect their ability to get housed or the length of time it took. They did find a curvilinear relationship between the age of the HUD VASH program and the length of time to get housed. Newer and older programs got Veterans into housing faster than did programs in the middle ranges.

The number and intensity of the rules surrounding a housing program may affect the likelihood that a consumer will relate positively to their housing program and remain housed. Lipton, Siegel, Hannigan, Samuels, and Baker (2000) found that individuals in high intensity programs were more likely to leave the program within the first 120 days when compared to persons in medium or low intensity programs (the greater the intensity, the more restrictive the rules and the less autonomy the residents had). However, in all of the housing programs they examined, substance abuse was highly correlated to leaving housing and older age was correlated with staying housed longer (Lipton, et al., 2000).

Program style or size may also affect the consumer’s likelihood of remaining housed. Wong, Park, and Nemon (2006) found that facility size was correlated with shelter policies for access; smaller shelters had more exclusion criteria and restrictions for entry, while larger facilities had higher percentages of mandatory family programming. They also found that service-inclusive programs imposed more constraints on resident freedoms, making more rules which led to increases in reports of social isolation and longer lengths of stay in shelters (Y.-L. I. Wong, et al., 2006). The residents in their study responded best to transitional housing programs that had less bureaucratic control, more previously homeless staff, and more personalized approaches (Y.-L. I. Wong, et al., 2006).

Tenure can also be influenced but the consumer’s entry into a supported housing program. If it is a difficult or lengthy process to become houses, those consumers may never successfully enter into a housing program or may quickly leave once placed. In a study examining the HUD VASH system, Kasprow, et al. (2000) found that the median time from intake assessment and referral to HUD VASH placement was 100 days. It ranged from 1 day to 1 year (Kasprow, et al., 2000). They also found that the median time between program entry and receipt of housing voucher was 38 days (Kasprow, et al., 2000). Similarly, the median time
between receiving a voucher and moving into an apartment was 37 days (Kasprow, et al., 2000). Within the same study, the researchers found that the variables related to income potential were all correlated with likelihood of being referred to HUD VASH. The variables included receipt of public support, days worked in the past 30 days, and in the last 3 years did they usually maintain full or part time employment (Kasprow, et al., 2000). HUD VASH wanted proof that each person referred to housing would have access to a stable income (Kasprow, et al., 2000).

Similarly, using a sample of 2,925 homeless Veterans entering the HUD VASH program at 36 sites, O’Connell, Kasprow, and Rosenheck (2010) found that it took an average of 108 days for a homeless Veteran to get housed. Once housed they stayed in the HUD VASH program an average of 2.6 years with three-fourths of the Veterans leaving the program within 5 years (O’Connell, Kasprow, & Rosenheck, 2010). However, 82% of the Veterans were still housed at the time they left the HUD VASH program (O’Connell, et al., 2010). They also found that few Veterans were receiving rehabilitation or employment services and most services given were centered on obtaining the housing (O’Connell, et al., 2010).

**Measures of Admission and Tenure** are missing from current literature. There is a need for recognized standards with which we can measure the ability to get into a housing program and remain in a housing program. Each program may have different requirements for admissions criteria, treatment responsibilities, or levels of choice for the resident. However, in one article by Tsemberis and Asmussen (1999) housing programs were deemed successful if participants were placed in housing as soon as it became available, no more than 15 days.

**Relationships and Autonomy.** The resident’s relationship to the housing, staff, and service providers is a crucial element of supported housing. Supported housing calls for the separation of housing from treatment programs; not contingent on treatment progress or relapses (Carling, 1990; Johnson & Rogers, 2009; Kasprow, et al., 2000; Keck, 1990; Rog & Randolph, 2002; Siegel, et al., 2006; Tsemberis & Asmussen, 1999; Y.-L. Wong, et al., 2007). Consumer choice is essential is selecting housing, how the resident wants to live, and what treatments they will engage in (Carling, 1990; Fakhoury, et al., 2002; Johnson & Rogers, 2009; Ridgway & Zipple, 1990a, 1990b; Rog & Randolph, 2002; Tsemberis & Asmussen, 1999; Yeich, et al., 1994). The resident is treated as a normal person, not as a patient and has the same rights as any other tenant with their own lease (Carling, 1990; Fakhoury, et al., 2002; Johnson & Rogers, 2009; Lipton, et al., 2000; Parkinson & Nelson, 2003; Ridgway & Zipple, 1990a, 1990b; Rog & Randolph, 2002; Siegel, et al., 2006; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000; Y.-L. Wong, et al., 2007; Yeich, et al., 1994). They are given the same autonomy over their lives and their space with an emphasis on personal privacy (Johnson & Rogers, 2009; Keck, 1990; Nelson, et al., 2005; Nelson, et al., 1997; Siegel, et al., 2006; Y.-L. Wong, et al., 2007; Yeich, et al., 1994).

Overall, within the supported housing model, control lies with the individual (Fakhoury, et al., 2002; Johnson & Rogers, 2009; Nelson, et al., 1997; Ridgway & Zipple, 1990a, 1990b). Staff tries to assist consumers with their self-identified goals by building strong working bonds with consumers (Kasprow, et al., 2000). They foster a working relationships based on trust and respect (Nelson, et al., 1997; Y.-L. Wong, et al., 2007). Case managers are utilized to create linkages to existing community supports (Kasprow, et al., 2000; Ridgway & Zipple, 1990a, 1990b). Because these relationships take time and involve the building of trust, continuity of staffing is crucial to its success (Carling, 1990). Consumers’ happiness and life satisfaction has
been shown to be positively correlated with greater choice and less influence by others (Ogilvie, 1997). This article showed that even when the conditions were not ideal, the consumer’s ability to make their own choices was related to their satisfaction with life and the program.

**Relationships and Autonomy Measures.** Some measures that have previously been used to examine relationships in housing have been the subscales of the Policy and Service Characteristics Inventory (PASCI) which measures policies and practices of residential programs (Y.-L. I. Wong, et al., 2006). The subscale measures expectations for functioning in admission of clients, acceptance of problem behavior, and resident participation (Y.-L. I. Wong, et al., 2006). Also, the Overall Choice and Empowerment Scale has been used to measure client’s choice and level of autonomy (Siegel, et al., 2006).

**Organization.** It has been suggested that a supported housing program should operate with an emphasis on choice, regular housing, and flexible supports (Carling, 1990; Ogilvie, 1997). Wong, Filoromo, and Tennille (2007) describe five operational domains of supported housing; consumer choice, typical and normalized housing, resource accessibility, consumer control, and individualized and flexible supports. A supported housing program should operate with the notion of developing the most facilitative environment rather than a least restrictive environment (Leff, 1995; McCarthy & Nelson, 1991; Ridgway & Zipple, 1990a; Shepherd, 1995).

In order to create an effective supported housing program there must be an element of staff empowerment. Since staff spend most of their time working independently, supervisors should provide an environment conducive to teamwork while still allowing their staff the autonomy to handle situations with their clients as they arise (Brown & Wheeler, 1990). Research has found that effective staff training in housing programs leads to better quality of services, lower staff turnover, greater participation in social activities, and less hospital admissions (Raskin, et al., 1998). They have also found that it would be beneficial for all staff to be flexible, creative, and have counseling skills (Brown & Wheeler, 1990; Livingston, et al., 1992). It can also be very beneficial for some staff members to have personal experiences in common with the consumers (Brown & Wheeler, 1990; Carling, 1990; Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000).

One suggestion was that case managers should focus some of their time on maintaining active liaisons between local housing authorities and clients (Hopper & Barrow, 2003; Kasprow, et al., 2000). It was also suggested that they develop lists of available appropriate housing and act as a representative between the consumer and the interested landlords (Hopper & Barrow, 2003; Kasprow, et al., 2000). Another suggestion was for supported housing programs to maintain resources for flexible cash assistance (Culhane, Metraux, & Hadley, 2002; Livingston, et al., 1992).

In order to allow supported housing staff to be as effective as possible, it has been suggested that a case manager to consumer ratio of 1:25 is ideal (Rosenheck, et al., 2003). However, other researchers argue for even smaller caseloads of 6-7 consumers at a time (Brown & Wheeler, 1990). Depending on the program and model used, some clients may need more attention and assistance than others. Therefore, small caseloads and flexible staff schedules might be very beneficial to the consumers and the overall program success (Brown & Wheeler, 1990).
Other suggestions for successful programs include that there should be enough working vehicles for staff and consumer needs (Brown & Wheeler, 1990). Secondly, staff must have the ability to take and relay accurate phone messages (Brown & Wheeler, 1990). The program and staff should have the ability to process checks almost on demand (Brown & Wheeler, 1990). This way the consumer can have access to their own money even outside of banking hours without paying a check cashing fee. Along the same lines, there must be enough petty cash available with minimal paperwork for emergencies (Brown & Wheeler, 1990).

Still others argue the importance of peer staff in housing programs. Some research has set a standard of maintaining that 50% of staff should be people in recovery from homelessness, substance abuse, or psychiatric disability (Tsemberis & Asmussen, 1999). Having staff that lived through similar experiences will help develop a peer culture with the consumers, staff and providers.

**Organizational Measures.** One way to measure the consumer’s choice is to use the Pearlin and Schooler’s (1978) Mastery scale to assess the extent to which a person perceives control over their own life (Nelson, et al., 1997). Previous research examining the elements of a housing program’s organization have found that staff attitudes have direct effects on the residents (Snyder, Wallace, Moe, & Liberman, 1994). Houses with staff that scored high on Expressed Emotion scales (higher rates of criticism) had higher rates of residents leaving the housing programs (Snyder, et al., 1994). They found that the greater the level of criticism in a living environment, the lower the quality of lives of the patients. Other suggestions were to measure the staff/resident interactions using the Quality of Interactions Schedule (QUIS) (Dean, Proudfoot, & Lindesay, 1993) or the Hospital-Hostel Practices Profile (HHPP) (Wykes, Sturt, & Creer, 1982).

Examining job duties is another way of trying to measure the organization of a housing program. In supported housing case managers have the responsibility of coordinating services and providing referrals to other agencies (Brown & Wheeler, 1990; Tsemberis & Asmussen, 1999). While, in order to support their staff, managers give directions through broad ethical guidelines instead of specific standard operating procedures (Brown & Wheeler, 1990).

### b. Description of VA Housing Programs

**Department of Housing and Urban Development/VA Supported Housing: HUD VASH** *(Taken from the Department of Veterans Affairs website, Homeless Veterans Housing Support Services: HUD VASH and Grant Per Diem sections.)*

The Department of Housing and Urban Development and the Department of Veterans Affairs Supported Housing (HUD VASH) Program, through a cooperative partnership, provides ongoing long-term case management treatment services, supportive services and permanent housing support for homeless Veterans who require these supports to live independently. Eligible homeless Veterans receive VA provided case management and supportive services to support stability and recovery from physical and mental health, substance use, and functional concerns contributing to or resulting from homelessness.
HUD has allocated over 20,000 "Housing Choice" Section 8 vouchers to Public Housing Authorities (PHAs) throughout the country for eligible homeless Veterans to assist with rent payment. This program allows Veterans and their families to live in Veteran-selected apartment units. The vouchers are portable, allowing Veterans to live in communities where VA case management services can be provided. The program goals include promoting maximal Veteran recovery and independence to sustain permanent housing in the community for the Veteran and the Veteran's family.

This program was designed to address the needs of the most vulnerable homeless Veterans and is especially helpful to Veterans with families, women Veterans, recently returning Veterans and Veterans with disabilities. To be eligible for this program, Veterans must be VA Health Care eligible, homeless and in need and participate in case management services in order to obtain and sustain permanent independent community housing.

**Grant and Per Diem Program.** VA’s Homeless Providers Grant and Per Diem Program is offered annually (as funding permits) by the Department of Veterans Affairs Health Care for Homeless Veterans (HCHV) Programs to fund community agencies providing services to homeless Veterans. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination.

Only programs with supportive housing (up to 24 months) or service centers (offering services such as case management, education, crisis intervention, counseling, services targeted towards specialized populations including homeless women Veterans, etc.) are eligible for these funds. The program has two levels of funding: the Grant Component and the Per Diem Component.

2. Preliminary development

   a. Existing measures used to develop the HHSPM-V

The original measure was based on one developed for the Boley Homelessness Prevention Project (Clark & Rich, 2000). This measure, in turn, was based on the Dartmouth Assertive Community Treatment Scale (D-ACTS; Teague, Bond & Drake, 1998) and was modified by a conceptual mapping process with stakeholders in the Boley Program to determine the key elements in the housing program. The elements identified for that measure included obtaining housing; housing-related services; linkages for services and resources; organizational climate; and host agency characteristics.
The Dartmouth Assertive Community Treatment Scale (DACTS; Teague et al. 1998) has been used internationally for more than a decade as the standard measure of fidelity to assertive community treatment. It was developed in the mid-1990s as part of a multi-site study but came into widespread use to define and measure this complex service model. Its format made it useful for both research and program implementation and quality improvement. It draws on data from a variety of sources that are integrated in a common framework, which places critical ingredients on anchored 5-point scales. The DACTS has served as prototype and sometimes source of items for a number of subsequent program-level measures for evidence-based practices and interventions in a range of projects, including the Boley measure (see above).

An enhanced measure has been developed (Monroe-DeVita et al., in press;) to address a number of issues including the evolution of the ACT model over the past 15 years; progress in fidelity measurement (Mowbray et al., 2003); an increased emphasis on process as opposed to structure; and some gaps in the DACTS that posed risks when the measure was used outside of its original study context. This measure appears likely to succeed the DACTS as the standard measure for ACT. The current measure of housing programs for Veterans has continued the 5-point anchored scale format and includes several items that trace their lineage directly or indirectly to the DACTS, including for example the staff to client ratio and explicit admission criteria.

In addition, other measures were reviewed as we further developed our measure. As many of the items referred to a supported housing model, we reviewed the Substance Abuse and Mental Health Services Administration’s - Center for Mental Health Services (CMHS) – Supported Housing Toolkit. Certain items were originally used from the CMHS measure such as housing quality, integration with the neighborhood, choice of living arrangements and housing choice. As the VA is increasingly moving toward a Housing First model, we also reviewed a draft of the fidelity assessment developed by Sam Tsemberis (2010). While not explicitly incorporating items, we did use it as a guide to label certain items thus creating a Housing First scale within the larger measure.

In order to better address organizational issues for behavioral healthcare agencies, we reviewed the Organizational Readiness for Change (TCU ORC) which contains four separate modules which can be administered collectively or individually, depending on assessment strategy. This assessment focuses on organizational traits that predict program change (Lehman et al., 2002). It includes scales from four major domains—motivation, resources, staff attributes, and climate.

The housing measure that was developed included 9 organization questions of which 4 were from the TCU ORC measure. These included the following: (1) organizational climate, (2) administrative support/direction, (3) peer culture/team orientation, and (4) paperwork. The additional 5 questions were developed specifically for this measure and included other items: (1) program is committed to a recovery orientation, (2) safe environment, (3) peer run program, (4) programs are front door vs. continuum of care approach, and (5) support for flexible approach with Veterans including some flexible funds. These additional items were included after some preliminary interviews were conducted with VA program directors who indicated these areas to be important.
The VA is committed to a recovery orientation so The Housing and Housing Services Program Measure – Veteran’s Version (HHSPM) was reviewed to ensure that a recovery-orientation is reflected in each of the 5 primary domains: Community, Services, Access, Relationship, and Organization. Items reflecting a recovery orientation were identified. Items were also added and revised to more accurately reflect a recovery orientation. Two instruments were used as a comparison in the review process:

- The Recovery Oriented Systems Indicator measure (ROSI) is a consumer outcome measure that developed as part of a collaborative effort among a number of State Mental Health Authorities, national organizations, consumer survivor leaders, and mental health recovery researchers entitled “Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators”. It provides a core set of system-level indicators that measure the critical elements and processes of recovery-oriented services in mental health programs and delivery systems (Onken, et. al., 2004; Dumont, et. al., 2006).

- The Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) (Winarski et. al., 2008) is a mental health service provider agency measure developed under contract to Florida’s Medicaid authority and tested as part of a state wide pilot study. The SAPT was designed to provide a measure for recovery services capability and supports outcomes described in the Recovery Oriented Systems Indicators Measure (ROSI).

b. Visit to model program

Before beginning the study, the team decided the best way to begin our understanding of the domains and concepts as they related to Veterans was to visit a model program. The VAMC chosen had been recognized as a good program to understand all elements of VA housing programs. Members of the research team visited the model VAMC to see how they deal with homelessness among Veterans. The Program Manager arranged a tour to a GPD provider and one of the HUD offices and time to speak with her and a few of her staff. During the trip, the USF staff met with members of the VISN network including the Network Homeless Coordinator, the Program Manager for Healthcare for Homeless Veterans, the section 8 Manager of one of the Housing Authorities, the VA GPD Liaison, a VA HUD VASH case manager, and staff and a client at a GPD provider. Information from this visit was used to better structure the first study.

c. Early organizing domains

To better determine the scope of the measure we used information from the model VAMC that we visited and items and measures discussed as important to supported housing from our literature review by Carling (1990; 1993), Wong, Filoromo, & Tennille (2007) and Rog (2004). As a result we started with these basic broad domains with possible areas of consideration within.
Table 1. Organization of possible domains to consider

Context
  Community context
    Natural supports
    Social environment / climate
    Proximal economic environment
    Transportation options
    Community program availability
  Housing integration
    Housing integration
  Decent, safe, and affordable housing
    Housing affordability
    Decent quality
    Safe

Programs, services, & integration
  De facto program mission & goals
  Population / geographic range
  Relationships b/w housing agencies & other agencies
    (administrative/authority level)
    PHA
    Other
    Systems integration
    Communication type and frequency
  Connections among service programs (service level)
    Separation of housing and other services
    Communication/linkages among related programs (staff)
  Services available
    Characteristics, each type
      Restrictions / criteria / indications
      Quality
      Delivery location / provider
    Menu of services and resources
    Housing supervision approach/ Staff on-site vs. off
    Other resources
  Access / entry process / tenure
  Process of status change (homeless to housed)
    Pre-entry preparation support
    Speed of entry
    Procedures
    Choice of housing
Choice of housing
  Housing options
  Choice of living arrangements

Access to housing
  Admission criteria
  Preconditions to entry
  Formal time limits
  Conditions for retention
  Procedures for eviction

Outreach effort & process

Historical LOS
  Program
  Tenant

Relationship to housing, other services, & staff

Relationship of Veteran to housing
  Privacy
  Rights of tenancy

Flexibility / voluntariness of extra-housing services
  Tenant service preferences
  Service options
  Consumer driven services
  Availability and adequacy of services

Service quantity
  Intensity of service
  Frequency of contact

Quality of Veteran-staff interaction
  Strong working alliance
  Consumer involvement
  Continuity of staffing

Match between program, consumer needs / interests

Organizational features

Administrative support / direction
  Staff autonomy / empowerment
  Administrative / clinical support
  Organizational Climate
  Risk / safety management

Staff roles & interactions
  Actual job responsibilities
  Scheduling

Program / staff recovery orientation

Program governance

Once domains were established we also wanted to determine the appropriate levels of measurement and what samples were needed to be fully informed on a program. As an example we have shown the relationship between a VAMC and a HUD office:
2. Study 1

a. Purpose

The purpose of the first study was to better understand the nature of HUD VASH and GPD programs and to develop a sense of what aspects of these programs were important and impactful from the perspective of multiple stakeholders.

b. Methods

For the first study we obtained IRB approval through the USF Institutional Review Board and the R & D department at a VAMC located in a large metropolitan area in the southern United States. All study staff obtained WOC status and the protocol was reviewed and approved by the VAMC R & D committee before final review by the IRB.

The team conducted 25 interviews in the Site 1 VAMC. We used two team members for each interview, one person to do the actual interview and the other person to handle the recording of each interview and take notes. Prior to the beginning of each interview, the participant was given a consent form to review and sign. VA staff and the providers had a separate consent form from the Veterans. The participants were given a signed copy to keep and the originals were forwarded to the VA to store in a locked cabinet.

The team interviewed participants in both the GPD and HUD VASH programs. At the time of the study, each program was in a different VA service department. The following GPD participants were interviewed: 1 GPD liaison; 1 program assistant; 3 Community Providers (in two separate areas); and 9 Veterans (in 4 different facilities). We conducted the following interviews with HUD VASH participants: 6 staff at the VAMC; 1 supervisor; 1 employee with the women’s program HCHV; and 2 Veterans.
Each participant was asked open-ended questions designed to elicit their description of the program and its salient features. The same interview was conducted with each participant regardless of program. Questions asked of VA staff, providers and Veterans were:

- Please tell me about your housing program.
  - (Prompts for questions 2-6: what do you think are the most important aspects of your service in regards to: community; services/programs/linkages; access to housing/admission criteria/conditions for tenure; relationships among housing staff and Veterans; organization/staff?)
- What do you think are the most important aspects (elements) of your service or the program you are in?
- What do you think are the most helpful aspects (elements) of your service or the program you are in?
- Which elements of your service or the program you are in do you think work well?
- Which elements of your service or the program you are in do you think do not work well?
- How would you change your services or the services of the program you are in?
- What do you think are internal agency or program barriers hindering optimal care?
- What do you think are external barriers (outside of your agency) hindering optimal care?
- How do Veterans get into housing services?
- What helps Veterans get into housing services?
- What do you think are barriers making it hard for Veterans to (get into) housing services?
- What do you think helps Veterans remain in housing services?
- What do you think are barriers making it hard for Veterans to remain in housing services?

Team members were then divided into groups of two and given notes of several interviews to review to see if any common themes were present. Team members were assigned interviews that they did not conduct so as to give each interview the most unbiased evaluation. Interviews were utilized by the team in rating each theme in terms of how they: (1) related to items existing in the measure, (2) suggested changes to existing items, or (3) dealt with topics not covered within the measure.

**c. Results**

The following are some of the major themes discovered within the interviews. If needed, changes were made to the measure to reflect these themes. Anchors were also modified or created to more realistically capture the continuum of each domain.

**Caseloads.** The first major theme of the interviews was concerns over the size of caseloads. Both GPD providers and HUD VASH case managers felt their case loads were too large and they were sacrificing quality of services for quantity of cases. Some GPD providers felt they had too many beds for the number of staff. HUD VASH case managers mentioned that they would like to spend more time with each client and less time with paperwork and commuting.
between clients. However, almost all providers and staff mentioned the increased demand for more beds and housing vouchers. Along with the increase in availability they would like an increase in staff.

**Relationships.** Participants and research team members felt it would be important to add a component to the measure that captured information about the relationship between GPD providers and the VA, as well as the relationship between HUD VASH and other departments or services in the VA. These relationships are seen to vary drastically between programs and staff member. A similar theme that was stated repeatedly was that the VA doesn’t link to other community service providers and appears to have difficulty communicating with providers, community members, Veterans, and their families. They were seen as not being “customer service oriented”.

**Staff Attitudes.** The team felt there was a need to add a component that captures the attitudes of staff and to set up a score system for the research team to evaluate staff and their beliefs toward the housing system. Some staff and Veterans believe that GPD is the trial run for HUD VASH and that the Veterans are being tested. “Motivation to better themselves” is often mentioned by VA staff and the providers as a requirement. The team wondered how the level of motivation is defined/determined and then measured.

**Community.** It was also felt that there was a need to address the relationships between neighbors and housing as the setting for both GPD and HUD VASH apartments seems to influence many other factors for both staff and Veterans.

**Rules.** Some participants mentioned a need for an item to address the level of rules, what they are specifically and rule enforcement for each program or provider. For example, “Do the Veterans participate in shaping house rules in GPD and is there a blending of homeless Veterans with general population in GPD housing?”

A series of items existed on the measure to capture the level of rules and involvement by Veterans in making the rules. Some of the rules have to do with admissions. Some have to do with tenure. Others have to do with involvement of the Veterans in rule making. Finally, some of the items have to do with enforcement of the rules.

**Housing Choice.** Also mentioned was the concept of housing choice and how much opportunity really exists for different housing options and time allowed finding housing options for the Veteran. Some case managers mentioned they did not have enough time to develop the relationships they wanted with area landlords. Others commented on the short placement time (60 days) being restrictive to Veterans trying to find housing. Some GPD providers and Veterans wondered if there were any strategies for supporting conflict resolution with roommates. Could the Veterans be moved or would they be forced to work it out themselves?
**Supervision.** From the interviews it appeared that some Veterans wanted more supervision. One suggestion was for the VA to match the vets and their wants to programs’ restrictiveness. One interview also suggested matching the Veteran and their needs to either GPD or HUD VASH. They commented that some Veterans may be more successful if the program was matched with their needs.

**Transportation.** Another major theme of these interview responses was that transportation was a great concern. The Veterans were not sure where the pickup locations and destinations were. They also did not know the transportation schedule. The participants thought that transportation should be provided with a free choice of destination as well as a general increase in overall access to transportation for some areas, particularly for those Veterans in more rural areas. Another issue with transportation is distance from housing to the VAMC and getting to medical appointments.

**Knowledge.** The issue of knowledge of VA service array was also prevalent in the interviews. Education is needed for Veterans and providers about the service array offered by the VA. Many interviewees expressed that a need exists to develop strategies for ensuring that Veterans, organizations, and families are aware of VA and other community services. This could include education and marketing techniques. It was mentioned in multiple interviews that the VA relies too heavily on word of mouth in disseminating information about their services. Participants felt it was very important that the VA educate community agencies about services through the VA and whom to contact within the VA to get Veterans help. It is also crucial for the VA to be clear as to the requirements and qualifications to receive services in order to insure consistency of interpretation of rules and regulations. The VA should consider developing a method to recognize how well Veterans and case managers know the parameters of their own program. There also seems to be a misconception of a continuum of care between GPD and HUD VASH. Some staff and Veterans believe that you need to complete GPD before you can be placed in HUD VASH.

There are not many items covering the education/knowledge of program staff and Veterans. It has been something our team has been trying to address by modifying the anchors to some existing questions.

**Additional Services.** The issue of child custody, money management, legal issues, and poor credit reconciliation were also mentioned across the interviews. A major gap expressed in several interviews was related to deposits for HUD VASH (i.e. rent deposit, electric deposit, moving costs, etc.). Also expressed was the issue of needing an income or job in order to be accepted into HUD VASH, however to get a job they need an address, for some this is a real issue. It was also mentioned that once evicted the Veterans lose their housing voucher. Some comments included the need for money mediation. It was mentioned that if the Veteran’s electric is turned off for more than 24 hours they lose their HUD VASH voucher. Money mediation may be able to help in situations like this.
**Service Array.** Many Veterans interviewed were concerned with getting dental benefits. They wanted to find out how to qualify and which programs included it as part of their services. Also, many Veterans and a few providers and staff mentioned that they thought the families of Veterans should qualify for some services. Services that may be appropriate for Veteran families included counseling and medical. This was especially true for children of single women whom were Veterans.

**Homeless Prevention.** The VA should also address homeless prevention by providing aid to Veterans in times of crisis before they lose their housing.

Since we are only interviewing staff, providers, and Veterans already engaged with housing programs, we do not have any items on homeless prevention. We do have items on maintaining housing once placed though.

**Housing Requirements.** Another theme that was discussed was what happens to Veterans prior to placement into housing and the requirements to be able to get into housing. Being homeless can be traumatic - Veterans are more likely to be victimized when they are homeless and there is a need for a place for the Veterans to stay while awaiting housing. One of the concerns that arose out of the interviews was what do VA staff and providers do when they are able to place a Veteran but don’t know how or where to contact them. Do Veterans get skipped if they are difficult to locate? Also, some HUD VASH case managers mentioned the need for a recruitment strategy for housing (recruiting landlords).

**Housing Hurdles.** The HUD standard of 60 days to use a voucher is too tough. The program is new and a lot of the staff are new and it is too hard to get everyone housed in that amount of time. There is also the issue of Veterans not having the necessary paperwork completed, or documentation needed to complete the application. There is a substantial wait to get a HUD VASH voucher if the Veteran is on the waiting list. Some of the questions that came up were: 1) How do they keep track of Veterans, 2) Is there a list, 3) How do they move through the list when it comes to placing in housing, 4) Do they track down Veterans they can’t reach or do they just move on to the next person on the list if they can’t find someone.

**Special VA Populations.** Programs can’t accept Veterans with a history of arson, making meth, or sexual offenses. Where do these people go for help? Some Veterans mentioned that since the housing programs don’t use a harm reduction model they can get kicked out of the program housing for using alcohol or drugs, even if they are not an addict or are prescribed the narcotics. For some programs the mandatory drug testing has a one strike and you’re out policy while for others there is a sobriety prerequisite, even for people with no substance abuse.

**Peer Support and Gender Specific Issues.** Several peer support or gender specific issues came up during the interviews. Some suggestions for change included: (1) there is no peer support, (2) the providers and staff need to be multidisciplinary, (3) more staff with a greater diversity are needed in order to meet the needs of the programs and the Veterans, (4) are there a
sufficient number of female staff to provide services for female Veterans, (5) there exists a handoff of the Veteran from the outreach person to the case manager once they are engaged in the program. The comment wanted to know if there was a link between the type of outreach or the person who performed it and the successful placement of a Veteran in housing. Some positive components mentioned that already exist within the VA include: (1) the VA currently has support groups for Veterans that are gender specific and (2) the HUD VASH staff have a team approach to their work.

3 Study 2

a. Purpose

The purpose of our second study was to refine the measure, refine the questions needed to elicit anchor points and to explore assessments of reliability and validity of the measure.

b. Methods

The team conducted 33 interviews at a second VAMC also located in a large metropolitan area in the south eastern United States. We used two team members for each interview, one person asked the interview questions and both people recorded the responses and took notes. When only 1 person was available for the interview, they audio recorded the interview and another team member listened to the tape and took their own notes at a later time. Prior to the beginning of each interview, the participant was given a consent form to review and sign. VA staff and the providers had a separate consent form from the Veterans. The participants were given a signed copy to keep and the originals were forwarded to the VA to store in a locked cabinet.

The team interviewed participants, providers, and liaisons in both the GPD and HUD VASH programs. The following consisted of GPD interviews: 5 GPD liaison interviews were conducted; 6 program providers (one for each GPD program); and 16 Veterans (from the 6 different programs). We conducted the following interviews with HUD VASH participants: 3 case managers (from 3 different areas); and 3 Veterans (from 2 different areas).

c. Results

Validity and reliability tests of the program measure data were conducted using program measure information obtained during interviews with Site 2 VAMC participants. A total of 96 program measure ratings were obtained from 26 GPD interviews (6 programs) and 6 VASH interviews (4 programs) for programs operating in the Site 2 VAMC catchment area.

**Descriptive statistics on HHSPM-V.** A qualitative approach to reliability was first performed by examining the frequency distributions and patterns of missing data in scored housing measure protocols. Some items on the housing program measure are not explicitly
covered by the interview protocols. As a result, in some cases raters have coded these items as missing when scoring the protocols, while the other person rating the same interview has scored these items based on other information. Additionally, because some program measure items only relate to GPD programs, and not to VASH programs, frequency distributions and patterns of missing data for each item were examined by program type (i.e., GPD and VASH).

Within the measure 4 items have been given scores based on official publicly available information and not on information obtained during the interview. Item A5 addresses the distance between housing and the VAMC in order to determine convenience of location. In order to obtain this information the addresses of the housing or the housing area and the VAMC were entered into MapQuest. The distance between the two sites was used to calculate convenience of location from housing to VA services. The second official data item, A6 reports unemployment rates for each housing area. Unemployment rates were reported by county and taken from the Bureau of Labor Statistics from 2010. We created anchors based on the median national unemployment rate at the time. The third item scored from official data was A16. This item was scored using the Rural-Urban Commuting Area Codes (RUCAs). RUCAs are reported by the Census Bureau and are based on census tract level information and reported by zip codes. RUCAs are calculated using the Urbanized Area and Urban Cluster definitions developed by the Bureau of Census along with employment commuting information. This information was used to classify areas not only by their distance from a major city but also how isolated they are. They are currently working on creating a standardized national definition for rural frontier/remote as part of the Office of Rural Health Policy (ORHP). The final item that was scored using official data was A12. This item classified the availability of affordable housing for each area. The availability of affordable housing was measured using the number of hours of work a week needed for 1 person making the mean renters wage of the area to meet fair market value for an 1 bedroom apartment where rent is <30% of their income as reported by the National Low Income Housing Coalition. Using the mean renters wage and hours of work needed to afford housing we can determine that the higher the number of hours needed to work, the less availability of rentals priced proportionately to average renters incomes in the community.

**Frequency distributions** for the program measure items are presented below in Table 2 based on 96 program measure ratings obtained from 26 GPD and 6 VASH interviews from programs operating in the Site 2 VAMC area. Cases in which raters recorded different patterns of missing data based on the same interview were identified. Raters discussed the rationale for their discrepant patterns of missing data and used this information to incorporate additional prompts and other adjustments to the interview protocol to minimize missing data.
## Table 2. Responses to Each HHSPM-V Item by Program Type.

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<th>VASH Programs (18 Scored Interviews)</th>
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</table>
Reliability. Although the interview protocol was designed to be administered and scored by one person, two raters were utilized for each interview in order to examine the inter-rater reliability of each item on the HHSPM-V. The second rater was either in the room for the interview or scored the measure based on an audiotape of the interview. Each rater scored the measure independently. Cohen’s Kappa statistic is an index of inter-rater reliability. Values generally range from 0 to 1.0, with larger numbers indicating better agreement between raters. Low values near zero suggest that agreement is attributable to chance alone. As a rule of thumb, values of Kappa from 0.21 to 0.40 are considered fair, 0.40 to 0.59 moderate, 0.60 to 0.79 substantial, and 0.80 and higher are outstanding (Landis & Koch, 1977). Inter-rater reliabilities were calculated based on pairs of ratings from 26 GPD and 6 VASH interviews from programs operating in the Site 2 VAMC area. Program measures scored by consensus were not included in these analyses. Table 3 presents information on Cohen’s Kappa statistics that were computed to gauge the inter-rater reliability of each item on the housing program measure. The table also presents information of the statistical significance of each Kappa.

Table 3. Inter-Rater Reliability of Items on the HHSPM-V

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<th>Item</th>
<th>Descriptor</th>
<th>Cohen’s Kappa</th>
<th>Significance Level (p =)</th>
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<td>NA¹</td>
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<tr>
<td>D.1</td>
<td>CONTROL OVER LIVING ENVIRONMENT</td>
<td>.038</td>
<td>NS</td>
</tr>
<tr>
<td>D.2</td>
<td>PRIVACY</td>
<td>.888</td>
<td>.001</td>
</tr>
<tr>
<td>D.3</td>
<td>PRIVACY: STAFF</td>
<td>.326</td>
<td>NS</td>
</tr>
<tr>
<td>D.7</td>
<td>SERVICE CHOICE</td>
<td>.171</td>
<td>NS</td>
</tr>
<tr>
<td>D.11</td>
<td>SERVICE OPTIONS: FLEXIBILITY</td>
<td>.181</td>
<td>NS</td>
</tr>
<tr>
<td>D.14</td>
<td>VETERAN INVOLVEMENT</td>
<td>.409</td>
<td>.002</td>
</tr>
<tr>
<td>D.16</td>
<td>RECOVERY ORIENTATION</td>
<td>.490</td>
<td>.007</td>
</tr>
<tr>
<td>D.18</td>
<td>VETERAN / STAFF RATIO</td>
<td>.759</td>
<td>.004</td>
</tr>
<tr>
<td>D.20</td>
<td>INDIVIDUALIZED HOUSING PLAN</td>
<td>NA²</td>
<td>NA²</td>
</tr>
<tr>
<td>D.21</td>
<td>CHOICE OF LIVING ARRANGEMENTS: HOUSEMATES</td>
<td>.432</td>
<td>.004</td>
</tr>
<tr>
<td>E.1</td>
<td>COMMITMENT TO A RECOVERY ORIENTATION</td>
<td>.001</td>
<td>NS</td>
</tr>
<tr>
<td>E.2</td>
<td>ORGANIZATIONAL CLIMATE</td>
<td>NA²</td>
<td>NA²</td>
</tr>
<tr>
<td>E.3</td>
<td>ADMINISTRATIVE SUPPORT / DIRECTION</td>
<td>1.0</td>
<td>.002</td>
</tr>
<tr>
<td>E.10</td>
<td>PEER CULTURE / TEAM ORIENTATION</td>
<td>.200</td>
<td>NS</td>
</tr>
<tr>
<td>E.14</td>
<td>SAFE ENVIRONMENT</td>
<td>NA²</td>
<td>NA²</td>
</tr>
<tr>
<td>E.15</td>
<td>PAPERWORK</td>
<td>.706</td>
<td>.006</td>
</tr>
<tr>
<td>E.18</td>
<td>PEER RUN PROGRAM</td>
<td>.843</td>
<td>.001</td>
</tr>
<tr>
<td>E.19</td>
<td>FRONT DOOR</td>
<td>.025</td>
<td>NS</td>
</tr>
<tr>
<td>E.20</td>
<td>FLEXIBLE APPROACH</td>
<td>.213</td>
<td>NS</td>
</tr>
</tbody>
</table>

1. Kappa coefficient and significance level not computer due to missing data.
2. Kappa coefficient and significance level not computed because at least one variable is a constant.
There was much variability in the HHSPM-V items’ inter-rater reliabilities. Kappa values ranged from a low of 0.001 to a high of 1.0. Applying the descriptive classifications of Landis and Koch (1977), Table 4 summarizes the HHSPM-V items’ inter-rater reliabilities. Kappa values were “poor” for 18 items, “fair” for 18 items, “moderate” for 22 items, “substantial” for 7 items, and “outstanding” for 5 items. Kappas were not computed for 10 items either because of missing data or because ratings were a constant.

Table 4. Summary of Inter-Rater Reliabilities for HHSPM-V Items

<table>
<thead>
<tr>
<th>Range of Kappas</th>
<th>Description</th>
<th># HHSPM-V Items with Kappa in This Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00 to 0.20</td>
<td>Poor</td>
<td>18</td>
</tr>
<tr>
<td>0.21 to 0.40</td>
<td>Fair</td>
<td>14</td>
</tr>
<tr>
<td>0.40 to 0.59</td>
<td>Moderate</td>
<td>22</td>
</tr>
<tr>
<td>0.60 to 0.79</td>
<td>Substantial</td>
<td>7</td>
</tr>
<tr>
<td>0.80 to 1.00</td>
<td>Outstanding</td>
<td>5</td>
</tr>
</tbody>
</table>

Note. These kappa ranges and descriptors are taken from Landis & Koch (1977).

Based on review of the HHSPM-V items and conversations with VA and Center staff regarding domains they would like to view to make the data meaningful for policy, programming, and research, sets of related housing measure items were identified that appear on the surface to measure conceptually similar domains. These domains include: Community, Organizational Linkages, Strength and Quality of Services, Number and Variety of Services, Housing and Service Choice/Veteran-Centered Care, Admission Requirements, Rules for Tenure in Housing, Organizational Climate, Recovery Orientation, Housing First Readiness, and Low Demand Environment. Based on 96 HHSPM-V ratings obtained from 26 GPD and 6 VASH programs operating in the Site 2 VAMC area, Cronbach’s alphas were computed to examine the internal consistency of these proposed item groups. This was initially performed using all items in each group. Alphas were next optimized for each group by selectively removing item one at a time to determine if the internal consistencies could be improved by using a smaller set of items. Values of alpha typically range from 0 to 1.0, with higher values indicating better internal consistency. George and Mallery (2003) provide the following rule of thumb to characterize alpha values: 0 to .49 is unacceptable, .50 to .59 is poor, .60 to .69 is questionable, .70 to .79 is acceptable, .80 to .89 is good and .90 or greater is excellent. Nunnaly (1978) indicated that .70 is an acceptable reliability coefficient, although he noted that lower thresholds are sometimes used in the literature.

Table 5 presents information on the internal consistency of the proposed domains. The alpha for each initial item pool is first presented. Individual items were then removed from each domain’s item pool to maximize the internal consistencies, and Table 5 presents the resulting alphas for each of these steps. Along with the information about missing data, results from the internal consistency reliability analyses were used to refine the manner in which the HHSPM-V items elicit information. Specifically, modifications were made to the interview protocol and the anchors describing each HHSPM-V’s response option.

The proposed Community domain did not exhibit a questionable level of internal consistency. An alpha for the initial six items could not be computed due to extensive missing
data for some items. Even after items were individually removed to optimize alpha, the resulting internal consistency was still questionable at .667. The initial four items in the Organizational Linkages domain demonstrated a questionable alpha of .650. This was improved to a good alpha of .890 once item A14 (Relationship with PHA) was removed. The remaining three items dealt with a team orientation (E10) and relationships with community agencies (A15) and the VAMC (A18). It is interesting that item A14 assessing the PHA relationship did not neatly fit with these other items.

The initial 12 items on the Strength and Quality of Services domain had a questionable alpha of .675. Once four items were individually removed the resulting alpha for this 8-item domain increased to a good value of .867. The initial 10 items on the Number and Variety of Services domain had a questionable alpha of .695 that was improved to a good value of .852 once four items were individually removed. The initial 12 item pool for the Housing and Service Choice/Veteran-Centered Care domain exhibited an acceptable alpha of .790. Once two items were individually removed, the internal consistency of the remaining 10-item domain increased to a good value of .851. The initial nine items on the proposed Admission Requirements domain had an unacceptable alpha of .433. After removing three items to optimize the internal consistency, the alpha for this domain improved to an acceptable value of .703. The initial 12-item Rules for Tenure in Housing domain had a good alpha of .866. Three items were individually removed, increasing the alpha to an excellent .906.

The initial nine items on the Organizational Climate domain had a good alpha of .834, which was improved to an excellent .908 after individually removing three items. The initial 50 items on the Housing First Readiness domain exhibited a good alpha of .864, which was improved to an excellent value of .903 after 4 items were individually removed. The 43 items on the Low Demand Environment domain yielded acceptable internal consistency at .772. Eleven items were individually removed to maximize the internal consistency, and the resulting alpha for the 31-item Low Demand Environment domain was an excellent .915.

Table 5. Internal Consistency of Domains on the HHSPM-V

<table>
<thead>
<tr>
<th>Domain</th>
<th># Items</th>
<th>Initial Item Pool</th>
<th>Items Removed</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>6</td>
<td>A1, A2, A5, A6, A12, A16</td>
<td>None</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td></td>
<td>A1</td>
<td>.625</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td></td>
<td>A2</td>
<td>.667</td>
</tr>
<tr>
<td>Organizational Linkages</td>
<td>4</td>
<td>A14, A15, A18, E10</td>
<td>None</td>
<td>.650</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td>A14</td>
<td>.890</td>
</tr>
<tr>
<td>Strength and Quality of</td>
<td>12</td>
<td>A13, A17, B4, B9, B10, B11, B12, B25, B26, B27, B29, D18</td>
<td>None</td>
<td>.675</td>
</tr>
<tr>
<td>Services</td>
<td>11</td>
<td></td>
<td>B26</td>
<td>.782</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td></td>
<td>B10</td>
<td>.808</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td></td>
<td>B9</td>
<td>.853</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td></td>
<td>A13</td>
<td>.867</td>
</tr>
<tr>
<td>Number and Variety of Services</td>
<td>10</td>
<td>B6, B7, B16, B17, B19, B20, B21, B22, B24, B31</td>
<td>None</td>
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<tr>
<td></td>
<td>9</td>
<td></td>
<td>B22</td>
<td>.810</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td></td>
<td>B6</td>
<td>.837</td>
</tr>
<tr>
<td>Domain</td>
<td># Items</td>
<td>Initial Item Pool</td>
<td>Items Removed</td>
<td>Alpha</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>---------</td>
<td>-----------------------------------------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>Housing and Service Choice / Veteran-Centered Care</td>
<td>7</td>
<td>B7</td>
<td>None</td>
<td>.852</td>
</tr>
<tr>
<td>Admission Requirements</td>
<td>11</td>
<td>D14</td>
<td>None</td>
<td>.815</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>E19</td>
<td>None</td>
<td>.851</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>C5, C8, C9, C10, C11, C12, C14, C28, C29</td>
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<td>.433</td>
</tr>
<tr>
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<td>C8</td>
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<td>.536</td>
</tr>
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<td>7</td>
<td>C11</td>
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</tr>
<tr>
<td></td>
<td>6</td>
<td>C10</td>
<td>None</td>
<td>.703</td>
</tr>
<tr>
<td>Rules for Tenure in Housing</td>
<td>12</td>
<td>C17, C19, C21, C22, C23, C25, C31, C32, C33, C34, C35, C36</td>
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<td>.866</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>C19</td>
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<td></td>
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<td>9</td>
<td>C21</td>
<td>None</td>
<td>.906</td>
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<tr>
<td>Organizational Climate</td>
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<td>D14, D16, E1, E2, E3, E14, E15, E18, E20</td>
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<td>.834</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>E18</td>
<td>None</td>
<td>.859</td>
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<tr>
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<td>6</td>
<td>D16</td>
<td>None</td>
<td>.908</td>
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<td>Recovery Orientation</td>
<td>10</td>
<td>A11, B10, C2, D7, D11, D14, D16, D20, E1, E18</td>
<td>None</td>
<td>NA*</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>E1</td>
<td>None</td>
<td>.404</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>D16</td>
<td>None</td>
<td>.475</td>
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<td>Housing First Readiness</td>
<td>50</td>
<td>A11, B6, B7, B9, B10, B12, B16, B17, B19, B20, B21, B22, B25, B26, B29, B31, C2, C5, C7, C8, C9, C10, C11, C12, C14, C28, C29, C17, C9, C21, C22, C23, C25, C31, C32, C33, C34, C35, C36, C38, D1, D2, D7, D11, D14, D16, D18, D20, E10, E18</td>
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<td>.864</td>
</tr>
<tr>
<td></td>
<td>49</td>
<td>B19</td>
<td>None</td>
<td>.876</td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>B25</td>
<td>None</td>
<td>.887</td>
</tr>
<tr>
<td></td>
<td>47</td>
<td>D18</td>
<td>None</td>
<td>.897</td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>E10</td>
<td>None</td>
<td>.903</td>
</tr>
<tr>
<td>Low Demand Environment</td>
<td>43</td>
<td>B4, B6, B7, B12, B16, B17, B19, B21, B24, B25, B26, B27, B29, B31, C7, C9, C10, C11, C12, C14, C19, C21, C22, C23, C25, C28, C29, C30, C31, C32, C33, C34, C35, C36, D1, D2, D3, D7, D11, D20, D21, E3, E14</td>
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<td>.772</td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>B4</td>
<td>None</td>
<td>.801</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
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<td>40</td>
<td>B25</td>
<td>None</td>
<td>.841</td>
</tr>
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<td>39</td>
<td>B19</td>
<td>None</td>
<td>.855</td>
</tr>
<tr>
<td></td>
<td>38</td>
<td>E3</td>
<td>None</td>
<td>.866</td>
</tr>
<tr>
<td></td>
<td>37</td>
<td>C30</td>
<td>None</td>
<td>.875</td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>B17</td>
<td>None</td>
<td>.892</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>C11</td>
<td>None</td>
<td>.896</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>33</td>
<td>B16</td>
<td>None</td>
<td>.906</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>B12</td>
<td>None</td>
<td>.911</td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>D20</td>
<td>None</td>
<td>.915</td>
</tr>
</tbody>
</table>
1. Internal consistency not computed due to missing data.
2. Internal consistency not computed due to a violation of reliability model assumptions (i.e., negative average covariance among items).

Table 6 summarizes the optimized internal consistencies and the number of items for each proposed domains. After individually removing items from the initial item pools, the resulting alpha values were unacceptable for one domain, questionable for one domain, acceptable for one domain, good for four domains, and excellent for four domains.

**Table 6. Summary of Each Domain’s Optimized Internal Consistency**

<table>
<thead>
<tr>
<th>Domain</th>
<th># Items</th>
<th>Items</th>
<th>Alpha Value</th>
<th>Descriptor¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>4</td>
<td>A5, A6, A12, A16</td>
<td>.667</td>
<td>Questionable</td>
</tr>
<tr>
<td>Organizational Linkages</td>
<td>3</td>
<td>A15, A18, E10</td>
<td>.890</td>
<td>Good</td>
</tr>
<tr>
<td>Strength and Quality of Services</td>
<td>8</td>
<td>A17, B4, B11, B12, B25, B27, B29, D18</td>
<td>.867</td>
<td>Good</td>
</tr>
<tr>
<td>Number and Variety of Services</td>
<td>7</td>
<td>B16, B17, B19, B20, B21, B24, B31</td>
<td>.852</td>
<td>Good</td>
</tr>
<tr>
<td>Housing and Service Choice / Veteran-Centered Care</td>
<td>10</td>
<td>C2, C37, C38, D1, D2, D3, D7, D11, D20, D21</td>
<td>.851</td>
<td>Good</td>
</tr>
<tr>
<td>Admission Requirements</td>
<td>6</td>
<td>C5, C9, C12, C14, C28, C29</td>
<td>.703</td>
<td>Acceptable</td>
</tr>
<tr>
<td>Rules for Tenure in Housing</td>
<td>9</td>
<td>C17, C22, C25, C31, C32, C33, C34, C35, C36</td>
<td>.906</td>
<td>Excellent</td>
</tr>
<tr>
<td>Organizational Climate</td>
<td>6</td>
<td>D14, E1, E2, E3, E14, E15</td>
<td>.908</td>
<td>Excellent</td>
</tr>
<tr>
<td>Recovery Orientation</td>
<td>8</td>
<td>A11, B10, C2, D7, D11, D14, D20, E18</td>
<td>.475</td>
<td>Unacceptable</td>
</tr>
<tr>
<td>Housing First Readiness</td>
<td>46</td>
<td>A11, B6, B7, B9, B10, B12, B16, B17, B20, B21, B22, B26, B29, B31, C2, C5, C7, C8, C9, C10, C11, C12, C14, C28, C29, C17, C9, C21, C22, C23, C25, C31, C32, C33, C34, C35, C36, C38, D1, D2, D7, D11, D14, D16, D20, E18</td>
<td>.903</td>
<td>Excellent</td>
</tr>
<tr>
<td>Low Demand Environment</td>
<td>31</td>
<td>B6, B7, B21, B26, B27, B29, B31, C7, C9, C10, C12, C14, C19, C21, C22, C23, C25, C28, C29, C31, C32, C33, C34, C35, C36, D1, D2, D3, D7, D11, D21</td>
<td>.915</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

¹. Descriptors for alpha are based on George and Mallery (2003).

**Validity.** In order to gain multiple perspectives, separate interviews were conducted with Veterans receiving housing services from and staff working in the housing programs. As an index of criterion-related validity, two-tailed correlations were computed to compare the Veteran and staff responses to each of the interview items that were completed by both Veterans and staff. A total of seven housing programs included interviews with HHSPM-V data obtained from both staff and Veterans. Because a different number of interviews were conducted with Veteran and staff from the participating programs, each program was given an average staff score and an average Veteran score for each item on the HHSPM-V. The correlations conducted using these average items scores. Average HHSPM-V item scores obtained from staff were also compared to average scores obtained from Veterans. Table 7 presents the correlations and
average scores. Of the 76 items on the HHSPM-V, there were statistically significant correlated between the Veteran and staff responses for 23. There was not a statistically significant correlation for 36 items, and correlations could not be computed for 17 items due one or more of the variables being a constant. With regard to average scores, staff more commonly reported higher scores than Veterans enrolled in the same program. Staff rated programs higher than Veterans for 50 items, Veterans rated the programs higher on 18 items, and Veteran and staff ratings were identical for two items; means for six items could not be computed due to missing data.

Table 7. Correspondence between Veteran and Staff Responses

<table>
<thead>
<tr>
<th>Item</th>
<th>Correlations</th>
<th>Significance Level ( (p = ) )</th>
<th>Average Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Correlation</td>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td>A.1</td>
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<td>NA(^1)</td>
<td>NA(^2)</td>
</tr>
<tr>
<td>A.2</td>
<td>NA(^1)</td>
<td>NA(^1)</td>
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</tr>
<tr>
<td>A.5</td>
<td>.975</td>
<td>.001</td>
<td>2.95</td>
</tr>
<tr>
<td>A.6</td>
<td>NA(^1)</td>
<td>NA(^1)</td>
<td>1.00</td>
</tr>
<tr>
<td>A.11</td>
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<td>.001</td>
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</tr>
<tr>
<td>A.14</td>
<td>1.0</td>
<td>.001</td>
<td>2.45</td>
</tr>
<tr>
<td>A.15</td>
<td>NA(^1)</td>
<td>NA(^1)</td>
<td>4.27</td>
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<tr>
<td>A.16</td>
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<td>NA(^1)</td>
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1. Correlation not computed because at least one variable is a constant.
2. Statistic not computed due to missing data.

**Discriminant validity** was next examined by comparing known differences between programs (e.g., tenure between GPD and VASH) and establishing that these differences are reflected in the relevant HHSPM-V items. These analyses were based on 96 HHSPM-V ratings were obtained from 26 GPD and 6 VASH programs operating in the Site 2 VAMC area. This
represented 18 HHSPM-Vs rated for VASH programs and 78 sets of ratings for the GPD programs. Two-tailed, independent sample t-tests were used to assess whether the GPD and VASH programs differed in their average scores for each HHSPM-V item (see Table 8).

**Table 8. Correspondence between GPD and VASH Housing Programs on HHSPM-V Items**

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<th>Item</th>
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<th>GPD SD</th>
<th>VASH Mean</th>
<th>VASH SD</th>
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<td>C.28</td>
<td>ADMISSIONS: ALCOHOL</td>
<td>3.27</td>
<td>1.28</td>
<td>4.83</td>
<td>0.39</td>
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<tr>
<td>C.29</td>
<td>ADMISSIONS: DRUGS</td>
<td>3.07</td>
<td>1.23</td>
<td>4.83</td>
<td>0.39</td>
<td>.001</td>
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<tr>
<td>C.30</td>
<td>TENURE IN HOUSING: TRANSITIONAL</td>
<td>2.17</td>
<td>0.38</td>
<td>1.14</td>
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<td>TENURE IN HOUSING - DRUGS</td>
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<td>TENURE IN HOUSING - VIOLENCE</td>
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<td>2.82</td>
<td>1.89</td>
<td>NS</td>
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<tr>
<td>C.36</td>
<td>ENFORCEMENT OF RULES</td>
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<td>3.77</td>
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<td>C.37</td>
<td>PETS ALLOWED</td>
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<td>C.38</td>
<td>HOUSING AFFORDABILITY</td>
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<td>0.00</td>
<td>4.30</td>
<td>0.67</td>
<td>.010</td>
</tr>
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<td>D.1</td>
<td>CONTROL OVER LIVING ENVIRONMENT</td>
<td>3.12</td>
<td>0.59</td>
<td>4.53</td>
<td>1.06</td>
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<tr>
<td>D.2</td>
<td>PRIVACY</td>
<td>1.39</td>
<td>0.69</td>
<td>4.46</td>
<td>1.21</td>
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<td>D.3</td>
<td>PRIVACY: STAFF</td>
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<td>0.82</td>
<td>4.00</td>
<td>1.55</td>
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<td>D.7</td>
<td>SERVICE CHOICE</td>
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<td>D.11</td>
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<td>0.85</td>
<td>3.80</td>
<td>1.01</td>
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<td>D.14</td>
<td>VETERAN INVOLVEMENT</td>
<td>2.08</td>
<td>0.82</td>
<td>1.75</td>
<td>1.22</td>
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<tr>
<td>D.16</td>
<td>RECOVERY ORIENTATION</td>
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<td>0.86</td>
<td>4.39</td>
<td>0.77</td>
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<td>D.18</td>
<td>VETERAN / STAFF RATIO</td>
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<td>0.54</td>
<td>3.13</td>
<td>0.35</td>
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<tr>
<td>D.20</td>
<td>INDIVIDUALIZED HOUSING PLAN</td>
<td>4.07</td>
<td>1.21</td>
<td>4.00</td>
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<td>D.21</td>
<td>CHOICE OF LIVING ARRANGEMENTS: HOUSEMATES</td>
<td>1.18</td>
<td>0.38</td>
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<td>E.1</td>
<td>COMMITMENT TO A RECOVERY ORIENTATION</td>
<td>3.94</td>
<td>0.42</td>
<td>1.92</td>
<td>0.90</td>
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<tr>
<td>E.2</td>
<td>ORGANIZATIONAL CLIMATE</td>
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<td>0.38</td>
<td>3.25</td>
<td>1.91</td>
<td>NS</td>
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<tr>
<td>E.3</td>
<td>ADMINISTRATIVE SUPPORT / DIRECTION</td>
<td>4.21</td>
<td>0.79</td>
<td>1.75</td>
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<tr>
<td>E.10</td>
<td>PEER CULTURE / TEAM ORIENTATION</td>
<td>3.93</td>
<td>0.96</td>
<td>2.70</td>
<td>1.57</td>
<td>.044</td>
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<td>E.14</td>
<td>SAFE ENVIRONMENT</td>
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<td>0.00</td>
<td>2.00</td>
<td>0.76</td>
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<td>E.15</td>
<td>PAPERWORK</td>
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<td>1.00</td>
<td>0.00</td>
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<td>E.18</td>
<td>PEER RUN PROGRAM</td>
<td>1.82</td>
<td>1.04</td>
<td>1.25</td>
<td>0.46</td>
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<td>E.19</td>
<td>FRONT DOOR</td>
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<td>1.30</td>
<td>1.56</td>
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<td>E.20</td>
<td>FLEXIBLE APPROACH</td>
<td>2.13</td>
<td>1.23</td>
<td>1.83</td>
<td>0.94</td>
<td>NS</td>
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</table>

1. Statistic not computed due to missing data.
2. Statistic not computed because the standard deviation of both groups is 0.
A similar series of independent samples t-tests was also performed on the HHSPM-V domains (see Table 9). These were conducted in two ways: 1) using domain average scores based on all initial items in the initial item pool, and 2) using the reduced set of items that improved the internal consistency of each domain. These analyses indicated that the VASH programs scored significantly higher than GPD programs on the following six domains: Housing and Service Choice/Veteran-Centered Care, Admission Requirements, Rules for Tenure in Housing, Recovery Orientation, Housing First Readiness, and Low Demand Environment. GPD and VASH programs did not differ on five of the domains, including: Community, Organizational Linkages, Strength and Quality of Services, Number and Variety of Services, or Organizational Climate. There were no domains on which GPD programs scored significantly higher than VASH programs.

Table 9. Correspondence between GPD and VASH Housing Programs on HHSPM-V

Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th># Items</th>
<th>GPD Mean</th>
<th>GPD SD</th>
<th>VASH Mean</th>
<th>VASH SD</th>
<th>Significance Level (p = )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>6</td>
<td>2.98</td>
<td>0.98</td>
<td>3.52</td>
<td>0.80</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>3.05</td>
<td>1.08</td>
<td>3.21</td>
<td>0.71</td>
<td>NS</td>
</tr>
<tr>
<td>Organizational Linkages</td>
<td>4</td>
<td>3.42</td>
<td>0.82</td>
<td>2.65</td>
<td>1.41</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3.86</td>
<td>0.57</td>
<td>2.87</td>
<td>1.65</td>
<td>NS</td>
</tr>
<tr>
<td>Strength and Quality of Services</td>
<td>12</td>
<td>3.10</td>
<td>0.75</td>
<td>3.13</td>
<td>0.85</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>3.21</td>
<td>0.88</td>
<td>2.80</td>
<td>1.25</td>
<td>NS</td>
</tr>
<tr>
<td>Number and Variety of Services</td>
<td>10</td>
<td>3.10</td>
<td>0.75</td>
<td>3.13</td>
<td>0.85</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>3.21</td>
<td>0.88</td>
<td>2.80</td>
<td>1.25</td>
<td>NS</td>
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<tr>
<td>Housing and Service Choice / Veteran-Centered Care</td>
<td>12</td>
<td>2.96</td>
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<td>3.06</td>
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<td>4.22</td>
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<tr>
<td>Admission Requirements</td>
<td>9</td>
<td>3.72</td>
<td>0.51</td>
<td>3.75</td>
<td>0.75</td>
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</tr>
<tr>
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<td>6</td>
<td>3.48</td>
<td>0.71</td>
<td>3.92</td>
<td>0.71</td>
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<tr>
<td>Rules for Tenure in Housing</td>
<td>12</td>
<td>2.26</td>
<td>0.45</td>
<td>3.89</td>
<td>1.09</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>2.08</td>
<td>0.48</td>
<td>3.97</td>
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<tr>
<td>Organizational Climate</td>
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<td>0.85</td>
<td>2.49</td>
<td>1.16</td>
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<tr>
<td></td>
<td>6</td>
<td>2.80</td>
<td>1.20</td>
<td>2.14</td>
<td>1.34</td>
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<tr>
<td>Recovery Orientation</td>
<td>10</td>
<td>3.18</td>
<td>0.58</td>
<td>3.71</td>
<td>0.66</td>
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<tr>
<td></td>
<td>8</td>
<td>3.02</td>
<td>0.63</td>
<td>3.85</td>
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<tr>
<td>Housing First Readiness</td>
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<td>0.28</td>
<td>3.66</td>
<td>0.42</td>
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<tr>
<td></td>
<td>46</td>
<td>3.02</td>
<td>0.27</td>
<td>3.73</td>
<td>0.40</td>
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<tr>
<td>Low Demand Environment</td>
<td>43</td>
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<td>0.34</td>
<td>3.51</td>
<td>0.45</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>31</td>
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<td>0.31</td>
<td>3.80</td>
<td>0.50</td>
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</table>

Another validity check was performed by comparing the HHSPM-V data to relevant information found in the VA’s administrative data from the Facility Survey. The same HHSPM-V data were used in these analyses as were used in the analyses that compared Veteran to staff responses. The facility Survey data examined were completed by program representatives in year 2009, although the HHSPM-V data were obtained in 2011. Despite this temporal lag,
Simple correlations were performed to explore the correspondence between the HHSPM-V and Facility Survey. As an initial step, individual items from the HHSPM-V were mapped onto items included on the Facility Survey. Table 10 summarizes results from two-tailed correlations comparing the data sources; only HHSPM-V items related to the Facility Survey were included in these analyses.

Table 10. HHSPM-V and Facility Survey Data Comparisons.

<table>
<thead>
<tr>
<th>HHSPM-V Items</th>
<th>Facility Survey Items</th>
<th>Correlations</th>
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<td>Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.13 FAMILY / GENDER-SPECIFIC</td>
<td>V11: family counseling</td>
<td>.500</td>
<td>.050</td>
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<tr>
<td></td>
<td>V21: child care</td>
<td>NA¹</td>
<td>NA¹</td>
</tr>
<tr>
<td></td>
<td>V22: domestic violence</td>
<td>.500</td>
<td>.050</td>
</tr>
<tr>
<td>A.16 RURAL - URBAN</td>
<td>III1: where is building located</td>
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<td>NA²</td>
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<tr>
<td>A.17 TRAUMA-INFORMED</td>
<td>V22: domestic violence service</td>
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<td>V2: legal services</td>
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<td>NA²</td>
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<td></td>
<td>V3: vocational services</td>
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<td>.961</td>
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<tr>
<td></td>
<td>V5: AIDS services</td>
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</tr>
<tr>
<td></td>
<td>V6: money management services</td>
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<tr>
<td></td>
<td>V7: rep payee services</td>
<td>NA²</td>
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<tr>
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<td>V10: MH assessment</td>
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<td>V11: family counseling</td>
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<td></td>
<td>V12: group therapy</td>
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<td>V13: individual therapy</td>
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<td>V15: aftercare</td>
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<td>V20: case management</td>
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<td>B.16 SUBSTANCE ABUSE SERVICES</td>
<td>V9: SA assessment</td>
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<td>V14: relapse prevention</td>
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<td>V15: aftercare</td>
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<td>V16: assistance obtaining social</td>
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<td>V8: transportation</td>
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<td>IV1: asked to leave if used alcohol</td>
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<td></td>
<td>IV2: asked to leave if used drugs</td>
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<td>B.27 CO-OCCURRING CAPABLE</td>
<td>III17: admission criteria</td>
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<td>IV1: asked to leave if used alcohol</td>
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<td>IV2: asked to leave if used drugs</td>
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<td>NA²</td>
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<td>B.31 ASSISTANCE IN OBTAINING HOUSING</td>
<td>V18: housing assistance</td>
<td>.676</td>
<td>.629</td>
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<td>C.5 SPEED OF ENTRY</td>
<td>V18: housing assistance</td>
<td>.866</td>
<td>.818</td>
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<td>HHSPM-V Items</td>
<td>Facility Survey Items</td>
<td>Correlations</td>
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<td>-----------------------------------------------------------</td>
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<td>III2: admission criteria mental confusion</td>
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<td>III3: admission criteria paranoid delusions</td>
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<td>III5: admission criteria inability to make bed</td>
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<td>III6: admission criteria danger to self or others</td>
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<td>III7: admission criteria psych meds</td>
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<td>III9: admission criteria alcohol problems</td>
<td>NA²</td>
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<tr>
<td></td>
<td>III10: admission criteria drug problems</td>
<td>NA²</td>
<td>NA²</td>
</tr>
<tr>
<td></td>
<td>III11: admission criteria under influence</td>
<td>.500</td>
<td>.000</td>
</tr>
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<td></td>
<td>III12: admission criteria needs detox</td>
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<td>III13: admission criteria serious physical illness</td>
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<td>III14: admission criteria pending charges</td>
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<td>III15: admission criteria recently released from jail</td>
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<td>III16: admission criteria sobriety</td>
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<td>III17: admission criteria - exclusions</td>
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<td>NA²</td>
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<td>C.8 ADMISSION: EMPLOYMENT STATUS</td>
<td>III17 option 5: admission criteria exclude inability to work</td>
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<td>III13: admission criteria</td>
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<td>NA²</td>
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<td>III10: admission criteria drug problems</td>
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</tr>
<tr>
<td></td>
<td>III11: admission criteria under influence</td>
<td>.500</td>
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</tbody>
</table>
### Refining the measure

#### a. Domains

Once the items had all been scored and all results reviewed, the team developed non-overlapping domains; where as much as possible the items were grouped by logical conceptual rationales. This differs from the principal components analysis described elsewhere which was done empirically. All but three items were included in the following broad categories:

1. Correlation not computed due to missing data
2. Correlation not computed because one or more variables is a constant

<table>
<thead>
<tr>
<th>HHSPM-V Items</th>
<th>Facility Survey Items</th>
<th>Correlations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>III12: admission criteria needs detox</td>
<td>.500</td>
</tr>
<tr>
<td></td>
<td>III16: admission criteria sobriety</td>
<td>.500</td>
</tr>
<tr>
<td></td>
<td>III17: admission criteria</td>
<td>NA²</td>
</tr>
<tr>
<td>C.11 ADMISSION: MENTAL HEALTH TREATMENT AND MEDICATIONS</td>
<td>III11-8: admission criteria</td>
<td>NA²</td>
</tr>
<tr>
<td></td>
<td>III17 options 1 - 5: admission criteria - exclusions</td>
<td>NA²</td>
</tr>
<tr>
<td>C.14 ADMISSION: CRIMINAL BACKGROUND CHECKS</td>
<td>III14: admission criteria pending charges</td>
<td>-.655</td>
</tr>
<tr>
<td></td>
<td>III15: admission criteria recently released from jail</td>
<td>NA²</td>
</tr>
<tr>
<td></td>
<td>III17 option 4: admission criteria, exclude those exiting jail/prison</td>
<td>NA²</td>
</tr>
<tr>
<td>C.21 TENURE: SUBSTANCE ABUSE TREATMENT</td>
<td>IV1: asked to leave if use alcohol</td>
<td>NA²</td>
</tr>
<tr>
<td></td>
<td>IV2: asked to leave if use drugs</td>
<td>NA²</td>
</tr>
<tr>
<td>C.31 TENURE IN HOUSING - ALCOHOL</td>
<td>IV1: asked to leave if drink</td>
<td>NA²</td>
</tr>
<tr>
<td>C.32 TENURE IN HOUSING - DRUGS</td>
<td>IV2: asked to leave if use drugs</td>
<td>NA²</td>
</tr>
<tr>
<td>C.34 TENURE IN HOUSING – ALCOHOL USE</td>
<td>IV1: asked to leave if drink</td>
<td>NA²</td>
</tr>
<tr>
<td>C.35 TENURE IN HOUSING – DRUG USE</td>
<td>IV2: asked to leave if use drugs</td>
<td>NA²</td>
</tr>
<tr>
<td>C.36 ENFORCEMENT OF RULES</td>
<td>IV1-4: substance use policies</td>
<td>NA²</td>
</tr>
</tbody>
</table>
### Table 11. HHSPM-V Domains

| Community Domain | A.1  | HOUSING QUALITY: Neighborhood Condition: Housing available to Veterans is of a high quality
|                 | Neighborhood Conditions | Noise |
|                 | 1. Noise                | Crime |
|                 | 2. Crime                | Poor Upkeep |
|                 | 3. Poor Upkeep          | Shopping unavailable |
|                 | HOUSING QUALITY: Whether housing meets HUD’s Housing Quality Standards (HQS). |
|                 | A-2                     | HOUSING – Convenient Location: Close to VA to access medical services easily, close to other services Veteran needs or wants to access. |
|                 | A.5                     | UNEMPLOYMENT RATE: Low unemployment rates compared to national average. |
|                 | A.12                    | AVAILABILITY OF AFFORDABLE HOUSING: There is a wide range of affordable housing per capita. |
|                 | A.16                    | RURAL VS. URBAN: Describes a continuum from small rural town to urban community. |
|                 | A High Score on the Community Domain (↑) suggests strong community resources supporting the housing program. |
| Organizational Linkages | A.14 | RELATIONSHIP WITH COMMUNITY AGENCIES: Public Housing Authorities Criteria Includes:
|                 | 1. written agreements  | 2. frequent communications |
|                 | 3. specific contact person | 4. procedures that facilitate issuing vouchers in a timely manner |
|                 | (Applies also to GPD’s as may have relationships to help Veterans after leaving the facility) |
|                 | A.15                    | RELATIONSHIP WITH COMMUNITY AGENCIES: Continuum of Care Programs (CoC; Homeless Coalition) Includes:
|                 | 1. regular attendance at Coalition meetings | 2. assuming leadership roles |
|                 | 3. participating in planning and priority setting | 4. large # referrals from community |
|                 | A.18                    | RELATIONSHIP WITH VAMC: GPD provider or VA homeless programs staff works closely with the staff at the VAMC in support of the Veterans and services to the Veterans. For the GPD provider this includes relationships with the GPD liaison. |
|                 | E.10                    | PEER CULTURE/ TEAM ORIENTATION – HUD VASH: All staff that work with homeless Veterans meet together as a team, across services and divisions. |
### E.10 PEER CULTURE/ TEAM ORIENTATION – GPD:

All staff that work with homeless Veterans meet together as a team, may include GPD liaison.

A High Score on the Organizational Linkages Domain (↑) suggests the VA, providers, and the community work well together to support the program.

#### Strength and Quality of Services

| A.13 | FAMILY / GENDER-SPECIFIC ISSUES: Housing services designed with needs of women and families issues in mind. Has at least 5 gender/family relevant aspects, examples: 1. segregated housing 2. women only services 3. gender matching for case management 4. provisions for children, families 5. trauma specific and trauma-informed care 6. emphasis on safety including safe neighborhoods |
| A.17 | TRAUMA-INFORMED HOUSING AND SERVICES: Includes an emphasis on safety, trauma-informed care, and trauma specific services including PTSD. |
| B.4 | 24 HOUR STAFFING: Combines on site staffing and on call services. |
| B.9 | TIME UNLIMITED SERVICES: Program continues to offer services before housing and after housing is lost or transitional housing has ended. |
| B.10 | IN-VIVO SERVICES: Program works to monitor status, develop community living skills in vivo rather than in office. |
| B.11 | INTENSITY OF SERVICE: High total amount of service time as needed. |
| B.12 | FREQUENCY OF CONTACT: High number of service contacts as needed. For HUD VASH contact is between case-manager and Veteran, for GPD programs contact is between provider and Veteran. |
| B.25 | STRUCTURE: Environment offers regular programmed activities or structured daily routine. |
| B.26 | HARM REDUCTION: Philosophy of Services – Substance abuse treatment services are offered within a harm reduction model. |
| B.27 | CO-OCCURRING CAPABLE: Philosophy and techniques of services integrate mental health and substance use issues. |
| B.29 | MOTIVATIONAL INTERVIEWING (MI): Extent to which program staff are fully trained and use MI in all services including: 1. At least one training event 2. Regular booster trainings 3. Clinical supervision on use of MI 4. At least one MI expert on staff 5. Use of a fidelity instrument to monitor MI sessions |
| D.18 | VETERAN / STAFF RATIO: Refers to HUD VASH case managers caseloads OR number of Veterans per GPD provider direct service staff. |

High scores on the Strength and Quality of Services Domain (↑) suggest strong service delivery using best practices.

#### Number & Variety of Services
| B.6 | **CLINICAL SERVICES:** Program has responsibility for assisting Veterans in obtaining case management, psychiatric, counseling, medical and other treatment services. *Including crisis and hospitalization services.* |
| B.7 | **LEGAL SERVICES:** Program has responsibility for assisting Veterans in obtaining legal services such as child support and credit reconciliation. |
| B.16 | **SUBSTANCE ABUSE SERVICES:** Program provides full range of substance abuse services:  
1. Substance abuse specialist as staff  
2. Substance abuse group  
3. AA or peer run groups  
4. Substance abuse education |
| B.17 | **VOCATIONAL SERVICES:** Program has vocational specialist, pre-employment, supported employment, vocational assessment and job placement services or assists Veterans in obtaining such services. Includes educational services and computer classes. |
| B.19 | **DAILY LIVING SKILLS TRAINING AND COUNSELING:** Program provides services to develop skills necessary to maintain housing including  
1. budgeting  
2. financial management  
3. gathering household items  
4. cooking  
5. medication management |
| B.20 | **WORK WITH SUPPORT SYSTEM:** With or without Veteran present, program provides support and skills for Veteran’s support network - family, neighbors, friends, and employers. |
| B.21 | **ADVOCACY FOR ENTITLEMENTS:** Assist in obtaining eligible benefits including Veterans (VA), disability, social security and food stamps. |
| B.22 | **LANDLORD-TENANT RELATIONS:** Program assists in negotiating lease and problem-solving tenant issues. |
| B.24 | **TRANSPORTING TO APPOINTMENTS:** Provides or arranges transportation to variety of appointments or errands as needed. |
| B.31 | **ASSISTANCE IN OBTAINING HOUSING:** Program engages in at least five activities to assist Veteran in obtaining stable housing and moving into the housing, for example, driving with Veteran to find suitable housing, moving assistance, recruiting landlords, and completing housing authority paperwork for HUD VASH. |

High scores on the Number & Variety of Services Domain (↑) suggest a number of services are offered including a good range of psychosocial activities.

**Housing and Service Choice/ Veteran-Centered Care**

| C.2 | **HOUSING CHOICE:** Extent to which Veterans can wait for the unit of their choice without losing their eligibility. A reasonable waiting period is the allowed “search” time for the local Housing Choice/Section 8 voucher program (usually 60 120 days). |
| C.37 | **PETS ALLOWED** |
| C.38 | **HOUSING AFFORDABILITY:** Cost of housing and related services is based on Veteran’s income & does not take the majority of their income. |
### D.1 CONTROL OVER LIVING ENVIRONMENT:
Decisions regarding his/her living environment are made primarily by the Veteran, including:
1. Visitation
2. Unit access
3. Curfew
4. Use of disposable income
5. Use of food stamps

### D.2 PRIVACY:
Housing environment provides maximum privacy including exclusive use of a bedroom, bathroom, and kitchen.

### D.3 PRIVACY: Staff:
Extent to which tenants control staff entry into the unit.

### D.7 SERVICE CHOICE:
Supports and services are chosen, refused or modified by the Veteran.

### D.11 SERVICE OPTIONS: Flexibility:
Extent to which the program is able to meet changing needs and preferences of Veterans
1. Variety of options are available
2. Changes based on continuing assessment
3. Flexibility of type, location, intensity, and frequency

### D.14 VETERAN INVOLVEMENT:
Veterans are involved as members of the team providing services.

### D.20 Individualized Housing Plan:
Program has responsibility for helping Veterans develop an individualized housing plan that focuses on their housing stabilization.

### D.21 CHOICE OF LIVING ARRANGEMENTS: HOUSEMATES:
Veterans may choose who to live with including roommates, significant others, spouses, and children.

### Higher scores Housing and Service Choice/ Veteran-Centered Care Domain (↑)
suggest more choice in housing, living environment and services; and Veteran-centered care.

#### Admission Requirements

| C.5 | SPEED OF ENTRY: Veterans are able to move quickly into housing (This is even if the speed is affected by a lack of vouchers). |
| C.8 | ADMISSION: INCOME: Veterans are admitted regardless of income. |
| C.9 | ADMISSION: MEDICAL STATUS: Veterans are admitted regardless of medical status including HIV and disability status. |
| C.10 | ADMISSION: SUBSTANCE ABUSE TREATMENT: Veterans can enter housing without participating in or completing substance abuse treatment such as a GPD program or VA treatment - outpatient or inpatient program. |
| C.11 | ADMISSION: MENTAL HEALTH: Housing for Veterans with mental health issues is:
1. not based on whether the Veteran is compliant with taking their psychiatric medication
2. not based on whether the Veteran is compliant with mental health treatment
3. will include Veterans with diagnoses of serious mental illnesses |
<table>
<thead>
<tr>
<th></th>
<th>ADMISSION: CASE MANAGEMENT:</th>
<th>Veterans with case management needs can always be provided housing regardless of whether they enroll in case management.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4</td>
<td>ADMISSION: CRIMINAL BACKGROUND CHECKS:</td>
<td>Criminal history never affects admission regardless of nature of charges.</td>
</tr>
<tr>
<td>28</td>
<td>ADMISSIONS: ALCOHOL:</td>
<td>Veterans have no requirement to be clean and sober from alcohol to enter the program.</td>
</tr>
<tr>
<td>29</td>
<td>ADMISSIONS: DRUGS:</td>
<td>Veterans have no requirement to be clean and sober from illegal drugs or drugs not prescribed for the Veteran to enter the program.</td>
</tr>
<tr>
<td><strong>High score on the Admission Requirements Domain (↑)</strong> represents ease of admission, low demand, and fewer requirements to be admitted to housing or housing program.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rules for Tenure in Housing**

| C.17 | PERMANENCE: | Housing tenure is assumed to be permanent with no actual or expected time limits. Program has a no eviction policy. |
| C.19 | TENURE: INCOME/EMPLOYMENT STATUS: | Veterans are allowed to remain in housing regardless of income or employment. |
| C.21 | TENURE: SUBSTANCE ABUSE TREATMENT: | Veterans can remain in housing without participating in or completing substance abuse treatment such as a GPD program or VA treatment - outpatient or inpatient program. |
| C.22 | TENURE: MENTAL HEALTH TREATMENT: | Housing for Veterans is not contingent on: 1. medications or 2. compliance with mental health treatment 3. and will include Veterans with diagnoses of serious mental illnesses |
| C.23 | TENURE: CASE MANAGEMENT: | Veterans with case management needs can always be remain in housing regardless of whether they continue with case management. |
| C.25 | TENURE: | Arrests or convictions do not affect tenure |
| C.31 | TENURE IN HOUSING - ALCOHOL: | Clean and sober from alcohol. |
| C.32 | TENURE IN HOUSING - DRUGS: | Clean and sober from illegal drugs or drugs not prescribed for the Veteran. |
| C.33 | TENURE IN HOUSING - Violence: | Tolerance for violent behavior. |
| C.34 | TENURE IN HOUSING – ALCOHOL USE: | Alcohol allowed on premises. |
| C.35 | TENURE IN HOUSING – DRUG USE: | Illegal drugs or drugs not prescribed for the Veteran allowed on premises. |
| C.36 | ENFORCEMENT OF RULES: | This applies to any rules described in “tenure in housing”. |

**High score for the Rules for Tenure in Housing Domain (↑) represents low demand housing with few requirements to staying housed, fewer residential contingencies.**

**Organizational Climate**

| D.14 | VETERAN INVOLVEMENT: | Veterans are involved as members of the team providing services. |
| D.16 | RECOVERY ORIENTATION: | Staff attitudes towards Veterans indicate respect, mutual partnership, optimism about recovery. |
### Special Scales

#### a. Safe Havens

**Background.** Many of the Veterans Affairs (VA) traditional homeless programs require sobriety and compliance with treatment for admission and continued stay. These requirements leave many Veterans with chronic homelessness experiencing repeated treatment and housing failures with limited or no access to programs that can assist them in leaving the streets. There is significant demand for low-demand Safe Haven housing approaches that serve Veterans without the traditional sobriety and treatment requirements. The Safe Haven model does not require sobriety or full compliance with treatment for admission or continued stay in the program; a harm reduction approach is a critical ingredient of the Safe Haven model. Many individuals experiencing homelessness cannot be fully compliant with traditional requirements and consequently have repeated failures resulting in chronic homelessness. Safe Havens attempt to reverse that trend by continuously engaging the Veteran using state-of-the-art, evidence-based therapies, but do not discharge the Veteran for noncompliance. The primary focus of the Veteran’s care in a Safe Haven program is housing stability.

The U.S. Department of Veterans Affairs (VA) National Homeless Program Office funded four Safe Haven model development projects under the direction of the VA National Center on Homelessness among Veterans in July 2010. These Safe Havens provide street outreach and community-based residential services to hard-to-reach Veterans with mental illness and substance use problems who are experiencing homelessness. The small facilities provide a

<table>
<thead>
<tr>
<th>E.1</th>
<th>PROGRAM IS COMMITTED TO A RECOVERY ORIENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.2</td>
<td>ORGANIZATIONAL CLIMATE: Program is characterized by mutual trust and cooperation among staff.</td>
</tr>
<tr>
<td>E.3</td>
<td>ADMINISTRATIVE SUPPORT / DIRECTION: Level of support for clinicians and those working directly with Veterans – availability, ease of hiring to meet need.</td>
</tr>
<tr>
<td>E.14</td>
<td>SAFE ENVIRONMENT: Staff feel their work and what they are asked to do is in a safe environment.</td>
</tr>
<tr>
<td>E.18</td>
<td>PEER RUN PROGRAM: All staff that work with homeless Veterans are Veterans and many are homeless or formerly homeless Veterans.</td>
</tr>
<tr>
<td>E.20</td>
<td>Support for Flexible approach with Veterans: Includes some flexible funds.</td>
</tr>
</tbody>
</table>

High scores for the Organizational Climate Domain (↑) indicate a supportive and Veteran-involved organization climate.
A low-demand, non-intrusive environment designed to re-establish trust and re-engage the Veteran in treatment services and transitional and permanent housing options.

Although Safe Havens are a very important component in the continuum of care for individuals who are homeless, programs differ in the specific ways in which they implement the model. Results from a large-scale study of 79 Safe Havens across the United States indicate that there is significant program variability that includes differences in admission criteria, length of stay, staffing, rules and expectations, service offerings, program structure, funding, and effectiveness (Ward Family Foundation, 2005). These variations suggest a need for a tool to facilitate documenting the similarities and differences between Safe Havens. To that end, a Safe Haven Fidelity Tool was developed as part of the more comprehensive HHSPM-V. The Safe Haven Fidelity Tool includes items designed to: 1) document programs’ fidelity to the low-demand Safe Haven model of care, and 2) document similarities and differences between the Safe Haven programs. The tool includes the items on the Low Demand domain of the program measure.

This tool was used as a guide for conducting fidelity site visits at the programs established as part of the VA’s Safe Haven model development project. These visits were intended to monitor and document the specific ways in which the programs implemented the Safe Haven’s low-demand environment.

Methods. Fidelity visits were conducted at VA Safe Havens approximately six months after they began operating in order to allow a reasonable start-up period. Each site visit was conducted by two staff members affiliated with the National Center on Homelessness among Veterans at University of South Florida, and the Safe Haven Fidelity Tool was used to guide these visits.

Four types of activities were used during each fidelity visit, including: 1) conducting interviews with VA and Safe Haven staff, 2) touring the facilities, 3) reviewing program materials, and 4) observing program activities. To the extent possible, all four activities were used to inform responses to each item on the Safe Haven Fidelity Tool. For instance, responses to the fidelity tool item concerning the degree of program “Structure” relied on: 1) input from staff interviews, 2) touring the facility to look for a posted daily or weekly schedule, 3) reviewing a copy of the program’s daily or weekly schedule, and 4) observing routine program activities, if available.

Results from each fidelity visit are organized into the following five categories: 1) aspects of the physical facility, 2) program staffing, 3) approach to substance use, 4) services, and 5) program rules. Table 12 below shows which fidelity review activities were used to inform each category of results.
### Table 12. Areas Examined and Activities Used in the Safe Haven Fidelity Site Visits

<table>
<thead>
<tr>
<th>Fidelity Category</th>
<th>Activities Used to Inform Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Facility</td>
<td>-Facility tour</td>
</tr>
<tr>
<td>Program Staffing</td>
<td>-Staff interviews</td>
</tr>
<tr>
<td></td>
<td>-Program materials</td>
</tr>
<tr>
<td>Approach to Substance Use</td>
<td>-Staff interviews</td>
</tr>
<tr>
<td></td>
<td>-Facility tour</td>
</tr>
<tr>
<td></td>
<td>-Program materials</td>
</tr>
<tr>
<td></td>
<td>-Observation of program activities</td>
</tr>
<tr>
<td>Services</td>
<td>-Staff interviews</td>
</tr>
<tr>
<td></td>
<td>-Program materials</td>
</tr>
<tr>
<td></td>
<td>-Observation of program activities</td>
</tr>
<tr>
<td>Program Rules</td>
<td>-Staff interviews</td>
</tr>
<tr>
<td></td>
<td>-Facility tour</td>
</tr>
<tr>
<td></td>
<td>-Program materials</td>
</tr>
</tbody>
</table>

### b. Housing First

As with Safe Havens, the VA is moving to a low demand model for permanent housing for homeless Veterans with serious mental health and substance use problems. The Housing First model moves homeless participants from the streets immediately into permanent housing. With stable and supportive treatment services, program participants are better able to focus on the core mental and physical issues that led them to homelessness. Housing First can be contrasted with a continuum of housing "readiness," which typically subordinates access to permanent housing to other requirements.

This transition is being accomplished in two ways; one is by allocating new funds for programs explicitly based on a Housing First model. The second is by considering the transition of existing HUD VASH vouchers to a Housing First model. In order to acknowledge and accompany this direction for the Center, the team identified items consistent with a Housing First Model. As mentioned earlier, in the original development of the measure the team had reviewed a draft fidelity measure of Housing First by Tsemberis. It has now been published (Tsemberis, 2010) and the selected items were chosen for their fit with his conceptual framework as well as items in his measure. The resulting items are included as Appendix 2.
c. Recovery-Oriented Services

The Veterans Administration identified recovery-oriented services as a critical program feature in the program handbook Uniform Mental Health Services in VA Medical Centers and Clinics (VHA Handbook 1160.01, 2008). The handbook’s focus is consistent with findings from the report of President Bush’s New Freedom Commission that identified recovery from mental illness as the central paradigm for developing new national policy and for guiding the development of recovery-oriented practices in mental health programs (New Freedom Commission on Mental Health, 2003).

The Housing and Housing Services Program Measure – Veteran’s version (HHSPM-V) was reviewed to ensure that a recovery-orientation is reflected in each of the 5 primary domains: Community, Services, Access, Relationship, and Organization. Items reflecting a recovery orientation were identified. Items were also added and revised to more accurately reflect a recovery orientation. Two instruments were used as a comparison in the review process:

- The Recovery Oriented Systems Indicator measure (ROSI) is a consumer outcome measure that was developed as part of a collaborative effort among a number of State Mental Health Authorities, national organizations, consumer survivor leaders, and mental health recovery researchers entitled “Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators”. It provides a core set of system-level indicators that measure the critical elements and processes of recovery-oriented services in mental health programs and delivery systems (Onken, et. al., 2004; Dumont, et. al., 2006).
- The Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) Version 2.0 is a mental health service provider agency measure developed under contract to Florida’s Medicaid authority and tested as part of a state wide pilot study (Winarski et. al., 2011). The SAPT was designed to provide a measure for recovery services capability and supports outcomes described in the Recovery Oriented Systems Indicators Measure (ROSI).

Ten subscales for recovery-oriented services were identified within the housing measure, including items A.11, B.10, C.2, D.7, D.11, D.14, D.16, D.20, E.1 (new), and E.18. The housing measure, with recovery sub-scales, was piloted at HUD VASH and GPD program sites. The pilot interviews informed the refinement of interview anchors.
6. Using the measure for management and administration of the VA Housing portfolio

a. Sites reviewed

Measures were completed at GPD programs and VAMCs by PHA in the following areas:

<table>
<thead>
<tr>
<th>Number of VAMC’s</th>
<th>Two major metropolitan area VAMCs located in the south eastern United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>− 2</td>
<td>Site 1 (study 1) Site 2 (study 2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HUD VASH (by PHA)</th>
<th>To capture the variability in HUD VASH programs, the team attempted to measure different programs if they were under different Public Housing Authorities (PHA). Site 1 - 6 (2 PHA’s) Site 2 - 3 (3 PHA’s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>GPD’s</th>
<th>Site 1 - 4 Site 2 - 6</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Total number of interviews</th>
<th>Numbers will include liaisons, providers, case managers, supervisors, and Veterans: Site 1 - 25 Site 2 - 33 Total - 58</th>
</tr>
</thead>
</table>

| Total number of measures completed | 14 |

b. Profiles of sites and programs

Although the measure developed over time we were able to use consensus and available information to score programs from all of the programs visited. What follows are the results, in graphic form of our application of the measure to each program, summarized by the domains we determined. We start with a summary of the domains for aid in interpreting the graphs. Please note the scores are connected by a line for ease of comparison and should not be understood that the data is continuous, it is all categorical.
<table>
<thead>
<tr>
<th>Domain</th>
<th>A High Score suggests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Strong community resources supporting the housing program</td>
</tr>
<tr>
<td>Organizational Linkages</td>
<td>VA, providers, and the community work well together to support the program</td>
</tr>
<tr>
<td>Strength and Quality of Services</td>
<td>Strong service delivery using best practices</td>
</tr>
<tr>
<td>Number &amp; Variety of Services</td>
<td>A number of services are offered including a good range of psychosocial activities</td>
</tr>
<tr>
<td>Housing and Service Choice/Veteran-Centered Care</td>
<td>More choice in housing, living environment and services; Veteran-centered care</td>
</tr>
<tr>
<td>Admission Requirements</td>
<td>Ease of admission, low demand, fewer requirements to be admitted to housing or housing program</td>
</tr>
<tr>
<td>Rules for Tenure in Housing</td>
<td>Low demand housing with few requirements to staying housed, fewer residential contingencies</td>
</tr>
<tr>
<td>Organizational Climate</td>
<td>A supportive and Veteran-involved organization climate</td>
</tr>
</tbody>
</table>
Site 2 (HUD VASH & GPD)
Developing A Typology Of Sites And Programs

After reviewing the results of our application of measure to the sites reviewed, various typologies were considered. Two particular continuums stood out, the level of demand involved in getting and keeping housing for the Veterans, and the amount and quality of services available. As a result, the following typology was developed:

<table>
<thead>
<tr>
<th>Services</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Demand Housing</td>
<td>Both HUD-VASH and at least one GPD could be characterized in this category</td>
<td>Only HUD VASH programs were found in this category</td>
</tr>
<tr>
<td>High Demand Housing</td>
<td>The majority of GPD programs were found to be in this category</td>
<td>This was the second most common category for GPD programs</td>
</tr>
</tbody>
</table>

This classification was applied to selected sites but included an arbitrary cut-off point. Further work can be done to both define the categories and decided on appropriate categories.

Next Steps

There are a number of directions to be pursued following the extensive work done in this series of studies. One includes the further development of the measure to refine and increase its validity and usefulness by:

- Refining the questions used to elicit the information on each item. The results of the reliability study suggest that those items that are more concretely assessed have higher inter-rater reliability and leave less room for error.
- Eliminating items that do not have high validity or reliability or that do not appear to measure the relevant domains as consistently as others and may be unnecessary. This culling can be strengthened by the use of principal components analysis which also contributes to our understanding of which items contribute to the relevant domains.

There is a great deal of work that can still be done on the development of typologies. The one described here is based on services and level of demand of housing. This work would include:

- Refining the cutoffs for classification in each category. For example, the classification described above does not have a middle category. Mid-range scores could be left out or another level of each category could be added.
- Understanding the needs of a particular group of Veterans, for example, women Veterans and developing appropriate typologies for those groups.
- Similarly, the groupings could be based on current policy or practice issues in the VA or nationally.
The measure developed has already proven helpful in informing important policy decisions, such as the possible conversion of GPD’s to Safe Havens. As the VA moves toward a policy of low demand housing, they are also moving towards a policy of Housing First for their permanent housing programs such as HUD VASH. This measure can also be used to determine various HUD VASH programs readiness to become Housing First programs.

Finally the primary purpose of this series of studies was to better understand the dimensions of the housing programs and then use these descriptions to see which programs work best for which people. Of great interest to the National Center and those committed to ending homelessness for Veterans would include using existing data (NEPEC or HOMES, for example) and determining how Veterans outcomes are affected by various domains in the measures and if this differs based on Veteran characteristics such as mental health status, substance use disorders, or histories of homelessness.
References


Appendix 1.

Housing and Housing Services Program Measure – Veterans Version (HHSPM-V)

Program Type: __________ VISN: ____ VAMC: ____ Interviewer(s):________________________ Date: _______

RATINGS/ANCHORS

<table>
<thead>
<tr>
<th>Item #</th>
<th>Criterion</th>
<th>Ratings / Anchors</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A.2</td>
<td>HOUSING QUALITY</td>
<td>Housing does not meet HQS.</td>
<td>25 percent of units meet HQS.</td>
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<tr>
<td></td>
<td></td>
<td>For GPD, 40 miles or more to VAMC</td>
<td>For GPD, 30 or more miles, but less than 40 miles to VAMC</td>
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<tr>
<td></td>
<td></td>
<td>For HUD VASH average of 1 for satisfactions for convenience</td>
<td>For HUD VASH average of 2 for satisfactions for convenience</td>
</tr>
<tr>
<td>A.5</td>
<td>HOUSING – Convenient Location – close to VA to access medical services easily, close to other services Veteran needs or wants to access</td>
<td>Unemployment rates for area that are 10.6 and higher</td>
<td>Unemployment rates for area that are 9.1 through 10.5</td>
</tr>
<tr>
<td>A.6</td>
<td>UNEMPLOYMENT RATE</td>
<td>People live in settings where 80% or more of the tenants meet disability-related eligibility criteria</td>
<td>People live in housing units where 60-79% of the total number of units has been set aside for people meeting disability-related eligibility criteria</td>
</tr>
<tr>
<td>A.11</td>
<td>INTEGRATION WITH COMMUNITY: The extent to which an individual’s housing unit is clustered with housing units occupied by people with disabilities vs. scattered throughout the community expressed as percent (%) of units set aside for people with special needs groups including people who are homeless</td>
<td>People live in housing units where 60-79% of the total number of units has been set aside for people meeting disability-related eligibility criteria</td>
<td>People live in housing units where 40-59% of the total number of units has been set aside for people meeting disability-related eligibility criteria</td>
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<tr>
<td>A.13</td>
<td>FAMILY / GENDER-SPECIFIC ISSUES: Housing and services designed with needs of women and families issues in mind. Has at least 5 gender/family relevant aspects, examples: 1. segregated housing 2. women only services 3. gender matching for case management 4. provisions for children, families 5. trauma specific and trauma-informed care 6. emphasis on safety including safe neighborhoods</td>
<td>Rating 1: No gender specific provisions at all.  Rating 2: Has one gender specific provision  Rating 3: Has two gender specific provisions  Rating 4: Has three to four gender specific provisions  Rating 5: Has five to six gender specific provisions</td>
<td></td>
</tr>
<tr>
<td>A.14</td>
<td>RELATIONSHIP WITH COMMUNITY AGENCIES: Public Housing Authorities Criteria: Includes 1. written agreements, 2. frequent communications, 3. specific contact person, 4. procedures that facilitate issuing vouchers in a timely manner (Applies also to GPD’s as may have relationships to help Veterans after leaving the facility)</td>
<td>Rating 1: Weak relationship with PHA with none of the criteria met  Rating 2: One of the criteria  Rating 3: Two of the criteria  Rating 4: Three of the criteria  Rating 5: Strong relationship between the Public Housing Authority and VA staff. Includes written agreements, frequent communications, specific contact person, procedures that facilitate issuing vouchers in a timely manner</td>
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<td>Item #</td>
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<tr>
<td>A.15</td>
<td>RELATIONSHIP WITH COMMUNITY AGENCIES: Continuum of Care Programs (CoC; Homeless Coalition) Includes 1. regular attendance at Coalition meetings, 2. assuming leadership roles, 3. participating in planning and priority setting, 4. large # referrals from community</td>
<td>Weak relationship with Community Agencies, Continuum of Care Programs (CoC; Homeless Coalition)</td>
<td>One of the criteria</td>
</tr>
<tr>
<td>A.16</td>
<td>Rural vs. Urban – Describes a continuum from small rural town to urban community</td>
<td>Isolated small rural town</td>
<td>Rural town</td>
</tr>
<tr>
<td>A.17</td>
<td>TRAUMA-INFORMED HOUSING AND SERVICES – Includes an emphasis on safety, trauma-informed care, and trauma specific services including PTSD</td>
<td>No indication of awareness of trauma issues</td>
<td>Emphasis on safety with some trauma informed care, no trauma specific programs</td>
</tr>
<tr>
<td>A.18</td>
<td>RELATIONSHIP WITH VAMC: The GPD provider or VA homeless programs staff works closely with the staff at the VAMC in support of the Veterans and services to the Veterans For the GPD provider this includes relationships with the GPD liaison</td>
<td>Very infrequent communication with VAMC, low level of support</td>
<td>Good communication on medical records level, otherwise little communication or support</td>
</tr>
<tr>
<td>A.1</td>
<td>HOUSING QUALITY: Neighborhood Condition Housing available to Veterans is of a high quality Neighborhood Conditions 5. Noise 6. Crime 7. Poor Upkeep 8. Shopping unavailable</td>
<td>Poor quality in all four neighborhood conditions</td>
<td>Poor quality in three of four neighborhood conditions</td>
</tr>
<tr>
<td>Item #</td>
<td>Criterion</td>
<td>Ratings / Anchors</td>
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<tr>
<td>A-12</td>
<td>AVAILABILITY OF AFFORDABLE HOUSING: There is a wide range of affordable housing per capita</td>
<td>1</td>
<td>2</td>
</tr>
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</table>

**B. SERVICES**  
(Services, Programs, & Linkages: Characteristics & Quantities, Each Type)

<p>| B.4 | 24 HOUR STAFFING | This combines on site staffing and on call services | Program staff are based on site and no on call services after business hours. | Program staff are based on site during business hours but are never on call OR staff are not on site but are on call 24/7 | Program staff is based on site during business hours and are on call 24/7. | Program staff are based on site during business hours and on weekends and are on call 24/7 | Program staff are based on site 24/7 |
| B.6 | CLINICAL SERVICES: program has responsibility for assisting Veterans in obtaining case management, psychiatric, counseling, medical and other treatment services. Including crisis and hospitalization services | Program does not assist Veterans in obtaining clinical services | Program assists Veterans in obtaining case management services only | Program assists Veterans in obtaining case management and counseling services | Program assists Veterans in obtaining all counseling and psychiatric services | Program assists Veterans in obtaining psychological, psychiatric, medical and other services |
| B.7 | LEGAL SERVICES: program has responsibility for assisting Veterans in obtaining legal services such as child support and credit reconciliation | Program is never responsible for any legal services | Program is not typically responsible for any legal services, although Veterans are sometimes referred to at least one legal resource | Program assists Veterans in obtaining legal services when needed, although there is not a list of legal staff who are willing to work with Veterans | Program assist Veterans in obtaining all legal services, and the program maintains a list of legal staff that are willing to work with Veterans. | Program assists Veterans in obtaining all legal services, with legal staff occasionally presenting to program staff and/or Veterans about their available services |
| B.9 | TIME UNLIMITED SERVICES: program continues to offer services before housing and after housing is lost or transitional housing has ended. | Program offers services only while Veteran is housed with that program. | Veterans are discharged from services if they lose housing but may be readmitted if they complete certain criteria, such as detox treatment or inpatient treatment | Veterans continue to receive services during housing loss but may be discharged for not meeting “housing readiness” or other progress criteria. | Veterans continue to receive services during housing loss but they are provided by a different agency or group. Services may have a brief hiatus during institutional stays. | Veterans continue to receive program services even during housing loss due to eviction, short-term inpatient treatment or other absences. |
| B.10 | IN-VIVO SERVICES: program works to monitor status, develop community living skills in vivo rather than in office. | Less than 20% in time in community. | 20 - 39% | 40 - 59% | 60 - 79% | 80% of total service time is in the Veteran’s home or in the community |
| B.11 | INTENSITY OF SERVICE: high total amount of service time as needed. | Average of less than 15 minutes/month or less per Veteran. | 15 - 49 minutes/month | 50 - 84 minutes/month. | 85 - 119 minutes/month. | Average of 2 hours, month or more per Veteran. |</p>
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<tr>
<td>B.12</td>
<td>FREQUENCY OF CONTACT: high number of service contacts as needed. For HUD VASH contact is between case-manager and Veteran, for GPD programs contact is between provider and Veteran.</td>
<td>1. No regular contact on a monthly basis. May contact sporadically but no minimum or regular schedule of contact. 2. Average of regularly contacting Veteran 1 contact or less a month 3. Average of regularly contacting Veteran 2 times a month or less 4. Average of regularly contacting Veteran once a week. 5. Average of regularly contacting Veteran 2 or more times a week.</td>
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</tr>
<tr>
<td>B.16</td>
<td>SUBSTANCE ABUSE SERVICES: program provides full range of substance abuse services: 5. Substance abuse specialist as staff 6. Substance abuse group 7. AA or peer run groups 8. Substance abuse education</td>
<td>Program provides no substance abuse services, refers externally. Program provides one substance abuse service Program provides two substance abuse services Program provides 3 substance abuse services Program provides full range of substance abuse services (4).</td>
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</tr>
<tr>
<td>B.17</td>
<td>VOCATIONAL SERVICES: program has vocational specialist, pre-employment, supported employment, vocational assessment and job placement services or assists Veterans in obtaining such services. Includes educational services and computer classes</td>
<td>Program neither provides nor assists Veterans in obtaining vocational/educational services. Program does not provide vocational/educational services, only links Veterans to external sources Program offers one vocational/educational service and links Veterans to external sources for all other services Program offers multiple vocational/educational services and links Veterans to external sources for all other services Program provides full range of vocational/educational services including computer classes and has vocational specialists as employees.</td>
<td></td>
</tr>
<tr>
<td>B.19</td>
<td>DAILY LIVING SKILLS TRAINING AND COUNSELING: program provides services to develop skills necessary to maintain housing including 6. budgeting, 7. financial management, 8. gathering household items, 9. cooking, 10. medication management</td>
<td>Program provides no housing related services and does not regularly refer for such services Program provides no housing related services but does regularly refer for such services Provides classes or instruction in one area of daily living skills Provides classes or instruction in two or three areas of daily living skills Provides classes or instruction in four or more areas of daily living skills</td>
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<td>Item #</td>
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<tr>
<td>B.20</td>
<td>WORK WITH SUPPORT SYSTEM: with or without Veteran present, program provides support and skills for Veteran’s support network - family, neighbors, friends, and employers. Work on metric</td>
<td><strong>Ratings</strong> / <strong>Anchors</strong></td>
<td><strong>Rating</strong></td>
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<td></td>
<td>Less than .5 contacts per month per Veteran with support system.</td>
<td></td>
<td>Four or more contacts per month per Veteran with support system in the community.</td>
</tr>
<tr>
<td>B.21</td>
<td>ADVOCACY FOR ENTITLEMENTS: assist in obtaining eligible benefits including Veterans, disability, social security and food stamps</td>
<td>Program does not assist Veterans in obtaining benefits</td>
<td>Program is active in helping Veterans obtain benefits in three or more of the identified areas</td>
</tr>
<tr>
<td>B.22</td>
<td>LANDLORD-TENANT RELATIONS: program assists in negotiating lease and problem-solving tenant issues.</td>
<td></td>
<td>Program staff assists fully in negotiating and problem-solving landlord - tenant relations.</td>
</tr>
<tr>
<td>B.24</td>
<td>TRANSPORTING TO APPOINTMENTS: provides or arranges transportation to variety of appointments or errands as needed.</td>
<td>No transportation assistance is provided</td>
<td>Routinely provides or arranges transportation to variety of appointments or other errands as regular service, with minimal advance notice needed.</td>
</tr>
<tr>
<td>B.25</td>
<td>STRUCTURE: environment offers regular programmed activities or structured daily routine.</td>
<td>Little or no structured activity or routine</td>
<td>Regular programmed activities are offered within a harm reduction model.</td>
</tr>
<tr>
<td>B.26</td>
<td>HARM REDUCTION Philosophy of Services – Substance abuse treatment services are offered within a harm reduction model.</td>
<td>Abstinence is the only goal of substance abuse services and the only goal presented to Veterans</td>
<td>Veterans receiving substance abuse services set the goals in their lives and services are aimed at achieving those goals which may include but not necessarily include abstinence from substances.</td>
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</table>

**Notes:**
- B.20 Work on metric: Less than .5 contacts per month per Veteran with support system.
- B.21 Advocacy for Entitlements: Program does not assist Veterans in obtaining benefits. Program informally helps Veterans obtain benefits in one or more areas. Program is active in helping Veterans obtain benefits in one of the identified areas. Program is active in helping Veterans obtain benefits in two of the identified areas. Program is active in helping Veterans obtain benefits in three or more of the identified areas.
- B.22 Landlord-Tenant Relations: Program staff is not involved in landlord - tenant relations at all. Program staff is seldom involved in landlord - tenant relations. Program staff occasionally works with landlords in tenant relations. Program staff often works with landlords in tenant relations.
- B.24 Transporting to Appointments: Information on transportation provided (e.g., bus maps and schedules). Bus tokens or passes provided, no direct services. Occasionally provides or arranges transportation to variety of appointments or other errands, but this must be scheduled days in advance. Routinely provides or arranges transportation to variety of appointments or other errands as regular service, with minimal advance notice needed.
- B.25 Structure: Little or no structured activity or routine. Some structured weekly activity and routine, although there is no regularly maintained schedule of such events. Some structured daily activity and routine, and there is a regularly maintained list schedule of these activities. Regular programmed activities are offered, and a daily schedule of such activities is available.
- B.26 Harm Reduction: Abstinence is the only goal of substance abuse services and the only goal presented to Veterans. Abstinence is the predominant goal of substance abuse services, but steps to abstinence are presented and rewarded - abstinence encouraged. Abstinence is a common though not predominant goal of substance abuse services, and steps to abstinence are presented and rewarded. Veterans receiving substance abuse services set the goals in their lives and services are aimed at achieving those goals which may include but not necessarily include abstinence from substances.
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<th>Ratings / Anchors</th>
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<tr>
<td>B.27</td>
<td>CO-OCURRING CAPABLE: Philosophy and techniques of services integrate mental health and substance use issues</td>
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<td></td>
<td>Services are offered for one area only – i.e. SA or MH</td>
<td>Services are offered for primarily for one area only – i.e. SA or MH but referrals are offered in the other area (e.g. referring to AA groups, dual diagnosis groups or to a psychiatrist)</td>
<td>Services are offered for primarily for one area only – i.e. SA or MH but one or two services are offered in the other area or in the area of dual diagnosis (e.g. special training or dual diagnosis groups or the services of a psychiatrist)</td>
</tr>
<tr>
<td>B.29</td>
<td>MOTIVATIONAL INTERVIEWING (MI). Extent to which program staff are fully trained and use MI in all services including: 1. At least one training event 2. Regular booster trainings 3. Clinical supervision on use of MI 4. At least one MI expert on staff 5. Use of a fidelity instrument to monitor MI sessions</td>
<td>Program staff are not at all familiar with motivational interviewing</td>
<td>Program includes at least one of the events/occurrences listed by at least one staff.</td>
</tr>
<tr>
<td>B.31</td>
<td>ASSISTANCE IN OBTAINING HOUSING. Program engages in at least five activities to assist Veteran in obtaining stable housing and moving into the housing, for example, driving with Veteran to find suitable housing, moving assistance, recruiting landlords, completing housing authority paperwork for HUD VASH</td>
<td>Program does not offer assistance in obtaining permanent housing</td>
<td>Program offers one or two services toward obtaining and moving into permanent housing</td>
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<tr>
<td>C. ACCESS (Access to Housing / Admission Criteria / Conditions for Tenure)</td>
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<tr>
<td>C.2</td>
<td>HOUSING CHOICE: Extent to which Veterans can wait for the unit of their choice without losing their eligibility. A reasonable waiting period is the allowed “search” time for the local Housing Choice/Section 8 voucher program (usually 60-120 days)</td>
<td>Veterans must accept the unit offered or not be involved with the program. Veterans must accept the unit offered and no waiting for units is allowed. Prospective Veterans who refuse one unit offered can still be involved with the program but they lose priority for units. Veterans can wait for the unit of their choice, but they are allowed a set number of choices before they lose priority for units. Veterans can wait for the unit of their choice without losing priority but still must find suitable housing within a reasonable time, for example the length of time before the HUD Voucher expires.</td>
<td>Veterans can wait a reasonable time for the unit of their choice without risk of discharge from the program or losing priority for services or units.</td>
</tr>
<tr>
<td>C.5</td>
<td>SPEED OF ENTRY: Veterans are able to move quickly into housing (This is even if the speed is affected by a lack of vouchers)</td>
<td>Veterans have to wait over four months to move into housing. Veterans are able to move into housing in more than 90 days but less than 120 days from admission to services. Veterans are able to move into housing in more than 60 days but less than 90 days from admission to services. Veterans are able to move into housing in more than 30 days but less than 60 days from admission to services. Veterans are able to move into housing in more than 30 days or less from admission to services.</td>
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<tr>
<td>C.7</td>
<td>EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.</td>
<td>Program has no set criteria and takes all types of Veterans. Program has a generally defined mission but the admission process is dominated by organizational convenience, pressures from referral sources or the need to fill beds for example. The program makes an effort to seek and select a defined set of Veterans but accepts most referrals and/or does not have careful screening. Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure, pressures from referral sources or the need to fill beds for example.</td>
<td>The program actively recruits a defined population and all cases comply with explicit admission criteria.</td>
</tr>
<tr>
<td>C.8</td>
<td>ADMISSION: Income Veterans are admitted regardless of income</td>
<td>Veteran must always have some income to be eligible for housing. Veteran income often affects eligibility for housing. Veteran income sometimes affects eligibility for housing. Veteran income rarely affects eligibility for housing. Veteran income never affects eligibility for housing.</td>
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</tr>
<tr>
<td>C.9</td>
<td>ADMISSION: MEDICAL STATUS Veterans are admitted regardless of medical status including HIV and disability status</td>
<td>Veterans with medical problems are never provided housing. Veterans with medical problems are rarely provided housing regardless of medical status. Veterans with medical problems are sometimes provided housing regardless of medical status. Veterans with medical problems are often provided housing regardless of medical status. Veterans with medical problems can always be provided housing regardless of medical status.</td>
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<tr>
<td>C.10</td>
<td>ADMISSION: SUBSTANCE ABUSE TREATMENT Veterans can enter housing without participating in or completing substance abuse treatment such as a GPD program or VA treatment - outpatient or inpatient program</td>
<td>Veterans with substance abuse issues are never provided housing unless they have participated in or completed some type of substance abuse treatment (0% of the time). Veterans with substance abuse issues are rarely provided housing unless they have participated in or completed some type of substance abuse treatment (1%-33% of the time). Veterans with substance abuse issues are sometimes provided housing only if they have participated in or completed some type of substance abuse treatment (34%-65% of the time). Veterans with substance abuse issues are often provided housing without having participated in or completed some type of substance abuse treatment (66%-99% of the time). Veterans with substance abuse issues can always be provided housing regardless of whether they participated in or completed some type of substance abuse treatment (100% of the time).</td>
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</table>
| C.11  | **ADMISSION: MENTAL HEALTH** Housing for Veterans with mental health issues is:  
1. not based on whether the Veteran is compliant with their psychiatric medication  
2. not based on whether the Veteran is compliant with mental health treatment  
3. will include Veterans with diagnoses of serious mental illnesses  
Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia are not eligible  
Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia may not be eligible. Occasional exceptions are made  
Housing for Veterans is contingent on two of the three issues listed in the description.  
Housing for Veterans is contingent on one of the three issues listed in the description.  
Housing for Veterans is not contingent on compliance with mental health treatment including medications and is regardless of diagnosis. | **1** | **2** | **3** | **4** | **5** |
| C.12  | **ADMISSION: CASE MANAGEMENT** Veterans with case management needs *can always be* provided housing regardless of whether they enroll in case management  
Veterans with case management needs are never provided housing unless they are enrolled in case management (0% of the time)  
Veterans with case management needs are sometimes provided housing only if they are enrolled in case management (34%-65% of the time)  
Veterans with case management needs are often provided housing without having to enroll in case management (66%-99% of the time)  
Veterans with case management needs can always be provided housing regardless of whether they enroll in case management (100% of the time) | **1** | **2** | **3** | **4** | **5** |
| C.14  | **ADMISSION: CRIMINAL BACKGROUND CHECKS** Criminal history never affects admission regardless of nature of charges  
Veterans with any criminal history are never eligible for services  
Veteran with criminal history are rarely eligible for services, for example not with felony convictions are never  
Veteran with criminal history are sometimes eligible for services, for example not if convicted of a violent offense  
Veteran with criminal history are often eligible for services, for example they are only not eligible if convicted of a sexual offense or producing methamphetamines within public housing are never | **1** | **2** | **3** | **4** | **5** |
| C.28  | **ADMISSIONS: ALCOHOL**  
: Veterans have no requirement to be clean and sober from alcohol to enter the program  
The Veteran is required to have not used alcohol for 60 days or more regardless of substance use disorder status  
The Veteran is required to have not used alcohol for 30 – 59 days  
The Veteran is required to be sober upon entry to program but there is no day requirement | **1** | **2** | **3** | **4** | **5** |
| C.29  | **ADMISSIONS: DRUGS**  
: Veterans have no requirement to be clean and sober from illegal drugs or drugs not prescribed for the Veteran to enter the program  
The Veteran is required to have been clean from illegal drugs or drugs not prescribed for the Veteran for 60 days or more  
The Veteran is required to have been clean from illegal drugs or drugs not prescribed for the Veteran for 30 – 59 days  
The Veteran is required to be sober for illegal drugs or drugs not prescribed for the Veteran but there is no day requirement  
The Veteran is required to be sober for illegal drugs or drugs not prescribed for the Veteran to enter the program but there is no day requirement | **1** | **2** | **3** | **4** | **5** |
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<th>Rating</th>
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<tbody>
<tr>
<td>C.17</td>
<td><strong>PERMANENCE</strong>: housing tenure is assumed to be permanent with no actual or expected time limits. Program has no eviction policy.</td>
<td>Clear time limits on the length of stay for Veterans. They may be evicted for rule violations.</td>
<td>Need work</td>
<td>No rigid time limits, Veteran may have to move due to under utilization of services.</td>
<td>No actual or expected limits on housing tenure.</td>
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<tr>
<td>C.19</td>
<td><strong>TENURE</strong>: INCOME/EMPLOYMENT STATUS</td>
<td>Income or employment status <em>always</em> affects tenure in housing</td>
<td>Income or employment status <em>often</em> affects tenure in housing</td>
<td>Income or employment status <em>sometimes</em> affects tenure in housing</td>
<td>Income or employment status <em>rarely</em> affects tenure in housing</td>
<td>Income or employment status <em>never</em> affects tenure in housing</td>
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</tr>
<tr>
<td>C.21</td>
<td><strong>TENURE</strong>: SUBSTANCE ABUSE TREATMENT</td>
<td>Veterans with substance abuse issues are <em>never</em> allowed to remain in housing unless they enroll in substance abuse treatment</td>
<td>Veterans with substance abuse issues are <em>rarely</em> allowed to remain in housing unless they enroll in substance abuse treatment</td>
<td>Veterans with substance abuse issues are <em>sometimes</em> allowed to remain in housing only if they enroll in substance abuse treatment</td>
<td>Veterans with substance abuse issues are <em>often</em> allowed to remain in housing only if they enroll in substance abuse treatment</td>
<td>Veterans with substance abuse issues are <em>always</em> allowed to remain in housing whether or not they enroll in substance abuse treatment</td>
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<td>C.22</td>
<td><strong>TENURE</strong>: MENTAL HEALTH TREATMENT</td>
<td>Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia are not eligible.</td>
<td>Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia may not be eligible. Occasional exceptions are made.</td>
<td>Housing for Veterans is contingent on two of the three issues listed in the description.</td>
<td>Housing for Veterans is contingent on one of the three issues listed in the description.</td>
<td>Housing for Veterans is not contingent on compliance with mental health treatment including medications and is regardless of diagnosis</td>
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<td>C.23</td>
<td><strong>TENURE</strong>: CASE MANAGEMENT</td>
<td>Veterans with case management needs are <em>never</em> allowed to remain in housing unless they accept case management</td>
<td>Veterans with case management needs are <em>rarely</em> allowed to remain in housing unless they accept case management</td>
<td>Veterans with case management needs are <em>sometimes</em> allowed to remain in housing only if they accept case management</td>
<td>Veterans with case management needs are <em>often</em> allowed to remain in housing only if they accept case management</td>
<td>Veterans with case management needs are <em>always</em> allowed to remain in housing whether or not they accept case management</td>
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<td>C.25</td>
<td><strong>TENURE</strong>: Arrests or convictions do not affect tenure</td>
<td>Veterans are never allowed to remain in housing if they have <em>any</em> criminal activity</td>
<td>Veterans with arrests or convictions are <em>rarely</em> allowed to remain in housing, for example if they have felony arrests or convictions are never allowed to remain in housing</td>
<td>Veterans with arrests or convictions are <em>sometimes</em> allowed to remain in housing, for example if arrested or convicted of a violent offense they are not allowed to remain in housing</td>
<td>Veterans with arrests or convictions are <em>often</em> allowed to remain in housing, for example only if they are arrested or convicted of a sexual offense or producing methamphetamines within public housing are they are not allowed to remain in housing</td>
<td>Criminal activity never affects Veteran being allowed to remain in housing no matter the charges</td>
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<td>C.30</td>
<td>TENURE IN HOUSING; TRANSITIONAL (only applies to Safe Havens)</td>
<td>Most Veterans move out of the program and into other housing within 18 months</td>
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<td>Veterans have indefinite lengths of stay in program housing</td>
<td>Most Veterans move out of the program and into other housing within 12 months</td>
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<td>Most Veterans move out of the program and into other housing within 9 months</td>
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<td>Most Veterans move out of the program and into other housing within 6 months</td>
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<td>C.31</td>
<td>TENURE IN HOUSING - ALCOHOL: Clean and sober from alcohol</td>
<td>Most Veterans move out of the program and into other housing within 18 months</td>
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<td>Veterans will be evicted from the program housing</td>
<td>Most Veterans move out of the program and into other housing within 12 months</td>
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<td>if they are caught being under the influence of alcohol- (dry)</td>
<td>Most Veterans move out of the program and into other housing within 9 months</td>
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<td>Most Veterans move out of the program and into other housing within 6 months</td>
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<td>C.32</td>
<td>TENURE IN HOUSING - DRUGS: Clean and sober from illegal drugs or drugs</td>
<td>Most Veterans move out of the program and into other housing within 18 months</td>
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<td>not prescribed for the Veteran</td>
<td>Most Veterans move out of the program and into other housing within 12 months</td>
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<td>Veterans will not be evicted from the housing</td>
<td>Most Veterans move out of the program and into other housing within 9 months</td>
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<td>if they are caught being under the influence of alcohol</td>
<td>Most Veterans move out of the program and into other housing within 6 months</td>
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<td>but multiple violations will lead to eviction</td>
<td>Most Veterans will be asked to leave if they are caught consuming, possessing or</td>
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<td>were asked to leave if they are caught under the influence of illegal drugs or</td>
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<td>drugs not prescribed for the Veteran. in some cases the Veteran may be asked to</td>
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<td>leave even if the drugs are prescribed for them.</td>
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<td>Most Veterans will not be asked to leave if they are caught consuming, possessing</td>
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<td>or being under the influence of illegal drugs or drugs not prescribed for the</td>
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<td>Veteran. In some cases the Veteran may be asked to leave even if the drugs are</td>
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<td>prescribed for them.</td>
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<td>C.33</td>
<td>TENURE IN HOUSING - Violence: Tolerance for violent behavior</td>
<td>Most Veterans will not be asked to leave the program</td>
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<td>Veterans will be asked to leave the program if they</td>
<td>if they have a violent behavior that injures anyone within or outside the program</td>
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<td>have a single incident of violent behavior or threat of violent</td>
<td>Most Veterans will be asked to leave the program for any violent behavior that</td>
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<td>behavior against anyone within or outside the program</td>
<td>leads to a minimal injury or threatens another program participant</td>
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<td>Most Veterans will only be asked to leave the program if they demonstrate a</td>
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<td>violent behavior that leads to serious injury of another program participant</td>
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<td>C.34</td>
<td>TENURE IN HOUSING - ALCOHOL USE: Alcohol allowed on premises</td>
<td>Most Veterans will not be asked to leave if they are caught consuming, possessing</td>
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<td>Veterans will be asked to leave if they are</td>
<td>or being under the influence of illegal drugs or drugs not prescribed for the</td>
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<td>if they are ever found to be in possession of alcohol within the</td>
<td>Veteran. In some cases the Veteran may be asked to leave even if the drugs are</td>
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<td>Veterans will be asked to leave if they caught on multiple occasions</td>
<td>Most Veterans will be asked to leave if they are caught consuming, possessing or</td>
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<td>possessing alcohol within the program housing</td>
<td>were asked to leave if they are caught under the influence of illegal drugs or</td>
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<td>drugs not prescribed for the Veteran. in some cases the Veteran may be asked to</td>
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<td>leave even if the drugs are prescribed for them.</td>
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Ratings / Anchors:
- 1: Clean and sober from alcohol
- 2: Clean and sober from alcohol and illegal drugs
- 3: Clean and sober from alcohol, illegal drugs, and alcohol
- 4: Clean and sober from alcohol, illegal drugs, and alcohol
- 5: Clean and sober from alcohol, illegal drugs, and alcohol
- Ratings:
  - 1: Clean and sober from alcohol
  - 2: Clean and sober from alcohol and illegal drugs
  - 3: Clean and sober from alcohol, illegal drugs, and alcohol
  - 4: Clean and sober from alcohol, illegal drugs, and alcohol
  - 5: Clean and sober from alcohol, illegal drugs, and alcohol
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<th>Item #</th>
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<th>Rating</th>
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<tr>
<td>C.35</td>
<td>TENURE IN HOUSING – DRUG USE: Illegal drugs or drugs not prescribed for the Veteran allowed on premises</td>
<td>Veterans will be asked to leave if they are ever caught in possession of illegal drugs or drugs not prescribed for the Veteran within the program housing</td>
<td>Veterans will be asked to leave if they are caught multiple times possessing illegal drugs or drugs not prescribed for the Veteran within the program housing</td>
<td>Veterans will be asked to leave if they try to barter, sell, or buy illegal drugs or drugs not prescribed for the Veteran within the program housing</td>
<td>Veterans will only be asked to leave if they are caught multiple times trying to barter, sell, or buy illegal drugs or drugs not prescribed for the Veteran within the program housing</td>
<td>Veterans will not be asked to leave for any type of possession, sale, or purchase of illegal drugs or drugs not prescribed for the Veteran within the program housing</td>
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<td>C.36</td>
<td>ENFORCEMENT OF RULES – This applies to any rules described in “tenure in housing”</td>
<td>Veterans are closely monitored, e.g. drug testing and breathalyzers. One infraction of any of the rules and Veterans are asked to leave the program</td>
<td>If Veterans are “caught” breaking any of the rules, if they admit to it they are allowed a second chance and immediately placed on a probation.</td>
<td>If Veterans are “caught” breaking any of the rules, they are typically offered additional chances even if already on probation</td>
<td>Rules infractions are used as a chance for intervention, counseling, but continued infractions are grounds for eviction</td>
<td>There are few rules, no monitoring and Veterans cannot be evicted from housing</td>
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<td>C.37</td>
<td>PETS ALLOWED</td>
<td>Veterans are never allowed to keep pets in their homes</td>
<td>Only small caged pets are allowed (e.g., birds, fish)</td>
<td>Service animals only allowed</td>
<td>Some smaller pets allowed</td>
<td>Veterans are allowed to keep pets</td>
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<td>C.38</td>
<td>HOUSING AFFORDABILITY: Cost of housing and related services is based on Veteran income &amp; does not take the majority of their income. ( \text{Cf} \ \text{HUD} )</td>
<td>Veteran pays more than 30% of gross adjusted monthly income and, has no surplus money, personal needs allowance or items provided.</td>
<td>Veteran pays more than 30% of gross adjusted monthly income and is given a personal needs allowance or personal need items are provided for them.</td>
<td>Veteran pays no more than 30% of gross adjusted monthly income but maintains a surplus for personal expenses.</td>
<td>Veteran pays no more than 30% of gross adjusted monthly income in rent and utilities but housing is contingent on paying housing and utility bills.</td>
<td>Veteran pays no more than 30% of gross adjusted monthly income in rent and utilities and housing is not contingent on paying housing and utility bills.</td>
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<tr>
<td>D. RELATIONSHIPS and AUTONOMY (Relationships among Housing, Staff, Veterans)</td>
<td>Veteran has control over <strong>none</strong> of the following ( \text{including} ) 1. Visitation 2. Unit access 3. Curfew 4. Use of disposable income 5. Use of food stamps</td>
<td>Veteran has control over <strong>one only</strong> of the following 1. Visitation 2. Unit access 3. Curfew 4. Use of disposable income 5. Use of food stamps</td>
<td>Veteran has control over <strong>two or three only</strong> of the following 1. Visitation 2. Unit access 3. Curfew 4. Use of disposable income 5. Use of food stamps</td>
<td>Veteran has control over <strong>four only</strong> of the following 1. Visitation 2. Unit access 3. Curfew 4. Use of disposable income 5. Use of food stamps</td>
<td>Veteran has control over <strong>all five</strong> of the following 1. Visitation 2. Unit access 3. Curfew 4. Use of disposable income 5. Use of food stamps</td>
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<td>D.2</td>
<td>PRIVACY: housing environment provides maximum privacy including exclusive use of a bedroom, bathroom, and kitchen.</td>
<td>All rooms are shared with others including bedroom, bathrooms and common living areas</td>
<td>Each Veteran has their own bedroom but must share kitchen, bathroom and other common living rooms</td>
<td>Each Veteran has their own bedroom and bathroom but must share kitchen and other common living rooms</td>
<td>Each Veteran has their own bedroom and bathroom, and is allowed cooking facilities but must share other common areas</td>
<td>Each Veteran has their own bedroom and bathroom, kitchen and other common living areas</td>
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<td>D.3</td>
<td>PRIVACY: Staff The extent to which tenants control staff entry into the unit.</td>
<td>Program staff has free access to housing units, including the right to make unannounced visits.</td>
<td>Program staff may enter the unit uninvited only to initiate a security check</td>
<td>Program staff may enter the unit uninvited only in a crisis.</td>
<td>Program staff may enter the unit uninvited only under specific circumstances agreed on in advance</td>
<td>Program staff may not enter the unit unless invited by tenant.</td>
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<td>D.7</td>
<td>SERVICE CHOICE: Supports and services are chosen, refused or modified by the Veteran.</td>
<td>Prescribed by provider or staff to ensure safety and meet needs for structure for Veterans.</td>
<td>Staff established primary goals and Veterans have some choice about secondary goals.</td>
<td>Veteran may have varying degrees of choice, service provider choice usually prevails.</td>
<td>Significant Veteran control of services exists in design and provision with considerable staff input.</td>
<td>All services are Veteran driven. Veterans have the right to choose, refuse, and modify services and supports.</td>
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<td>D.11</td>
<td>SERVICE OPTIONS: Flexibility The extent to which the program is able to meet changing needs and preferences of Veterans.</td>
<td>Service needs are not assessed on an ongoing basis and service mix cannot be adapted to meet the changing needs and preferences of Veteran.</td>
<td>One of the three elements of flexibility are present</td>
<td>Two of the three elements of flexibility are present</td>
<td>All three elements are present but may not be strong.</td>
<td>All three elements are present and strong: 1. Variety of options are available 2. Changes based on continuing assessment. 3. Flexibility of type, location, intensity and frequency</td>
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<td>D.14</td>
<td>VETERAN INVOLVEMENT: Veterans are involved as members of the team providing services</td>
<td>Veterans have no involvement in service provision in relation to the program</td>
<td>Veteran(s) fill Veteran-specific service roles (e.g. self-help)</td>
<td>Veteran(s) formally assist in provision of direct services (e.g. co-lead groups). Some Veteran input into design and provision of services (e.g., Veteran advisory board).</td>
<td>Veteran(s) work in case management roles with reduced responsibility</td>
<td>Veteran(s) are employed as direct service staff with full professional status.</td>
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<td>D.16</td>
<td>RECOVERY ORIENTATION: Staff attitudes towards Veterans indicate respect, mutual partnership, optimism about recovery.</td>
<td>Staff strongly disagree that staff attitudes towards Veterans indicate respect, mutual partnership, and optimism about recovery</td>
<td>Staff disagree that staff attitudes towards Veterans indicate respect, mutual partnership, and optimism about recovery</td>
<td>Staff neither agree or disagree that staff attitudes towards Veterans indicate respect, mutual partnership, and optimism about recovery</td>
<td>Staff agree that staff attitudes towards Veterans indicate respect, mutual partnership, and optimism about recovery</td>
<td>Staff strongly agree that staff attitudes towards Veterans indicate respect, mutual partnership, and optimism about recovery</td>
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<td>D.18</td>
<td>VETERAN / STAFF RATIO: Refers to HUD VASH case managers caseloads OR number of Veterans per GPD provider direct service staff</td>
<td>Staff to client ratio is 1: over 50</td>
<td>Staff to client ratio is 1: between 41-50</td>
<td>Staff to client ratio is 1: between 35-40</td>
<td>Staff to client ratio is 1: between 25-34</td>
<td>Staff to client ratio is 1: between 1-24</td>
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<td>D.20</td>
<td>Individualized Housing Plan: program has responsibility for helping Veterans develop an individualized housing plan that focuses on their housing stabilization</td>
<td>Program doesn’t help develop any type of individualized service plan (develops plan with 0% of Veterans)</td>
<td>Program develops individualized service plans but includes a housing component with less than half of the Veterans (develops plan with &lt;50% Veterans)</td>
<td>Program develops individualized service plans and includes a housing component with over half of the Veterans (develops plan with 50% to 74% of Veterans)</td>
<td>Program develops individualized service plans and includes a housing component with almost all Veterans (develops plan with 75% to 99% of Veterans)</td>
<td>Program always develops individualized service plans and includes a housing component with Veterans (develops plan with 100% of Veterans)</td>
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<td>D.21</td>
<td>CHOICE OF LIVING ARRANGEMENTS: HOUSEMATES</td>
<td>Veterans are not allowed to have others living in their home or do not choose with whom they live</td>
<td>Veterans may request a specific roommate from the same program or request to have no roommate</td>
<td>Veterans may live with family members, but not unrelated people</td>
<td>Veterans may live with family members, or unrelated people if those people also qualify for the same type of housing</td>
<td>Veterans may choose who to live with including roommates, significant others, spouses, children</td>
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<td>E. ORGANIZATION (Organization / Staff)</td>
<td>Please note for HUD VASH interviews “program” refers to the HUD VASH program and immediate VA supervisors and staff</td>
<td>For GPD liaisons and providers “program” refers to the specific GPD program measured and relevant staff</td>
<td>No formal collection of information about Veteran’s satisfaction with services.</td>
<td>There is a process for collecting information on Veteran’s satisfaction with services.</td>
<td>There is a process for collecting information about Veteran’s satisfaction with services and about how services help with achieving recovery goals.</td>
<td>There is a process for collecting information about Veteran’s satisfaction with services and about how services help with achieving recovery goals that is integrated into quality improvement activities.</td>
<td>Veterans participate in a process for collecting information about Veteran’s satisfaction with services and about how services help with achieving recovery goals that is integrated into quality improvement activities.</td>
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<td>E.1</td>
<td>PROGRAM IS COMMITTED TO A RECOVERY ORIENTATION –</td>
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<td>E.2</td>
<td>ORGANIZATIONAL CLIMATE – The program is characterized by mutual trust and cooperation among staff</td>
<td>There is no mutual trust and cooperation among staff in this program</td>
<td>There is very little mutual trust and cooperation among staff in this program</td>
<td>There is some mutual trust and cooperation among staff in this program</td>
<td>There is often mutual trust and cooperation among staff in this program</td>
<td>There is a lot of mutual trust and cooperation among staff in this program</td>
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<td>E.3</td>
<td>ADMINISTRATIVE SUPPORT / DIRECTION – Level of support for clinicians and those working directly with Veterans – availability, ease of hiring to meet need</td>
<td>There is no administrative support for clinicians and those working directly with Veterans</td>
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<td>There is very little administrative support for clinicians and those working directly with Veterans</td>
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<td>There is some administrative support for clinicians and those working directly with Veterans</td>
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<td></td>
<td></td>
<td>There is often administrative support for clinicians and those working directly with Veterans</td>
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<td></td>
<td>There is a lot of administrative support for clinicians and those working directly with Veterans</td>
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<tr>
<td>E.10</td>
<td>PEER CULTURE/ TEAM ORIENTATION – HUD VASH - All staff that work with homeless Veterans meet together as a team, across services and divisions</td>
<td>Staff/Case Managers never work together as a team</td>
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<td></td>
<td>Staff/Case Managers work together very little as a team but only within their own program</td>
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<td></td>
<td>Staff/Case Managers sometimes work together as a team</td>
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<td>Staff/Case Managers almost always work together as a team</td>
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<td>Staff/Case Managers always work together as a team</td>
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<tr>
<td>E.10</td>
<td>PEER CULTURE/ TEAM ORIENTATION – GPD - All staff that work with homeless Veterans meet together as a team, may include GPD liaison</td>
<td>Staff/Case Managers never work together as a team</td>
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<td>Staff/Case Managers work together very little as a team but only within their own program</td>
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<td>Staff/Case Managers sometimes work together as a team</td>
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<td>Staff/Case Managers almost always work together as a team</td>
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<td></td>
<td></td>
<td>Staff/Case Managers always work together as a team</td>
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<tr>
<td>E.14</td>
<td>SAFE ENVIRONMENT – Staff feel their work and what they are asked to do is in a safe environment –</td>
<td>Staff/Case Managers feel their work and what they are asked to do is almost never in a safe environment.</td>
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<td>Staff/Case Managers feel their work and what they are asked to do is in a safe environment some of the time.</td>
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<td>Staff/Case Managers feel their work and what they are asked to do is in a safe environment about half the time.</td>
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<td>Staff/Case Managers feel their work and what they are asked to do is in a safe environment most of the time.</td>
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<td></td>
<td>Staff/Case Managers feel their work and what they are asked to do is in a safe environment all of the time.</td>
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<td>E.15.</td>
<td>PAPERWORK</td>
<td>Staff/Case Managers are completely overwhelmed by paperwork</td>
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<td>Staff/Case Managers are almost always overwhelmed by paperwork</td>
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<td>Staff/Case Managers are moderately overwhelmed by paperwork</td>
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<td>Staff/Case Managers are almost never overwhelmed by paperwork</td>
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<td>Staff/Case Managers are never overwhelmed by paperwork</td>
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<tr>
<td>E.18</td>
<td>PEER RUN PROGRAM – All staff that work with homeless Veterans are Veterans and many are homeless Veterans</td>
<td>There are no staff that work with homeless Veterans who are Veterans</td>
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<td>Up to 33% of staff that work with homeless Veterans are Veterans or homeless Veterans</td>
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<td>34 – 66% of staff that work with homeless Veterans are Veterans or homeless Veterans</td>
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<td>67 – 99% of staff that work with homeless Veterans are Veterans or homeless Veterans</td>
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<td>All staff that work with homeless Veterans are Veterans and many are homeless Veterans</td>
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<td>E.19</td>
<td>All programs are a front door vs. a continuum of care approach (Applies only at the VAMC level)</td>
<td>When the Veteran enters a program he/she is only offered the possibility of entering that program.</td>
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<td>When the Veteran enters a program he/she is very seldom offered a choice among GPD, HUD VASH, residential treatment, or short term preventive assistance.</td>
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<td>When the Veteran enters a program he/she is sometimes offered a choice among GPD, HUD VASH, residential treatment, or short term preventive assistance.</td>
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<td>When the Veteran enters a program he/she is often offered a choice among GPD, HUD VASH, residential treatment, or short term preventive assistance.</td>
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<td>When the Veteran enters a program he/she is always offered a choice among GPD, HUD VASH, residential treatment, or short term preventive assistance, regardless of the entry point into the program</td>
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<td>Item #</td>
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<tr>
<td>E.20</td>
<td>Support for Flexible approach with Veterans including some flexible funds</td>
<td>There is no support for a flexible approach including flexible funds</td>
<td>There is a little support for a flexible approach including flexible funds</td>
<td>There is some support for a flexible approach including flexible funds</td>
<td>There is often support for a flexible approach including flexible funds</td>
<td>There is a lot of support for a flexible approach including flexible funds</td>
<td></td>
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</tbody>
</table>
### Appendix 2. HHSPM-V – Housing First items

**Housing and Housing Services Program Measure – Veterans Version (HHSPM-V)**

<table>
<thead>
<tr>
<th>Program Type:</th>
<th>VISN:</th>
<th>VAMC:</th>
<th>Interviewer(s):</th>
<th>Date:</th>
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#### RATINGS/ANCHORS

<table>
<thead>
<tr>
<th>Item #</th>
<th>Criterion</th>
<th>Ratings / Anchors</th>
<th>Rating</th>
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<tbody>
<tr>
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<td>1</td>
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<tr>
<td>A. COMMUNITY (Community Context, Social Environment Context, Natural Supports, Climate / Racial / Ethnic Mix)</td>
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<tr>
<td>A.11 INTEGRATION WITH COMMUNITY: The extent to which an individual’s housing unit is clustered with housing units occupied by people with disabilities vs. scattered throughout the community expressed as percent (%) of units set aside for people with special needs groups including people who are homeless</td>
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<tr>
<td>People live in settings where 80% or more of the tenants meet disability-related eligibility criteria</td>
<td>People live in housing units where 60-79% of the total number of units has been set aside for people meeting disability-related eligibility criteria</td>
<td>People live in housing units where 40-59% of the total number of units has been set aside for people meeting disability-related eligibility criteria</td>
<td>People live in housing units where 20-39% of the total number of units has been set aside for people meeting disability-related eligibility criteria</td>
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<tr>
<td>B. SERVICES (Services, Programs, &amp; Linkages; Characteristics &amp; Quantities, Each Type)</td>
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<tr>
<td>B.6 CLINICAL SERVICES: program has responsibility for assisting Veterans in obtaining case management, psychiatric, counseling, medical and other treatment services. Including crisis and hospitalization services</td>
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<tr>
<td>Program does not assist Veterans in obtaining clinical services</td>
<td>Program assists Veterans in obtaining case management services only</td>
<td>Program assists Veterans in obtaining all counseling and psychiatric services</td>
<td>Program assists Veterans in obtaining psychological, psychiatric, medical and other services</td>
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<tr>
<td>B.7 LEGAL SERVICES: program has responsibility for assisting Veterans in obtaining legal services such as child support and credit reconciliation</td>
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<tr>
<td>Program is never responsible for any legal services</td>
<td>Program is not typically responsible for any legal services, although Veterans are sometimes referred to at least one legal resource</td>
<td>Program assists Veterans in obtaining legal services, and the program maintains a list of legal staff who are willing to work with Veterans</td>
<td>Program assists Veterans in obtaining all legal services, with legal staff occasionally presenting to program staff and/or Veterans about their available services</td>
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<td>Item #</td>
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<td>B.9</td>
<td>TIME UNLIMITED SERVICES: program continues to offer services before housing and after housing is lost or transitional housing has ended.</td>
<td>Program offers services only while Veteran is housed with that program.</td>
<td>Veterans are discharged from services if they lose housing but may be re-admitted if they complete certain criteria, such as detox treatment or inpatient treatment.</td>
</tr>
<tr>
<td>B.10</td>
<td>IN-VIVO SERVICES: program works to monitor status, develop community living skills in vivo rather than in office.</td>
<td>Less than 20% in time in community.</td>
<td>20 - 39%</td>
</tr>
<tr>
<td>B.12</td>
<td>FREQUENCY OF CONTACT: high number of service contacts as needed. For HUD VASH contact is between case-manager and Veteran, for GPD programs contact is between provider and Veteran.</td>
<td>No regular contact on a monthly basis. May contact sporadically but no minimum or regular schedule of contact.</td>
<td>Average of regularly contacting Veteran 1 contact or less a month</td>
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<tr>
<td>B.16</td>
<td>SUBSTANCE ABUSE SERVICES: program provides full range of substance abuse services: 9. Substance abuse specialist as staff 10. Substance abuse group 11. AA or peer run groups 12. Substance abuse education</td>
<td>Program provides no substance abuse services, refers externally.</td>
<td>Program provides one substance abuse service</td>
</tr>
<tr>
<td>B.17</td>
<td>VOCATIONAL SERVICES: program has vocational specialist, pre-employment, supported employment, vocational assessment and job placement services or assists Veterans in obtaining such services. Includes educational services and computer classes</td>
<td>Program neither provides nor assists Veterans in obtaining vocational/educational services.</td>
<td>Program does not provide vocational/educational services, only links Veterans to external sources</td>
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<td>Item #</td>
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<td>Ratings / Anchors</td>
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</table>
| B.19  | **DAILY LIVING SKILLS TRAINING AND COUNSELING:** program provides services to develop skills necessary to maintain housing including:  

1. budgeting,  
2. financial management,  
3. gathering household items,  
4. cooking,  
5. medication management  

Program provides no housing related services and **does not** regularly refer for such services.  
Program provides no housing related services but **does** regularly refer for such services.  
Provides classes or instruction in **one** area of daily living skills.  
Provides classes or instruction in **two or more** areas of daily living skills. |
|       |                                                                                                              | Rating                                                                          |
| B.20  | **WORK WITH SUPPORT SYSTEM:** with or without Veteran present, program provides support and skills for Veteran’s support network - family, neighbors, friends, and employers.  

*Work on metric*  

Less than .5 contacts per month per Veteran with support system.  
.5 - 1 contact per month per Veteran with support system in the community.  
1 - 2 contact per month per Veteran with support system in the community.  
2 - 3 contacts per month per Veteran with support system in the community.  
Four or more contacts per month per Veteran with support system in the community. |
|       |                                                                                                              | Rating                                                                          |
| B.21  | **ADVOCACY FOR ENTITLEMENTS:** assist in obtaining eligible benefits including Veterans, disability, social security and food stamps  

Program does not assist Veterans in obtaining benefits.  
Program informally helps Veterans obtain benefits in one or more areas.  
Program is active in helping Veterans obtain benefits in one of the identified areas.  
Program is active in helping Veterans obtain benefits in two of the identified areas.  
Program is active in helping Veterans obtain benefits in three or more of the identified areas. |
|       |                                                                                                              | Rating                                                                          |
| B.22  | **LANDLORD-TENANT RELATIONS:** program assists in negotiating lease and problem-solving tenant issues.  

Program staff is not involved in landlord - tenant relations at all.  
Program staff is seldom involved in landlord - tenant relations.  
Program staff occasionally works with landlords in tenant relations.  
Program staff often works with landlords in tenant relations.  
Program staff assists fully in negotiating and problem-solving landlord - tenant relations. |
|       |                                                                                                              | Rating                                                                          |
| B.25  | **STRUCTURE:** environment offers regular programmed activities or structured daily routine.  

Little or no structured daily activity or routine.  
Some structured weekly activity and routine, although there is no regularly maintained schedule of such events.  
Some structured daily activity and routine, and there is a regularly maintained list schedule of these activities.  
Regular programmed activities are offered, and a daily schedule of such activities is available.  
Regular programmed activities are offered, a daily schedule of such activities is available and regularly maintained, and this is shared with Veterans. |
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<tr>
<td>B. 26</td>
<td>HARM REDUCTION Philosophy of Services – Substance abuse treatment services are offered within a harm reduction model.</td>
<td>Abstinence is the only goal of substance abuse services and the only goal presented to Veterans</td>
</tr>
<tr>
<td>B. 29</td>
<td>MOTIVATIONAL INTERVIEWING (MI).  Extent to which program staff are fully trained and use MI in all services including:</td>
<td>Program staff are not at all familiar with motivational interviewing</td>
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<td>6. At least one training event</td>
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<td>7. Regular booster trainings</td>
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<td>8. Clinical supervision on use of MI</td>
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<td>9. At least one MI expert on staff</td>
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<td>10. Use of a fidelity instrument to monitor MI sessions</td>
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<td>B. 31</td>
<td>ASSISTANCE IN OBTAINING HOUSING.  Program engages in at least five activities to assist Veteran in obtaining stable housing and moving into the housing, for example, driving with Veteran to find suitable housing, moving assistance, recruiting landlords, completing housing authority paperwork for HUD VASH</td>
<td>Program does not offer assistance in obtaining permanent housing</td>
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C. ACCESS
(Access to Housing / Admission Criteria / Conditions for Tenure)
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<th>Item #</th>
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<tr>
<td>C.2</td>
<td>HOUSING CHOICE: Extent to which Veterans can wait for the unit of their choice without losing their eligibility. A reasonable waiting period is the allowed “search” time for the local Housing Choice/Section 8 voucher program (usually 60-120 days)</td>
<td>1. Veterans must accept the unit offered or not be involved with the program. 2. Veterans must accept the unit offered and no waiting for units is allowed. Prospective Veterans who refuse one unit offered can still be involved with the program but they lose priority for units 3. Veterans can wait for the unit of their choice, but they are allowed a set number of choices before they lose priority for units 4. Veterans can wait for the unit of their choice without losing priority but still must find suitable housing within a reasonable time, for example the length of time before the HUD Voucher expires 5. Veterans can wait a reasonable time for the unit of their choice without risk of discharge from the program or losing priority for services or units</td>
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<td>C.5</td>
<td>SPEED OF ENTRY: Veterans are able to move quickly into housing (This is even if the speed is affected by a lack of vouchers)</td>
<td>1. Veterans have to wait over four months to move into housing 2. Veterans are able to move into housing more than 90 days but less than 120 days from admission to services 3. Veterans are able to move into housing more than 60 days but less than 90 days from admission to services 4. Veterans are able to move into housing in more than 30 days but less than 60 days from admission to services 5. Veterans are able to move into housing in 30 days or less from admission to services</td>
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<td>*C.7</td>
<td>EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.</td>
<td>1. Program has no set criteria and takes all types of Veterans 2. Program has a generally defined mission but the admission process is dominated by organizational convenience, pressures from referral sources or the need to fill beds for example. 3. The program makes an effort to seek and select a defined set of Veterans but accepts most referrals and/or does not have careful screening. 4. Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure, pressures from referral sources or the need to fill beds for example. 5. The program actively recruits a defined population and all cases comply with explicit admission criteria.</td>
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<td>C.8</td>
<td>ADMISSION: Income Veterans are admitted regardless of income</td>
<td>1. Veteran must always have some income to be eligible for housing 2. Veteran income often affects eligibility for housing 3. Veteran income sometimes affects eligibility for housing 4. Veteran income rarely affects eligibility for housing 5. Veteran income never affects eligibility for housing</td>
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<tr>
<td>C.9</td>
<td>ADMISSION: MEDICAL STATUS Veterans are admitted regardless of medical status including HIV and disability status</td>
<td>1. Veterans with medical problems are never provided housing 2. Veterans with medical problems are rarely provided housing regardless of medical status 3. Veterans with medical problems are sometimes provided housing regardless of medical status 4. Veterans with medical problems are often provided housing regardless of medical status 5. Veterans with medical problems can always be provided housing regardless of medical status</td>
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<td>C.10</td>
<td>ADMISSION: SUBSTANCE ABUSE TREATMENT Veterans can enter housing without participating in or completing substance abuse treatment such as a GPD program or VA treatment - outpatient or inpatient program</td>
<td>1. Veterans with substance abuse issues are never provided housing unless they have participated in or completed some type of substance abuse treatment (0% of the time) 2. Veterans with substance abuse issues are rarely provided housing unless they have participated in or completed some type of substance abuse treatment (1%-33% of the time) 3. Veterans with substance abuse issues are sometimes provided housing only if they have participated in or completed some type of substance abuse treatment (34%-65% of the time) 4. Veterans with substance abuse issues are often provided housing without having participated in or completed some type of substance abuse treatment (66%-99% of the time) 5. Veterans with substance abuse issues can always be provided housing regardless of whether they participated in or completed some type of substance abuse treatment (100% of the time)</td>
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<td>C.11</td>
<td>ADMISSION: MENTAL HEALTH</td>
<td>Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia are not eligible.</td>
<td>Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia may not be eligible. Occasional exceptions are made.</td>
</tr>
<tr>
<td>C.12</td>
<td>ADMISSION: CASE MANAGEMENT</td>
<td>Veterans with case management needs cannot always be provided housing regardless of whether they enroll in case management.</td>
<td>Veterans with case management needs are never provided housing unless they are enrolled in case management (0% of the time).</td>
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<tr>
<td>C.14</td>
<td>ADMISSION: CRIMINAL BACKGROUND CHECKS</td>
<td>Veterans with any criminal history are never eligible for services. Veterans with criminal history are rarely eligible for services, for example not with felony convictions are never.</td>
<td>Veteran with criminal history are rarely eligible for services, for example not if convicted of a violent offense.</td>
</tr>
<tr>
<td>C.28</td>
<td>ADMISSIONS: ALCOHOL</td>
<td>The Veteran is required to have not used alcohol for 60 days or more regardless of substance use disorder status.</td>
<td>The Veteran is required to have not used alcohol for 30 – 59 days.</td>
</tr>
<tr>
<td>C.29</td>
<td>ADMISSIONS: DRUGS</td>
<td>The Veteran is required to have been clean from illegal drugs or drugs not prescribed for the Veteran for 60 days or more.</td>
<td>The Veteran is required to have been clean from illegal drugs or drugs not prescribed for the Veteran for 30 – 59 days.</td>
</tr>
<tr>
<td>Item #</td>
<td>Criterion</td>
<td>Ratings / Anchors</td>
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<tr>
<td>C.17</td>
<td>PERMANENCE: housing tenure is assumed to be permanent with no actual or expected time limits. Program has no eviction policy.</td>
<td>Clear time limits on the length of stay for Veterans. They may be evicted for rule violations.</td>
<td>Need work</td>
</tr>
<tr>
<td>C.19</td>
<td>TENURE: INCOME/EMPLOYMENT STATUS</td>
<td>Income or employment status always affects tenure in housing</td>
<td>Income or employment status often affects tenure in housing</td>
</tr>
<tr>
<td>C.21</td>
<td>TENURE: SUBSTANCE ABUSE TREATMENT</td>
<td>Veterans with substance abuse issues are never allowed to remain in housing unless they enroll in substance abuse treatment</td>
<td>Veterans with substance abuse issues are rarely allowed to remain in housing unless they enroll in substance abuse treatment</td>
</tr>
<tr>
<td>C.22</td>
<td>TENURE: MENTAL HEALTH TREATMENT Housing for Veterans is not contingent on 1. medications or 2. compliance with mental health treatment 3.and will include Veterans with diagnoses of serious mental illnesses</td>
<td>Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia are not be eligible</td>
<td>Veterans with mental health issues are only provided housing if they are compliant with both mental health treatment and medications. Even then, Veterans that have been diagnosed with psychoses, thought disorders, schizophrenia may not be eligible. Occasional exceptions are made</td>
</tr>
<tr>
<td>C.23</td>
<td>TENURE: CASE MANAGEMENT</td>
<td>Veterans with case management needs are never allowed to remain in housing unless they accept case management</td>
<td>Veterans with case management needs are rarely allowed to remain in housing unless they accept case management</td>
</tr>
<tr>
<td>Item #</td>
<td>Criterion</td>
<td>1</td>
<td>2</td>
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<tr>
<td>C.25</td>
<td>TENURE: Arrests or convictions do not affect tenure</td>
<td>Veterans are never allowed to remain in housing if they have any criminal activity</td>
<td>Veterans with arrests or convictions are rarely allowed to remain in housing, for example if they have felony arrests or convictions are never allowed to remain in housing</td>
</tr>
<tr>
<td>C.31</td>
<td>TENURE IN HOUSING - ALCOHOL: Clean and sober from alcohol</td>
<td>Veterans will be evicted from the program housing if they are caught being under the influence of alcohol- (dry)</td>
<td>Veterans will not be evicted from the housing program the first time they are caught being under the influence of alcohol, but multiple violations will lead to eviction</td>
</tr>
<tr>
<td>C.32</td>
<td>TENURE IN HOUSING - DRUGS: Clean and sober from illegal drugs or drugs not prescribed for the Veteran</td>
<td>Veterans will not be permitted to remain in the program housing if they are caught consuming, possessing or being under the influence of illegal drugs or drugs not prescribed for the Veteran. In some cases the Veteran may be asked to leave even if the drugs are prescribed for them.</td>
<td>Veterans will not be permitted to remain in the program housing if they are caught consuming, possessing or being under the influence of illegal drugs or drugs not prescribed for the Veteran.</td>
</tr>
<tr>
<td>C.33</td>
<td>TENURE IN HOUSING - Violence: Tolerance for violent behavior</td>
<td>Veterans will be asked to leave the program if they have a single incident of violent behavior or threat of violent behavior against anyone within or outside the program</td>
<td>Veterans will be asked to leave the program if they have a violent behavior that injures anyone within or outside the program</td>
</tr>
<tr>
<td>C.34</td>
<td>TENURE IN HOUSING – ALCOHOL USE: Alcohol allowed on premises</td>
<td>Veterans will be asked to leave if they are ever found to be in possession of alcohol within the program housing</td>
<td>Veterans will be asked to leave if they caught on multiple occasions possessing alcohol within the program housing</td>
</tr>
<tr>
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<td>1</td>
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<tr>
<td>C.35</td>
<td>TENURE IN HOUSING - DRUG USE: Illegal drugs or drugs not prescribed for the Veteran allowed on premises</td>
<td>Veterans will be asked to leave if they are ever caught in possession of illegal drugs or drugs not prescribed for the Veteran within the program housing</td>
<td>Veterans will be asked to leave if they are caught multiple times possessing illegal drugs or drugs not prescribed for the Veteran within the program housing</td>
</tr>
<tr>
<td>C.36</td>
<td>ENFORCEMENT OF RULES - This applies to any rules described in “tenure in housing”</td>
<td>Veterans are closely monitored, e.g. drug testing and breathalyzers. One infraction of any of the rules and Veterans are asked to leave the program</td>
<td>If Veterans are “caught” breaking any of the rules, if they admit to it they are allowed a second chance and immediately placed on a probation.</td>
</tr>
<tr>
<td>C.38</td>
<td>HOUSING AFFORDABILITY: Cost of housing and related services is based on Veteran income &amp; does not take the majority of their income. HUD</td>
<td>Veteran pays more than 30% of gross adjusted monthly income and has no surplus money, personal needs allowance or items provided.</td>
<td>Veteran pays more than 30% of gross adjusted monthly income but is given a personal needs allowance or personal need items are provided for them.</td>
</tr>
<tr>
<td>D.1</td>
<td>CONTROL OVER LIVING ENVIRONMENT: decisions regarding his/her living environment are made primarily by Veteran. including</td>
<td>Veteran has control over none of the following</td>
<td>Veteran has control over one only of the following</td>
</tr>
<tr>
<td>D.2</td>
<td>PRIVACY: housing environment provides maximum privacy including exclusive use of a bedroom, bathroom, and kitchen.</td>
<td>All rooms are shared with others including bedroom, bathrooms and common living areas</td>
<td>Each Veteran has their own bedroom but must share kitchen, bathroom and other common living rooms</td>
</tr>
</tbody>
</table>

**D. RELATIONSHIPS and AUTONOMY**

(relationships among Housing, Staff, Veterans)
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>D.7</td>
<td><strong>SERVICE CHOICE:</strong> Supports and services are chosen, refused or modified by the Veteran.</td>
<td>Prescribed by provider or staff to ensure safety and meet needs for structure for Veterans.</td>
<td>Staff established primary goals and Veterans have some choice about secondary goals.</td>
</tr>
<tr>
<td>D.11</td>
<td><strong>SERVICE OPTIONS:</strong> Flexibility The extent to which the program is able to meet changing needs and preferences of Veterans. 4. Variety of options are available 5. Changes based on continuing assessment. 6. Flexibility of type, location, intensity and frequency.</td>
<td>Service needs are not assessed on an ongoing basis and service mix cannot be adapted to meet the changing needs and preferences of Veteran.</td>
<td>One of the three elements of flexibility are present</td>
</tr>
<tr>
<td>D.14</td>
<td><strong>VETERAN INVOLVEMENT:</strong> Veterans are involved as members of the team providing services.</td>
<td>Veterans have no involvement in service provision in relation to the program</td>
<td>Veteran(s) fill Veteran-specific service roles (e.g. self-help)</td>
</tr>
<tr>
<td>D.16</td>
<td><strong>RECOVERY ORIENTATION:</strong> Staff attitudes towards Veterans indicate respect, mutual partnership, optimism about recovery.</td>
<td>Staff strongly disagree that staff attitudes towards Veterans indicate respect, mutual partnership, and optimism about recovery</td>
<td>Staff disagree that staff attitudes towards Veterans indicate respect, mutual partnership, and optimism about recovery</td>
</tr>
<tr>
<td>D.18</td>
<td><strong>VETERAN / STAFF RATIO:</strong> Program has responsibility for helping Veterans develop an individualized housing plan that focuses on their housing stabilization.</td>
<td>Staff to client ratio is 1: over 50</td>
<td>Staff to client ratio is 1: between 41-50</td>
</tr>
<tr>
<td>D.20</td>
<td><strong>Individuated Housing Plan:</strong> Program develops individualized service plans and includes a housing component with over half of the Veterans (develops plan with 50% to 74% of Veterans).</td>
<td>Program doesn’t help develop any type of individualized service plan (develops plan with 0% of Veterans)</td>
<td>Program develops individualized service plans but includes a housing component with less than half of the Veterans (develops plan with &lt;50% Veterans)</td>
</tr>
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<tr>
<td>D.21</td>
<td>CHOICE OF LIVING ARRANGEMENTS: HOUSEMATES</td>
<td>Veterans are not allowed to have others living in their home or do not choose with whom they live</td>
<td>Veterans may request a specific roommate from the same program or request to have no roommate</td>
</tr>
<tr>
<td>E. ORGANIZATION (Organization / Staff)</td>
<td>Please note for HUD VASH interviews “program” refers to the HUD VASH program and immediate VA supervisors and staff For GPD liaisons and providers “program” refers to the specific GPD program measured and relevant staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.10</td>
<td>PEER CULTURE/TEAM ORIENTATION – HUD VASH - All staff that work with homeless Veterans meet together as a team, across services and divisions</td>
<td>Staff/Case Managers never work together as a team</td>
<td>Staff/Case Managers work together very little as a team but only within their own program</td>
</tr>
<tr>
<td>E.10</td>
<td>PEER CULTURE/TEAM ORIENTATION – GPD - All staff that work with homeless Veterans meet together as a team, may include GPD liaison</td>
<td>Staff/Case Managers never work together as a team</td>
<td>Staff/Case Managers work together very little as a team but only within their own program</td>
</tr>
<tr>
<td>E.18</td>
<td>PEER RUN PROGRAM – All staff that work with homeless Veterans are Veterans and many are homeless Veterans</td>
<td>There are no staff that work with homeless Veterans who are Veterans</td>
<td>Up to 33% of staff that work with homeless Veterans are Veterans or homeless Veterans</td>
</tr>
<tr>
<td>E.19</td>
<td>All programs are a front door vs. a continuum of care approach (Applies only at the VAMC level)</td>
<td>When the Veteran enters a program he/she is only offered the possibility of entering that program.</td>
<td>When the Veteran enters a program he/she is very seldom offered a choice among GPD, HUD VASH, residential treatment, or short term preventive assistance.</td>
</tr>
<tr>
<td>E.20</td>
<td>Support for Flexible approach with Veterans including some flexible funds</td>
<td>There is no support for a flexible approach including flexible funds</td>
<td>There is a little support for a flexible approach including flexible funds</td>
</tr>
</tbody>
</table>