SYRACUSE UNIVERSITY
INSTITUTE FOR VETERANS AND MILITARY FAMILIES
JPMorgan Chase & Co., Founding Partner

DRIVING COMMUNITY IMPACT

THE CASE FOR LOCAL, EVIDENCE-BASED COORDINATION IN VETERAN AND MILITARY FAMILY SERVICES AND THE AMERICASERVES INITIATIVE

Nicholas J. Armstrong, Ph.D.
COL James D. McDonough Jr., USA (Ret.)
Daniel Savage, M.P.P.

April 2015

This work was prepared with the support of the New York State Health Foundation and Accenture.

About the Paper

This paper addresses a prevailing view that a lack of coordination, collaboration, and collective purpose among veteran and military-family serving organizations—public, private, and nonprofit—poses a serious risk to long-term veteran and family wellbeing. Given the quantity and fragmentation of actors across the veterans' services landscape, local communities confront a challenge and opportunity to maximize and sustain positive impacts on their veterans and military families through improved, evidence-based coordination of resources, services, and care. We argue that collective impact, an innovative and proven approach to cross-sector collaboration on complex social problems, presents an opportunity for communities, in partnership with the VA, other government agencies, and private industry, to improve outcomes for veterans, transitioning servicemembers, and their families.

This paper serves two purposes. First, it leverages an extensive foundation of public health and public management research to underscore the need for and value of community-based collective impact models of service delivery in veterans' services. Second, the paper outlines the Institute for Veterans and Military Families' (IVMF) ongoing collective impact initiative, AmericaServes, and highlights preliminary outcomes from its first pilot network in New York City (NYCServes). The first-of-its kind in the nation, NYCServes is a public-private coordinated network of comprehensive services, resources, and care for separating service members, veterans, and their families.

Acknowledgments

This work was prepared with the support of the New York State Health Foundation and Accenture.

The authors express their sincere appreciation for the detailed and helpful comments by expert reviewers from government, industry, academia, philanthropy, and the nonprofit sector on a previous draft of this paper.

SYRACUSE UNIVERSITY
INSTITUTE FOR VETERANS AND MILITARY FAMILIES
JPMorgan Chase & Co., Founding Partner

DRIVING COMMUNITY IMPACT

THE CASE FOR LOCAL, EVIDENCE-BASED COORDINATION IN VETERAN AND MILITARY FAMILY SERVICES AND THE AMERICASERVES INITIATIVE

Nicholas J. Armstrong, Ph.D.
COL James D. McDonough Jr., USA (Ret.)
Daniel Savage, M.P.P.

April 2015

This work was prepared with the support of the New York State Health Foundation and Accenture.

VETERAN DEMAND FOR COORDINATED SERVICES

Week 1 sample of individual veteran referral requests to the NYCServes coordinated care and services network in New York City in winter 2015.

*I need help with many things. **I'm all alone** and cannot really depend on anyone.*

*I have been looking for **employment.** Have not been successful finding any. I don't have a place to call home. I'm **pretty much homeless** and my GI bill benefits are exhausted. I have no means of income. I am very depressed. **I don't know what to do.***

*Need help **finding a job** to support me and my 6 year old daughter, I need to find out **what services can be offered to me.** I had SNAP benefits but that was taken away from me I need to find out how I can receive them again.*

*I am in need of **financial assistance** mostly with food for my children.*

*In desperate **need of housing.** Will need assistance with security deposit. Currently working full time however saving is difficult due to delinquent bills **when I was unemployed.***

*I'm having issues at my residence with family and I have two months to save and **find a place to live.** Being that **I am unemployed,** I **depend on my GI Bill to support myself and my son.** ... I'm not sure where to turn because I also **need childcare and I pay for my dental and health needs out of pocket.** I'm overwhelmed with the HRA [child support enforcement] offices here in NY. I just need some guidance and God willing some help.*

*I was hurt but was discharged for a different reason. How do I get **help for my injury? I need housing of my own.** Staying with family because I'm hurt right now.*

Introduction

A clear gap in services for veterans and military families persists across America. Contrary to what most might expect, however, this gap is far from a lack of public concern, resources, or programmatic effort. The "Sea of Goodwill" (Copeland & Sutherland, 2010) toward those who have voluntarily chosen to wear our nation's cloth appears deep and teeming with life—for now. Rather, the gap lives between the public, private, and nonprofit organizations that serve them. Put simply, the leading gap in veterans and military family services is not a lack of resources or capacity, but a lack of collaboration, coordination, and collective purpose.

Indeed, American support for veterans is truly remarkable and comprehensive. The federal government offers a wide range of medical and health services, educational programs, and transition supports for our 22 million veterans (VA, 2014b) and 1.4 million servicemembers (DoD, 2015) and their families. The 2016 budget request for the Department of Veterans Affairs (VA) alone nears a record $170 billion. Likewise, a nonprofit sector bursting with advocates, service providers, philanthropic institutions, passionate professionals, and volunteers working across nearly 45,000 organizations dedicated to veteran and military family support further complements these resources. Moreover, in recognition of the unique skills and character that military service imparts, private industry actively seeks out veterans for employment and training opportunities.

Still, despite the wealth of resources and opportunities, some veterans lag behind the general population in key health and wellness indicators and remain vulnerable to financial, employment, relationship, and legal-related difficulties, as well as homelessness and substance abuse in their transition back to civilian life (GAO, 2014a). The government's efforts, while necessary and valuable, do not fully position veterans for success following their military service. Many challenges and are influenced by social and local factors—i.e., the "social determinants of health" (Wilkinson & Marmot, 2003)—and are beyond the health care system's reach. The private and nonprofit sectors are often better positioned to address such challenges.

But notwithstanding the combined goodwill and determination across all sectors of our economy, collective efforts remain largely fragmented in addressing veteran and military family challenges. As Berglass and Harrell (2012) clearly stated, "only a partnership of stakeholders—informed by a common goal, committed to best practices and operating in a scalable way in the communities to which veterans return—can satisfy our national imperative" to ensure veterans' long-term health and wellbeing.

With challenge comes opportunity, however. Due to great diversity and fragmentation of actors across the veterans' services landscape, local communities confront a challenge and an opportunity to maximize and sustain positive impacts on their veterans and military families through improved, evidence-based coordination of resources, services, and care. Collective impact—an innovative and proven approach to

COLLECTIVE IMPACT AS CHALLENGE AND OPPORTUNITY

Jacob Harold, President and CEO, GuideStar USA, February 18, 2015, Serving Our Post-9/11 Veterans and Military Families Summit, George W. Bush Institute, Dallas TX

Collective impact starts with collective purpose, and the nonprofit sector always has to remind itself that we're a means to an end, we're not an end in and of ourselves; that may mean that we're often referring a client or a funder to someone else.

There's a lot of work to be done, on multiple levels to ensure that veterans are able to get to the service they need…the idea of No Wrong Door…you enter Organization A and you're in search of job training, it turns out that Organization A is focused on mental health services, but Organization B across the street has job training. And how can we ensure that Organization A shifts that veteran over to Organization B in a fluid way? That requires a sense of collective purpose. And it also requires a sense of actually knowing what organization B is all about and what their processes are, even at a very high level.

---

cross-sector collaboration (Kania & Kramer, 2011)—represents a paradigm shift in how organizations tackling complex social problems can accomplish what no single organization can alone. We argue that collective impact presents an opportunity for communities, in partnership with the VA, other government agencies, and private industry, to improve outcomes for veterans, transitioning servicemembers, and their families.

This paper serves two purposes. First, it leverages an extensive foundation of public health and public management research to underscore the need for and value of community-based collective impact models of service delivery in veterans' services. Given the recent emergence of several important collaborative models in veterans' services (e.g., Altarium Institute, 2015; Augusta Warrior Project, 2015; NAVSO, 2015; Nevada Dept. of Veterans Services, 2015; Points of Light, 2015; USC-CIR, 2015; Zero8Hundred, 2015), it is important to demonstrate how the collective impact model and its organizing principles may further inform and encourage best practice and enhance the outcomes of these and future community-based collaborative initiatives. Second, the paper outlines the Institute for Veterans and Military Families' (IVMF) ongoing collective impact initiative, AmericaServes, and highlights preliminary outcomes from its first pilot network in New York City (NYCServes). The first-of-its kind in the nation, NYCServes is a public-private coordinated network of comprehensive services, resources, and care for separating service members, veterans, and their families.

This paper is intended for all stakeholders in the veterans' services community—veterans, families, providers, and funders—with a keen interest in improving long-term health and wellness outcomes for veterans. The collective impact approach to services coordination is significant to a number of stakeholders in veterans' services.

- **For transitioning servicemembers, veterans and military families** as consumers of supportive services, collective impact models may potentially lead to a number of improvements. Users are likely to find faster, more simplified navigation across service providers; more personalized, supportive case management and referrals; and the ability to provide regular customer satisfaction feedback.
- **For service providers,** participation in a collective impact initiative should provide instant access to a centralized and specialized databank of providers and consumers to facilitate multi-need case management, referrals, and follow-up, and consequently, increase trust and satisfaction among veteran and military family consumers. Enhanced data collection and feedback will also help providers refine service approaches and demonstrate achievement and impact to funders.
- **For funders,** supporting collective impact networks with specific quality, data collection, and evidence-based practice requirements will encourage organizations to adhere and perform to specific standards of service. The collective approach will achieve local outcomes more efficiently and with more impact than that of individual organizations.

The pages that follow are organized into four main sections and a conclusion. In the following section, we highlight the national challenge to meeting veterans' myriad health and wellness needs and emphasize the importance and shortfalls in addressing the social factors that affect veteran wellness. Next, we provide a primer on the rising use of cross-sector collaborations, public-private partnerships, and collective impact models to address complex social challenges. Here we highlight the opportunity that collective impact presents for improved coordination and outcomes in veterans services. The final two final sections highlight the IVMF's approach to supporting collective impact and feature preliminary results from its pilot initiatives in New York City, Pennsylvania, and North Carolina.

The Challenge: Veteran Health and Wellness

RESPONSIBILITY FOR VETERAN HEALTH AND WELLNESS EXTENDS WELL BEYOND GOVERNMENT

By law, the VA is responsible for assisting veterans upon leaving the military via benefit programs and health care services totaling over $169 billion, according to the latest executive branch budget submission for fiscal year 2016. The health care arm of the VA—the Veterans Health Administration (VHA)—comprises the bulk of the VA's day-to-day operations. It is truly the nation's largest integrated health care system, covering more than 1,250 hospitals, local clinics, and vet centers (VA, 2015).

Yet, not all veterans receive their health care through the VA. Of the 22 million veterans alive today (VA, 2014b), only about 9 million are enrolled in the VHA and 1.1 million of the 1.8 million post-9/11 veterans eligible for VA health care have accessed VHA services from 2002 to 2013 (VA, 2014a). The VHA serves only 40 percent of all veterans and 61 percent of eligible post-9/11 veterans (since October 2001). Indeed, while not all veteran enrollees use VHA services, others depend greatly on the VHA reflected in the rising use of health care services among veteran enrollees (VA, 2013). Even so, about three in five veterans (and two in five post-9/11 veterans) receive their health care through other public or private providers (or not at all).

This is not surprising given how we designed the system. Despite VHA's size and scope today, Congress originally intended the system to serve as a safety net specifically for honorably discharged veterans with service-related injuries and disabilities or limited means (Kizer & Dudley, 2009, p. 314). It is therefore reasonable to expect that not all veterans will seek VA health care. Granted, even today, the VA is undergoing major department-wide reforms (VA, 2014c) to address its recent struggles related to waiting times and access to specialty care (VA, 2014d; GAO, 2014b). However, in terms of health care quality and effectiveness, studies still show that, since its reforms in the mid-1990s, VHA has performed comparably to, if not better than, the broader national healthcare system (Asch, McGlynn, Hogan, et al., 2004; Kizer & Dudley, 2009; Oliver, 2007).

Even so, the recent outrage over falsified records and waiting times in veteran hospitals clouds the broader issue that veteran and military family demand for services extends well beyond traditional health care—and thus beyond VHA's statutory responsibility. The U.S. Government Accountability Office (GAO) recently conducted a systematic review of academic literature from 2001 to 2013 focused on post-9/11 veteran reintegration (GAO, 2014a). From this analysis, five broad themes emerged that capture veterans' top transition difficulties and needs: financial and employment; relationships; legal; homelessness; and substance abuse. Disability compensation and other VA benefit programs—e.g., the Post-9/11 GI Bill and VA home loan guarantee—provide some critical financial resources to assist transitioning veterans. Training and employment programs across the VA and departments of Labor and Defense provide support too, though they have been widely cited as redundant and poorly coordinated (IVMF & INSCT, 2012; GAO, 2013).

Indeed, the VA assumes incredible responsibility—arguably undue responsibility in some aspects—for veterans' overall health and well-being. But wellness encompasses far more than sustaining physical health and fulfilling material need. It includes building quality social and community relationships and finding and sustaining a sense of purpose and belonging (Berglass & Harrell, 2012, p. 14). The VA was never designed to reintegrate veterans in to civilian society, repair their existing social relationships, or build new ones in the communities in which they ultimately settle. Likewise, VA is not a civilian workforce development program, nor was it ever intended to find veterans a new, meaningful purpose in life. Our country encompasses an immense federal system

The factors that make real impact on veterans' lives—families, friends, colleagues, jobs, schools, housing, and related service providers, to name a few—are all found in local communities. And it's on exactly these factors that attention and resources must be focused.

of 50 states, 3,031 counties, and 35,879 local municipalities or townships (Hogue, 2013). It is foolish to think that one federal agency, or even a few, can or should shoulder absolute responsibility for veteran wellness and reintegration—especially for health and wellness concerns that are both societal and local in nature.

SOCIAL FACTORS AND COMMUNITIES INFLUENCE HEALTH AND WELLNESS

Public health involves preventing injury, reducing disease, and increasing quality of life. From this, a traditional view of health follows through which policymakers and practitioners seek improvements in the quality, accessibility, and efficiency of care and service delivery. Health and wellness are also highly sensitive to social and economic factors as much as they may be individual, clinical, or scientific pursuits. This is why many leading public health experts and organizations such as the World Health Organization (WHO), Robert Wood Johnson Foundation (RWJF), and Institute of Medicine (IOM) strongly advocate for broader approaches that also address the many social and structural factors—i.e., determinants—affecting health outcomes beyond individual attributes and sufficient access to medical care.

The social determinants of health are "the conditions in which people are born, grow, live, work, and age" and include a range of factors outside of the health care system such as employment, education, housing, social cohesion, crime, and environmental conditions (WHO, 2015). More than two decades' worth of research suggests that these factors are strongly correlated with health outcomes (Bartley & Plewis, 2002; Berkman & Syme, 1979; Kawachi & Berkman, 2003; Marmot & Wilkinson, 2006; Moser, Fox, & Jones, 1984; Stansfeld & Marmot, 2002). Taken as a whole, this body of research shows that communities that "enable citizens to play a full and useful role in the social, economic, and cultural life of their society will be healthier than those where people face insecurity, exclusion, and deprivation" (Wilkinson & Marmot, 2003, p. 11; Wizemann & Thompson, 2014).

These social factors are critical areas for policy and health interventions since they influence both health risk and resilience for individuals and groups—families, neighborhoods, communities, and nations alike. Notably, the RWJF is making major investments in programs that focus on better addressing patients' social needs, as it recognizes the "growing consensus" for culture change across the health care community (Hill, 2014; RWJF, 2014). For example, in a 2011 RWJF survey of 1,000 primary care physicians, 85 percent agreed that patients' unmet social needs are leading to worse health and 87 percent said these are problems for everyone of all walks of life, not just low-income communities (RWJF, 2011). Yet in the same study, four in five physicians doubted their ability to meet their patients' social needs.

Certainly, public experts recognize the need for a broader, holistic approach to meeting health and wellness needs. Boston's Health Leads enables providers to prescribe basic resources such as food and heat for low-income patients. Rebecca Onie, its co-founder and CEO, says, "As recently as two years ago, the conversation in the health care sector was about whether the health care system should be responsible for its patients' social needs. Now the question is not whether, but how—how do we make this a reality for our patients" (RWJF, 2014)?

The same question applies here: How do we make this a reality for our veterans and military families? We know that transitioning service members often encounter a number of challenges (GAO, 2014a) and, for those stuck between military and civilian cultures, experience great distress, alienation from family and friends, and identity troubles (Demers, 2011). Yet, in a recent RAND survey of community-based mental health care professionals, only 19 percent were assessed as having a high degree of military cultural competency overall and only one in four felt familiar with general and deployment-related stressors for veterans or family members (Tanielian, Farris, et al., 2014, p. 11). We can certainly do better in terms of access to high quality and culturally sensitive care for veterans. But we also know from evidence that, for the general population, health is also improved through better education, safe and socially supportive environments, and meaningful employment (Marmot, 2006, p. 4). The factors that make real impact on veterans' lives—families, friends, colleagues, jobs, schools, housing, and related service providers, to name a few—are all found in local communities. And it's on exactly these factors that attention and resources must be focused.

MEETING THE DEMAND CALLS FOR A COLLECTIVE, COMMUNITY-BASED APPROACH

Over the past several years, leading figures and experts in veterans affairs have made numerous appeals for improved collaboration within and across the public, private, and voluntary sectors to advance veteran and military family well-being (Berglass, 2010; Carter, 2012, 2013; CJCS, 2014; Copeland & Sutherland, 2010; IVMF & INSCT, 2012). Beyond policy-oriented scholarship, research on collaboration between government and veteran serving organizations is sparse and tends to reach the similar, predictable conclusion that more and better collaboration is needed. This work mainly addresses specific issues

such as benefit claims assistance (Keiser & Miller, 2013), substance abuse (Chaney et al., 2011), service delivery efficiency (Auerbach, Weeks, & Brantley, 2013), and mental health (Burnam, Meredith, Tanielian, & Jaycox, 2009; Tanielian, Martin, & Epley, 2014). Few studies (GWBI & IVMF, 2015) have explored, in depth, how community-based, veteran-serving organizations collaborate in practice.

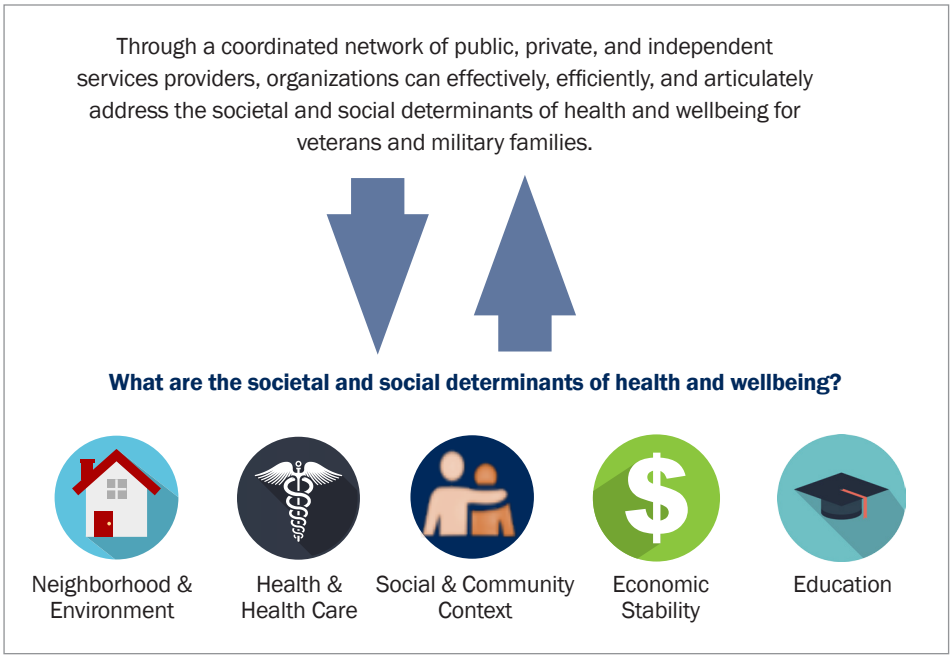
Returning veterans rarely experience transition challenges in isolation. Rather, the challenges they face are often multiple and confounding (Castro, Kintzle, & Hassan, 2014). For any combat veteran seeking mental health assistance, there is a strong chance that veteran is troubled by not only deployment-related experiences, but also financial, legal, housing, or family reintegration challenges. When seeking treatment or assistance with these issues, veterans often need help identifying and locating available services, navigating eligibility requirements, and making appointments. The RAND Corporation found that veterans, perhaps overwhelmed by the sea of resources, sought an expert knowledgeable on the various benefits and services and able to provide effective guidance as well as a "here's-what's-available-for-veterans.com" type website (Schell & Tanielian, 2011). Although a veteran may view challenges as isolated, the adept service provider would understand their interrelated nature and would facilitate and coordinate a holistic approach to the veteran's care through a network of local service providers. To navigate the sea of 45,000 organizations serving veterans and military families, technological solutions can help advocates and coordinators move beyond their local (often informal or personal) networks to locate the best and most timely resources available.

While few examples of this exist today in the world of veterans' services, public and private health care systems are continually developing leading models from which to draw lessons. At the national level, Medicare's Accountable Care Organizations feature opt-in networks of doctors who communicate among themselves and with patients to share medical records and test results. These doctors make collective health care decisions that reduce costs, increase efficiencies, and produce better health outcomes for patients (Medicare.gov, 2015). At a local level, in response to the Illinois General Assembly's 2001 Medicaid Reform law, Chicago's Together4Health network coordinates not only health care but also access to supportive services relevant to the social determinants of health (e.g., housing) to fight poverty, improve community health, and reduce state budget costs—a critical outcome for a state experiencing crisis-level deficits (Together4Health, 2015).

We propose a model that provides improved access to resources and personalized case management and assistance. Empowered by a technology-fueled network of providers, case managers will be able to identify veterans' multiple issues, locate the necessary resources and service providers, and manage services, resources, and care across organizations. But this effort requires the willingness of organizations to join service provider networks and to coordinate veteran and family member access to services, resources, and care with one another. Competition for scarce resources can either prevent or incentivize a community of coordination. Competition may also motivate organizations to seek funding to provide additional services beyond their core expertise or to develop administrative capacity to manage coordination among other organizations in their community. A successful community model of coordinated care must avoid a funding arms race and, instead, focus on organizational specialization.

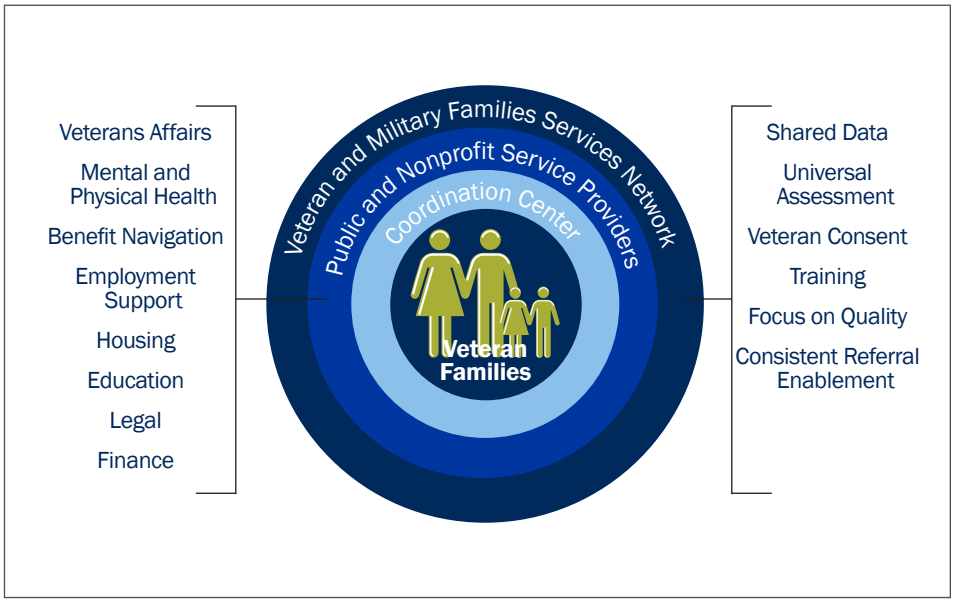
Additionally, organizations must

Figure 1. Needs Addressed By a Veteran and Military Family Services Collective Model



Collective impact presents an opportunity for communities, in partnership with the VA, other government agencies, and private industry, to improve outcomes for veterans, transitioning servicemembers, and their families.

Figure 2. A Coordinated Network Delivery System of Veteran and Military Family Service Providers



establish relationships of trust; that is, if I refer a veteran to you, for example, I must know that you will not damage my relationship with that veteran by providing low-quality services or a poor interaction. We want providers to focus on doing what they do best, while identifying specific performance requirements and supporting transparency in sharing information among the network. And we want providers to trust that veterans will receive an appropriate service of the best possible quality within a pre-defined timeframe. Service and care coordination thereby ensure that veterans receive transparent and unencumbered support across a high-performing, collaborative network that meets their multiple, overlapping needs at once.

We acknowledge that strong, selfless community leaders are needed to create the conditions for coordination. By leveraging the private sector's desire to innovate and the compelling evidence in favor of increased coordination, community leaders are well positioned to effect local adoption of such service and care coordination models. The value proposition of coordinated care networks is simple: they will produce a greater collective impact on veterans and military families in their community than the overall impact of individual providers operating independently without coordination and collaboration.

A Primer on Cross-Sector Collaboration and Collective Impact

Collaboration provides considerable returns across the public and private sector through enhanced learning, resource efficiency, planning capacity, competitiveness, and service delivery (Provan & Kenis, 2008). Organizations seek collaboration opportunities for a number of troublesome reasons, including issue complexity (e.g., homeland security, emergency management, climate change, and obesity), limited resources or expertise, risk and uncertainty, and unique stakeholder or consumer needs (Alter & Hage, 1993).

This is particularly evident today in the rising use of collaborative governing arrangements and networks of public and private organizations that co-produce and deliver public goods and services (Agranoff & McGuire, 2001, 2003; Bingham & O'Leary, 2008; Bingham, O'Leary, & Carlson, 2008; Emerson, Nabatchi, & Balogh, 2012; Goldsmith & Eggers, 2004; McGuire, 2006; Vangen, Hayes, & Cornforth, 2014). Privatization, the digital age, and consumer demand have fashioned new concepts such as "government by network" (Goldsmith & Eggers, 2004), "public-private partnerships" (Osborne, 2000), and integrated public service delivery, or "e-government" (West, 2004).

In the public health sector, the need for and benefits of collaboration are especially great. Public health is a complex, multidisciplinary, and multisector undertaking due to its technical, social, and environmental nature. Simultaneously tackling immediate clinical need, preventing and confronting emergent pandemic threats, and reducing the long-term structural and systemic social drivers of illness require an integrated, holistic approach. That approach involves continuous coordination across a complex maze of health care professionals and providers, government agencies, private and community-based organizations, and others.

Consequently, health policy and management trends reflect a clear move toward planning and delivering services through collaborative networks of care that integrate both public agencies and nonprofit organizations (Calman, Hauser, Lurio, Wu, & Pichardo, 2012; Elliott et al., 2014; Gilbody, Bower, Fletcher, Richards, & Sutton, 2006; Mays & Scutchfield, 2010; Provan, Beagles, & Leischow, 2011; Zahner, Oliver, & Siemering, 2014). Likewise, the Robert Wood Johnson Foundation, the nation's largest public health philanthropic organization, has recognized the advantages and potential impacts of cross-sector collaboration between the health care system and community development organizations to reduce or stamp out nonmedical causes of poor health (Arkin, Braveman, Egerter, & Williams, 2014; Hill, 2014; Israel, Schulz, Parker, & Becker, 1998; Mettessich & Rausch, 2013).

Simultaneously tackling immediate clinical need, preventing and confronting emergent pandemic threats, and reducing the long-term structural and systemic social drivers of illness require an integrated, holistic approach.

FROM COLLABORATION TO COLLECTIVE IMPACT

Within this broader movement toward increased cross-sector collaboration, organizations and their funders are now placing greater emphasis on the combined social value, or collective impact, that collaborative activities produce (Austin & Seitanidi, 2012; Edmondson & Hecht, 2014; Kania & Kramer, 2011; Weaver, 2014). Broadly defined, collective impact initiatives unite groups of actors from different sectors through a formalized, long-term commitment and common agenda to address a particular social problem (Kania & Kramer, 2011, p. 39). Unlike public-private partnership models that are often confined to the delivery or production of a single public good or service (Bel, Brown, & Marques, 2015; Brown, Potoski, & Van Slyke, 2013; Osborne, 2000), collective impact models engage the full range of stakeholders around a specific social issue of great need.

The idea of collective impact is motivated by the assumption that its alternative—i.e., the isolated impact of one or a few high performing and well-funded nonprofit organizations—is often insufficient for solving complex social problems that demand continuous learning and adaptation (Kania & Kramer, 2011, pp. 38-39). The Foundation Strategy Group's Collective Impact Forum has highlighted a number of successful and noteworthy examples of collective impact initiatives tackling various challenges such as secondary education (Pace & Edmondson, 2014), environmental reclamation (The Elizabeth River Project, 2015), and childhood obesity (Chomitz et al., 2012). Several of Bloomberg Philanthropy's collaborative efforts in New York City also model a collective impact approach (Freedman Consulting LLC & Bloomberg Philanthropy, 2013).

At least five conditions are known to drive success in collective impact initiatives (Kania & Kramer, 2011, pp. 39-40). The first condition is a shared commitment to a common agenda. Individual organizations have their own visions of the world around them and interests to pursue. For collective impact to work, however, all participants must find consensus around a set of shared goals, objectives, and actions.

Second, the group must develop common performance measurement system. Defining collective success and developing a set of measures and data for collection and monitoring safeguard both long-term goal alignment and accountability within the group (Provan, Veazie, Staten, & Teufel & Shone, 2005).

The idea of collective impact is motivated by the assumption that its alternative—i.e., the isolated impact of one or a few high performing and well-funded nonprofit organizations—is often insufficient for solving complex social problems that demand continuous learning and adaptation.

Third, each individual organization's activities must be mutually reinforcing. That is, shared data and evidence must inform a common plan or framework that, in turn, guides participants' activities in an integrated and coordinated way (Hanleybrown, Kania, & Kramer, 2012, p. 8).

Fourth, continuous communication is essential for the collective impact initiative to function effectively. Constant interaction and exchange of information are necessary to (1) build and sustain trust, a well-established element of network success (Klijn, Edelenbos, & Steijn, 2010), and (2) foster group learning and problem solving, also known as "communities of practice" (Wenger, 1998, 2015; Wenger, McDermott, & Snyder, 2002). Communication and evidence-based learning are critical to group innovation and finding new solutions to complex and evolving problems (Kania & Kramer, 2013).

The fifth and final key to achieving collective impact is the central administrative, or backbone, organization that governs collaboration and coordination across the group (Provan & Kenis, 2008, p. 236). Backbone organizations provide the necessary staffing and infrastructure to facilitate continuous communication, planning, data collection and evaluation, and related administrative tasks associated with making the initiative function effectively. Driven by the common agenda, backbone organizations guide vision and strategy, support aligned activities, establish shared measurement practices, build public will, advance policy, and mobilize funding for the group as whole (Turner, Merchant, Kania, & Martin, 2012).

IVMF Approach to Collective Impact

The IVMF is heavily engaged in collective impact initiatives supporting veterans and their families. Developing and enhancing trusted partnerships is the VA's number two strategic goal (VA, 2015e) and it is unmistakably clear that meeting veterans' social needs demands a collective, whole-of-nation approach to veteran reintegration (CJCS, 2014; IVMF & INSCT, 2012). A collective approach requires increased engagement, collaboration, goal alignment, and investment among the public, private, and independent sectors toward the advancement of veteran health and wellness. With approximately 45,000 nonprofit organizations serving veterans and military families and tens of thousands more providing social services to the general public, tremendous opportunity exists for the private and independent sectors—in partnership with government—to step in to fill the gap in meeting the wellness needs of veterans and by extension, their families.

Over the past two years, the IVMF has provided ground-level technical assistance to collective impact initiatives in communities across the country. In this time, using the Foundation Strategy Group collective impact model (Kania & Kramer, 2013), the Institute has adopted five guiding principles that inform our approach and support to communities in these efforts:

Figure 3. IVMF Principles for Supporting Collective Impact in Veterans Services

1. COMMUNITY-DESIGNED, OWNED, AND LED.

All communities are unique. Each has its own distinct needs and challenges. Each also has its own natural and material resources and preexisting human and social capital. As decades' worth of global research on community and international development suggests (Donais, 2009; Israel et al., 1998; Mansuri & Rao, 2004; Minkler & Wallerstein, 2008; Smith, 2005), the best and most sustainable initiatives are locally driven, adapted to the surrounding context (e.g., need and capacity), long-term, inclusive, and incorporate meaningful monitoring and evaluation processes.

With approximately 45,000 nonprofit organizations serving veterans and military families and tens of thousands more providing social services to the general public, tremendous opportunity exists for the private and independent sectors—in partnership with government—to step in to fill the gap in meeting the wellness needs of veterans and by extension, their families.

As supporting partner to a number of growing collective impact initiatives, the IVMF recognizes that, resources aside, the means—i.e., the people and organizations—through which impact will be delivered already exist in communities. Likewise, solutions for meeting the needs of veterans are likely to vary across communities as well. Rather than reinventing the wheel or prescribing a one-size-fits-all model, our approach is one of partnership, of community stakeholder authority and buy-in, and of leveraging existing capacity and efforts already under way.

More than any other organizing principle, the need to attract adaptive leaders into any community's efforts to better serve the needs of its veterans and their families is key. These leaders will create a culture and an environment that value building and sustaining their community's collective approaches that respond to veteran and family needs. Without principled and pragmatic leadership, building capacity across the public, private, and independent sectors to serve veterans and their families in a coordinated way will remain beyond the community's reach. Leaders who can push beyond entrenched parochialism and endure the burden of the veterans' sector, will be required to serve in their community if collective efforts are to take hold. That means finding and retaining leaders who can act without prejudice and bias toward all organizations, not just the few, regardless of whether or not they are defined as Veteran Service Organizations. These leaders can come from anywhere in the public, private, independent, or even philanthropic sectors. They must have authority to convene, guide planning and implementation, and retain technical assistance to help. They must also possess resources capable of supporting all three of these leader responsibilities.

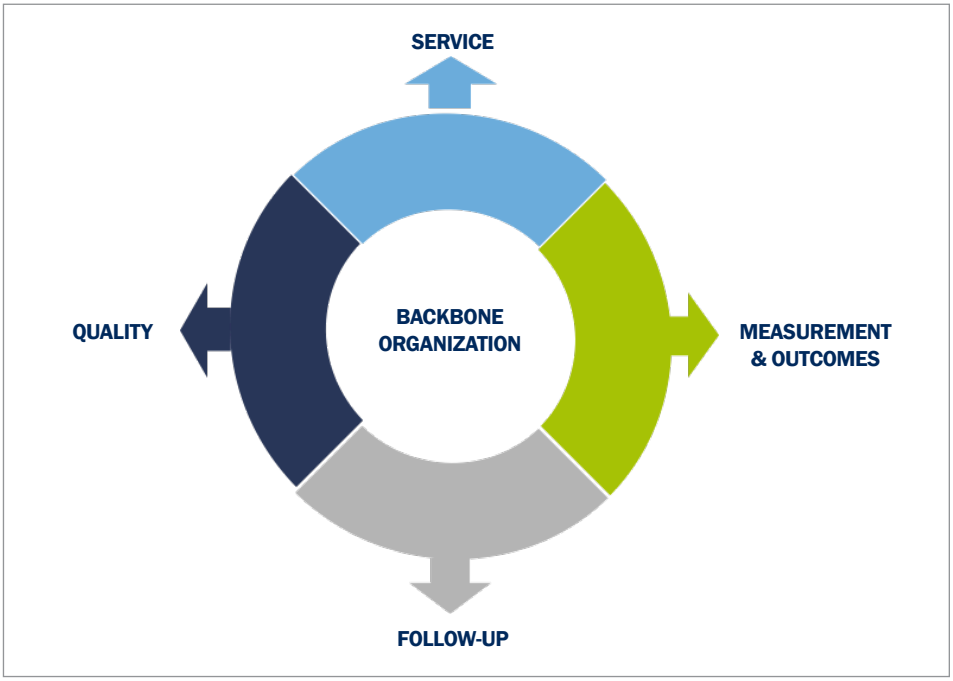
2. SELFLESS BACKBONE ORGANIZATION SUPPORT.

An effective backbone organization is essential for a collective impact initiative to succeed (Turner, Merchant, Kania, & Martin, 2012). A backbone organization's role, however, is less about directing and far more about governing through facilitation, coordination, and evaluation. The ideal backbone organization possesses a combination of strengths to serve in such a capacity: respect from the community; organizational maturity; humble and selfless leaders above self-interest and competition; and, beyond all else, a core capacity and focus to foster communication, joint planning, accountability, and transparency. In the ecosystem of veteran-serving organizations, an organization like Services for the Underserved (S:US)—enabled by technology provided by Unite US and whose primary function is to support from behind—stands out. S:US and similar organizations have unprecedented opportunity to envision the potential social value they may create by serving other organizations that serve veterans and their families directly.

3. LEVERAGE AND OPTIMIZE COMMUNITY STRENGTHS.

Identifying participants' key strengths and weaknesses in advance is vital to maximizing collective impact. The human services field is comprised of many loosely aligned actors and organizations. Each service area—e.g., employment and education; mental health; housing; family, child, and youth services; food and nutrition—is a critical element in the broader service delivery system that meets a community's distinct needs. Yet, the many organizations that provide these services have their own strengths and limitations on a range of factors such as organizational mission, funding, program eligibility, and organizational boundaries. In addition,

Figure 4. Backbone Organization's Commitment to the Coordinated Network



the breadth and scope of human and social services available at the community level exceed, with near certainty, those offered specifically to veterans and military families.

Successful collective impact initiatives are more than the sum of their parts. Leveraging the strengths and best aspects of all providers—including those that do not necessarily target veteran consumers—ensures that a community's collective resources are put to their best and most efficient use. In addition, open sharing of strengths and limitations enhances provider transparency and awareness to make more precise, informed referrals across the network, thereby enhancing their combined impact.

4. SHARED COMMITMENT TO CONTINUOUS LEARNING AND IMPROVEMENT.

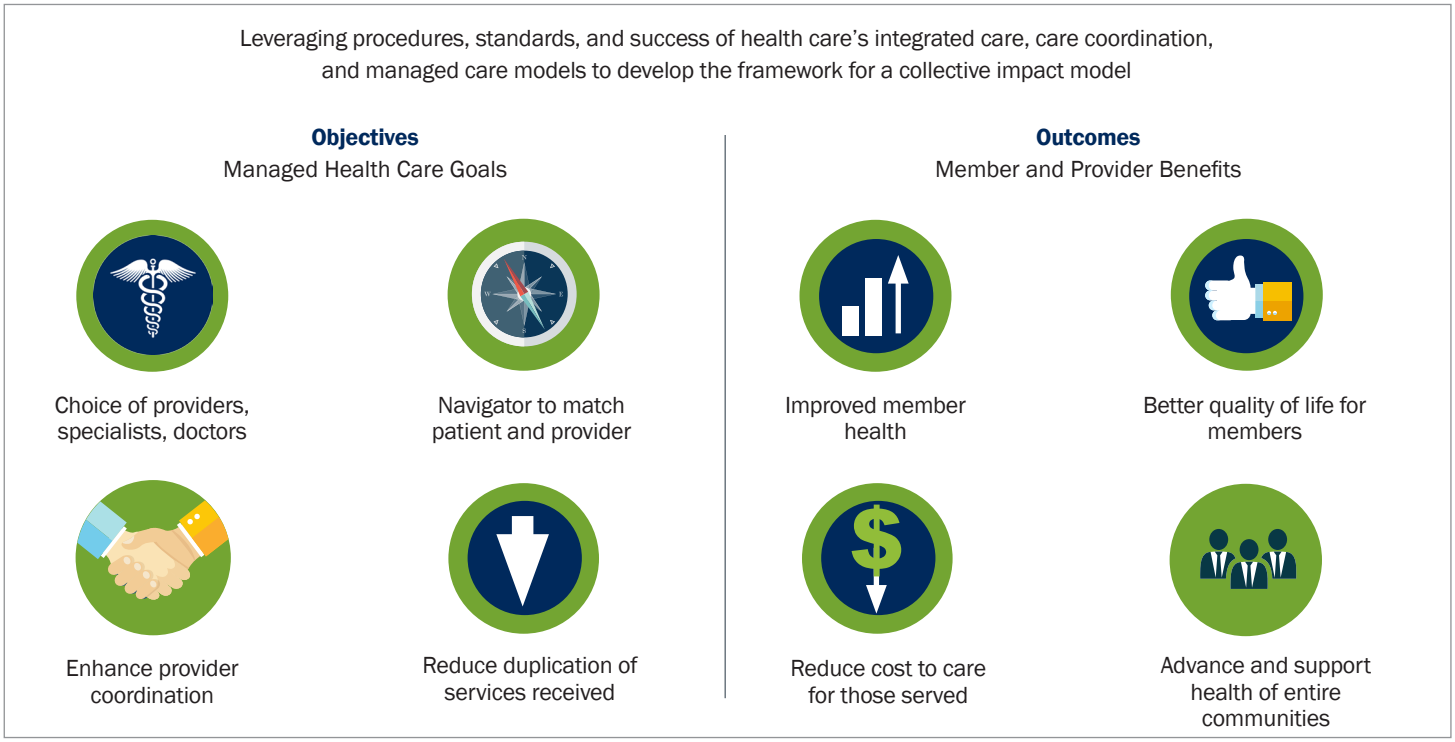
Members must commit to continuous learning through genuine engagement with other partner organizations in the group. This involves providing and receiving frequent and consistent feedback on observations related to individuals, external stakeholders, and within the collective itself. Continuous learning is developmental, present-minded, and prospective, as opposed to retrospective. Persistent communication and feedback build trust and support, but more importantly, resilience and adaptive capacity by enhancing the groups' ability to hastily detect unanticipated changes, opportunities, or risks, and respond with new resources or solutions (Kania & Kramer, 2013). Learning through practice also elevates the performance of all. In the short term, it builds confidence and expertise through increased knowledge and resource sharing. In the long term, it builds reputation and innovation (Wenger et al., 2002).

5. EVIDENCE AND DATA-DRIVEN PRACTICE.

The use of research and evidence to inform practice is critical to ensuring that professionals prove optimal services and care to individuals and families seeking assistance (Roberts & Yeager, 2006). Although communities may vary in size and other attributes, services of care and support should be informed by the best scientific or observational knowledge possible, applied consistently, and measured thoroughly nationwide (Institute of Medicine, 2001). Nevertheless, an apparent void remains in measurement and evaluation practices among veteran and military family serving organizations (GWBI & IVMF, 2015; Tanielian, Farris, et al., 2014).

Adding a new component to the Foundation Strategy Group collective impact approach, the IVMF is promoting evidence and data-driven care and

Figure 5. Designing the Solution: Drawing Comparisons to Health Care Coordination Models



services through implementation of a community of practice model supported by a technology-based knowledge and data management system. Importantly, the technology streamlines individual case management and referrals and tracks individual, provider, and network outcomes over time—most notably, data and evidence grounded by the social determinants of health and well-being. Beyond creating an open-door case management and referral system for community providers, this system encourages continuous learning, transparency, accountability, and increased social value. In addition, beyond anticipated performance gains, the enhanced data measurement and learning practices provide funders and partners additional risk mitigation. Combining a community of practice learning model with a technology-empowering case management infrastructure presents an innovative platform for community-based service providers to draw upon and increase quality and impact.

A SUPPLEMENT ON THE IMPORTANCE OF MEASUREMENT AND EVALUATION

Once participating public, private, and nonprofit actors agree to a set of shared goals and objectives, it is imperative to develop and implement a robust measurement and evaluation effort to capture collective return on investment (ROI) and to assess and communicate network effectiveness and impact. Cross-sector collaboration in the veteran and military family sector is challenging; market saturation coupled with diminishing funding opportunities has led to increased competition. As a result, once a collective impact effort overcomes these barriers to change, it becomes critically important to demonstrate that the network's value is greater than the sum of its parts.

After recognizing that a shared measurement and evaluation system is key for success, the providers within a collective impact network must identify relevant and important performance indicators to be captured and evaluated. This ensures collective buy-in, participation, and adherence to a set of agreed-upon standards and metrics.

While convincing providers to agree on a shared set of goals and objectives sounds challenging, identifying a collection methodology that enables the coordinated network to measure and track progress can be the most daunting task. Since most providers adhere to existing tracking requirements, they must also be willing to contribute to the additional qualitative and quantitative data points that the coordinated network requires. The backbone organization must be committed to reporting results to all to demonstrate the outputs and outcomes to providers and to demonstrate that the return from inputting the data is worth the additional time required to share it within the network. Each participating organization gains additional awareness of others' in the network through a simplified reporting process.

By identifying and integrating the right qualitative and quantitative measurement standards, a coordinated network can demonstrate the performance of its collective efforts, identify areas for improvement, set and monitor targets and goals, and increase trust and transparency through regular reporting to service providers and funders. Identifying measurement standards can be developed in collaborative working sessions with participating providers. But the challenge is in the change management: convincing and training organizations to integrate any additional data collection requirements into their day-to-day activities.

In addition to traditional methods of data collection such as common data fields and surveys, the network technology platform provides effective data aggregation. For example, an individual veteran record can provide the spectrum of services requested and utilized; time to serve from each domain of need; and quality outcomes generated for the veteran and military family member. By assessing these performance indicators, providers can identify internal process improvements, recognize potential redundancies, and see potential market expansion opportunities. If veterans in a given geography are consistently seeking and unable to receive educational benefit navigation services due to lack of provider presence, a local provider can document and establish a business case for expansion. This eliminates expansion based on assumptions about the market or redundant services and provides a rich context when making the case for funding. Using a single, integrated data tracking system across the network ensures the accepted use of commonly defined and understood indicators to measure and monitor outcomes.

The approach to measuring impact in collective efforts must follow a tangible life cycle (e.g., McLaughlin & Kaluzny, 2006):

1. Define the intended impact and how that impact is achieved;
2. Collect, measure, and verify data;
3. Refine insights, identify achievements and improvements;
4. Capitalize and report on achievements, agree on proposed approach for implementing improvements.

Most importantly, measurement and evaluation methods and performance indicators may need to evolve to encompass a network's needs and requirements as it grows in size and increases in complexity. The expectation should not be to get it right immediately, nor to see immediate growth and results, but to measure initial progress and use those findings to improve the network.

AmericaServes: IVMF Collective Impact in Motion

THE VALUE PROPOSITION

Collective impact is emerging in the veterans' services space. As its principles of collaboration, inclusive design, and social impact become increasingly appealing to communities, the model's long-term success depends not only on its demonstrable quality of impact on veterans and their families, but also on the measurement and evaluation tools employed to communicate funder and participant return on investment. Consequently, collective systems of veterans' services, resources, and care are gaining momentum, largely due to the growing support of funders and government entities that recognize the value of embedded measurement and evaluation systems and their supporting technology.

Recognizing the model's value and opportunity to advance veteran wellness, the IVMF has designed and is supporting collective impact initiatives—comprehensive, accountable models of services, resources, and care to serve veterans and their families—in a growing number of American communities. AmericaServes is the Institute's multi-state, multi-year initiative to position American communities at the forefront of delivering impactful, transformative, and inclusive services to veterans and family members through coordinated, evidence-based service delivery networks. The initiative is fueled in part by private philanthropic interests to achieve greater scale and impact in communities already serving those who served.

Figure 6. Building a Collective Impact Model

AmericaServes is the Institute's multi-state, multi-year initiative to position American communities at the forefront of delivering impactful, transformative, and inclusive services to veterans and family members through coordinated, evidence-based service delivery networks.

Our work in a growing number of communities—including Charlotte, North Carolina; Pittsburgh, Pennsylvania; and New York, New York—draws heavily upon these developments and focuses on generating unprecedented returns on investment. These returns measure not only individual organizational value, but also collective value within the community—i.e., the organization's contribution to a broader system of services, resources, and care.

The chief goal of AmericaServes is to generate greater organizational impact and improved individual outcomes for transitioning service members, veterans, and their families. The model is designed to infuse higher levels of quality, qualification, and professionalism in coordinated networks of services, resources, and care in communities across America. It also aims to produce a sufficient return on investment (RoI) within the networks to seed and sustain new forms of investment and trusted public-private partnerships between local communities and government.

The value generated for veterans and their families is inherent in the AmericaServes collective impact framework. Those seeking services have unprecedented access to a technology-supported network of high-quality, community-based service providers, which enables them greater access to resources than ever before. For veteran service providers, this value comes in the form of an enhanced ability to serve those at the core of their mission and better understanding of veteran needs throughout their community. The AmericaServes initiative further qualifies this benefit for providers by aligning the network's collective mission with providers own organizational goals, thereby conveying the important message that participation does not require mission change or creep. It ensures that providers are able to continue doing what they do best to generate greater outcomes.

Although value is more clearly visible to consumers and providers, the importance of collecting and communicating these outcomes to private funders and governments cannot be overlooked. The proliferation of collective impact models for veterans' services could potentially prompt a proportionate increase in funder demand for strategies that demonstrate stewardship of and return on investment. Meeting this demand most likely requires a technology solution that provides the network with case management, referral, and data collection capabilities that support a comprehensive measurement and evaluation plan. To facilitate RoI, partnerships with Unite US and Metis Associates/Gotham Culture provide AmericaServes with data collection and analysis resources that allow return on investment metrics to be easily tailored and shared with funding partners.

The best and most sustainable initiatives are locally driven, adapted to the surrounding context (e.g., need and capacity), long-term, inclusive, and incorporate meaningful monitoring and evaluation processes.

A COMMUNITY CENTRIC-APPROACH

Before entering into a community, the IVMF research team reviews local veteran population and demographic data such as unemployment rates, Point in Time (PIT) counts, proximity of military installations, and representation by era served. After analyzing the veterans, transitioning service members, and military consumers, we conduct a market scan of VA expenditures and public, private, and nonprofit providers serving veterans and their families in the communities. Upon identifying a small philanthropic investment for planning, we begin working in a community, in-person, in biweekly increments. We convene public, private, and nonprofit providers, who are often initially spurred to attend out of either interest or skepticism. Over the course of six months (e.g., Phase I Strategic Planning), we identify critical needs and gaps in service delivery, gather stakeholder feedback and observations, and form an expert roundtable of providers to design the requirements for a coordinated network. We form key relationships with stakeholders and often add new partners along the way. After six months, IVMF provides a final deliverable to the funder; the tangible deliverable is a requirements document for a localized coordinated network and an opportunity to approve transition into secondary implementation phase. Most notably, the intangible deliverable is the buy-in from community partners to challenge the status quo, their commitment to improving the delivery of services, resources, and care.

During the two-year Phase II Implementation, we work with the competitively identified Coordination Center and Unite US to welcome each provider into the network. Welcoming starts with a nine-point Provider Qualification that aggregates the organizations' programs and mission areas dedicated toward veterans and military families, their GuideStar rating, any accreditations, and the service domains that they cover. After the Provider Qualification is completed, providers complete participation and technology licensing agreements and commit to utilizing an informed consent document. Once their staff is trained on the use of technology, they become a working

provider within the network. During the two-year demonstration, the Coordination Center strives to add providers when there is an identified need and, if necessary, removes nonperforming providers from the network. Results are measured in real time, to demonstrate value to the consumers (veterans, transitioning service members, and military families), service providers, and funders. The quantitative and qualitative data collected will be used to advocate for sustainable funding from the federal government. The ultimate aim of the AmericaServes demonstration is to articulate the value of this to the public sector to seed and sustain.

NYCSERVES: NETWORK FORMATION

The IVMF launched its initial efforts to plan, design, build, and deploy a coordinated network of veteran service providers—including the VA's health care resources—in New York City in late 2013. Powered by a grant from the Robin Hood Foundation, IVMF convened public and private service providers in New York City to design and develop new ways of providing more accessible, navigable, and coordinated services to veterans across New York City's five boroughs. These discussions led to the development of a strategy for piloting the NYCServes coordinated network that would integrate private- and public-sector resources to increase efficiency and reduce redundant effort in veteran focused services.

NYCServes is a first-of-its-kind, privately funded network of more than 40 providers of human services that address the various social determinants of health and wellbeing for veterans (e.g., physical and mental health, employment, and housing). These organizations are connected via a technological platform provided by Unite US, through which they are able to efficiently and securely share information across the network. This network is coordinated by a backbone coordination center supported by Services for the Underserved (S:US), which plays a role similar to that of an Administrative Services Organization (ASO) in managed health care. The S:US assesses providers' capacities and assigns referrals accordingly, thereby lifting the coordination burden off the service providers so they can focus on delivering a high-quality service and experience to

Figure 7. The IVMF Approach to Supporting Collective Impact in Communities

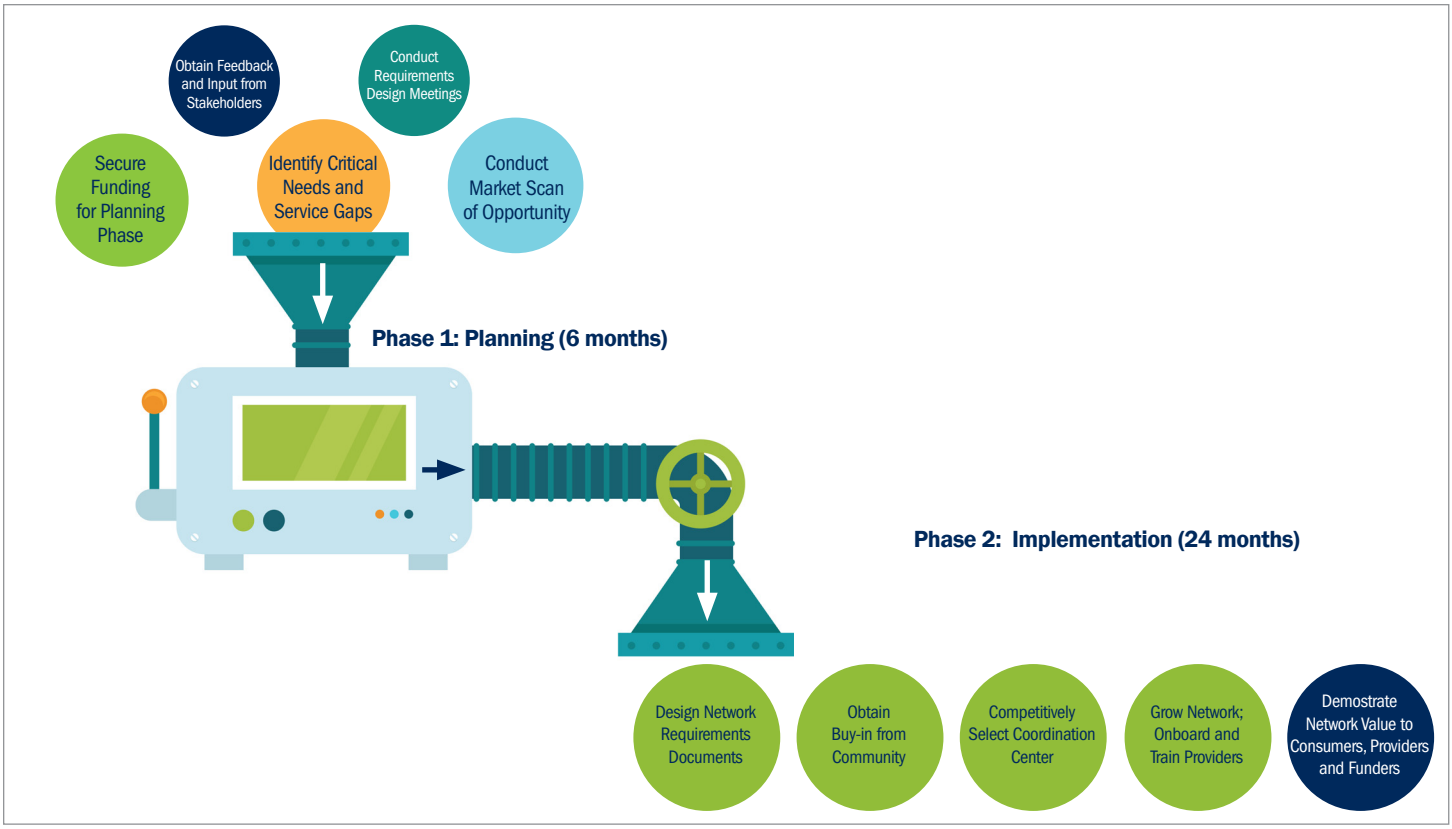
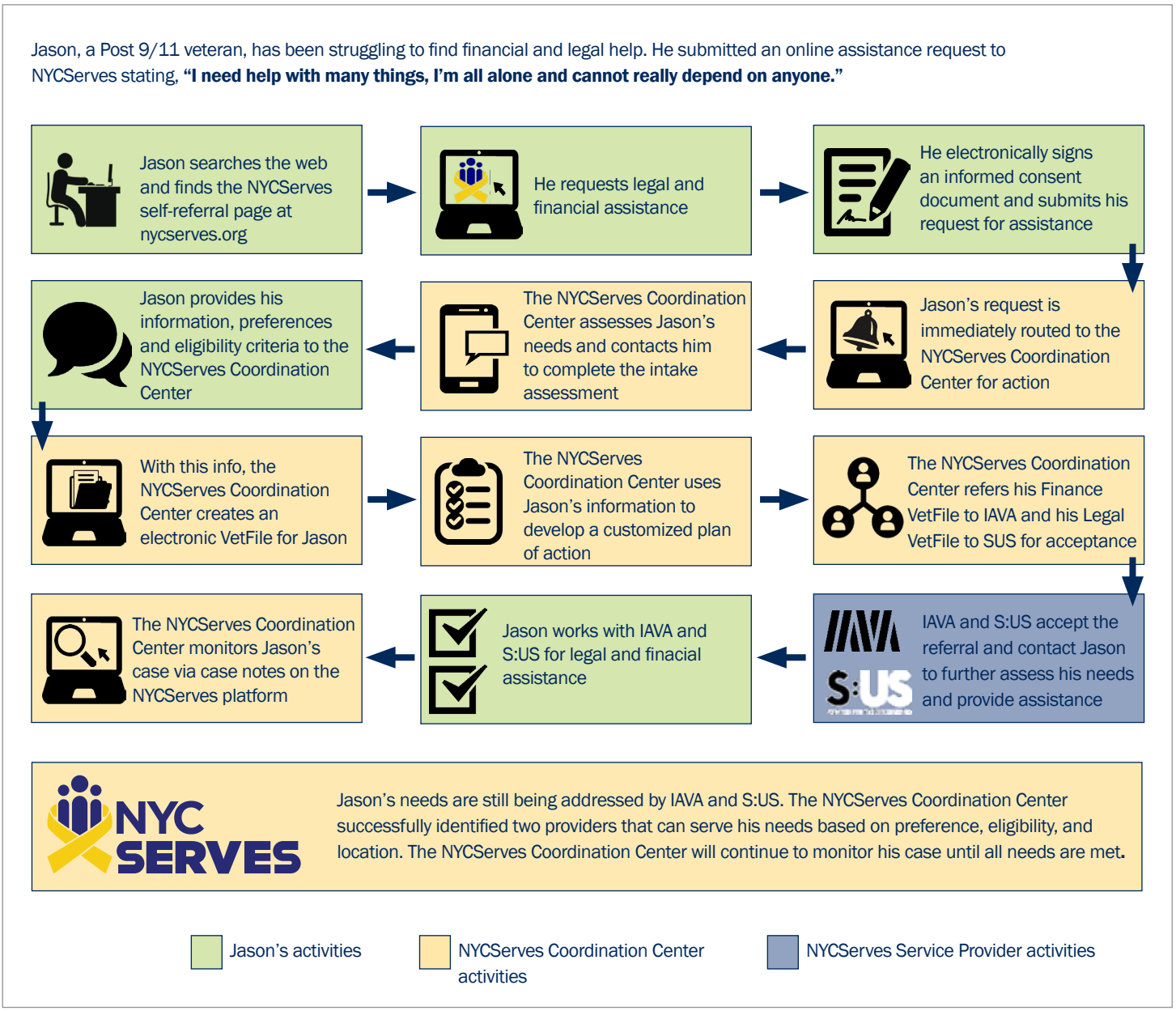


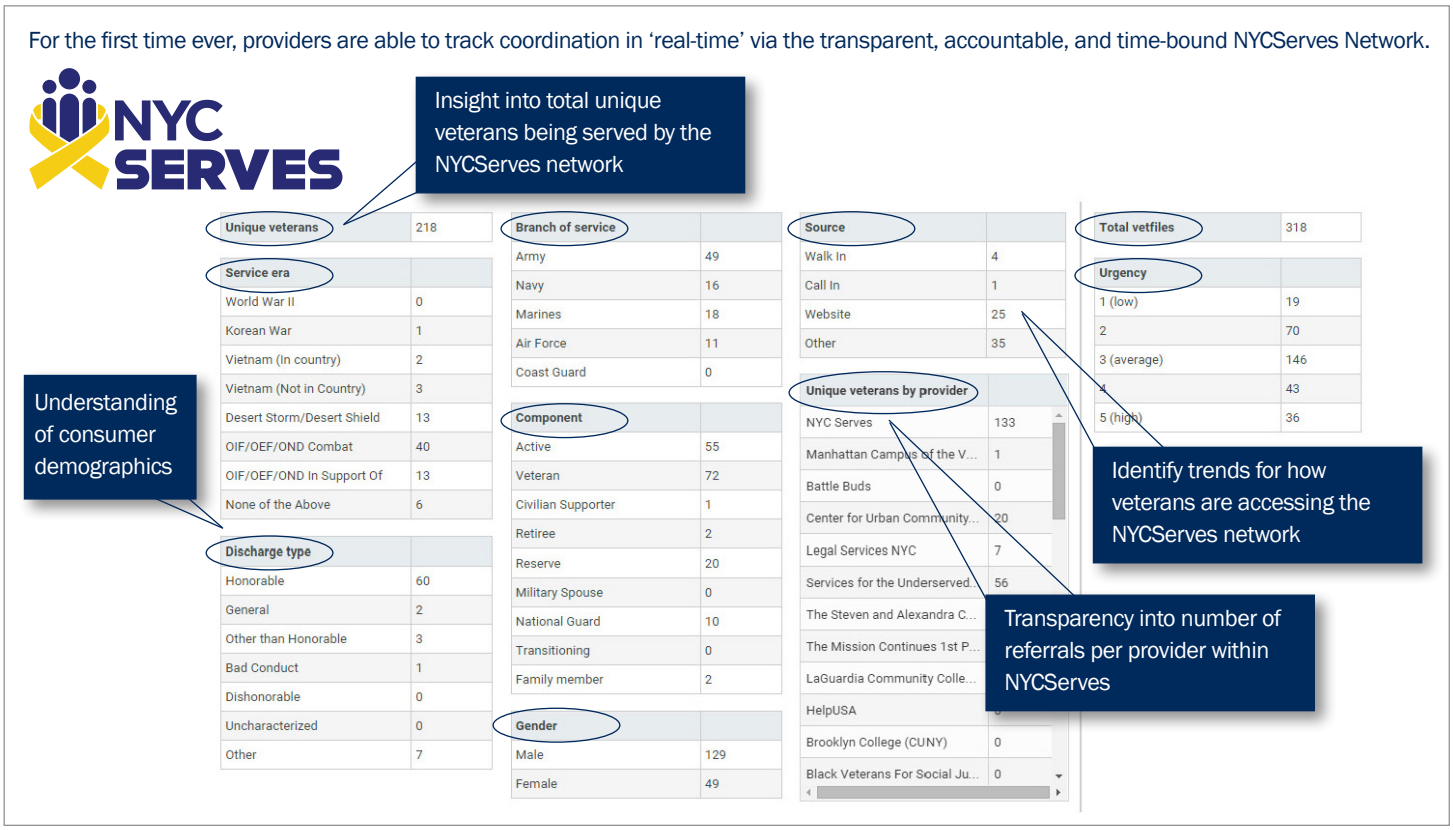
Figure 8. The NYCServes Referral: An Example



their veterans and family member clients.

NYCServes commenced an 18-month pilot phase in December 2014, supported by a blend of private funders, during which it aims to serve more than 3,000 veterans and family members. NYCServes has two goals. The first is proving the concept's viability. The second, and greater, goal is to demonstrate that the new value proposition in veterans' services, resources, and care is found in the collective outcomes of the parts rather than the parts themselves. NYCServes is the initial example of the future public-private partnership model that sets the standard for how America's veteran families are served: community- and evidence-based, collectively organized networks of service providers, resources, and caregivers.

Figure 9: The NYCServes Dashboard



DRIVING EVIDENCE-BASED PRACTICE THROUGH DATA

Driving evidence-based practice through robust data collection and application of lessons learned is paramount to NYCServes sustained impact and continuous improvement. In the early stages of the NYCServes pilot, it became apparent that embedding a culture of regular dialogue and feedback would be crucial to the network's long-term success. Accordingly, network participants agreed to establish a series of quarterly In Progress Reviews (IPRs), conducted both in-person and virtually, to promote learning and rapid improvement in process and service delivery. A key component of these periodic IPRs is to review the network data collected by

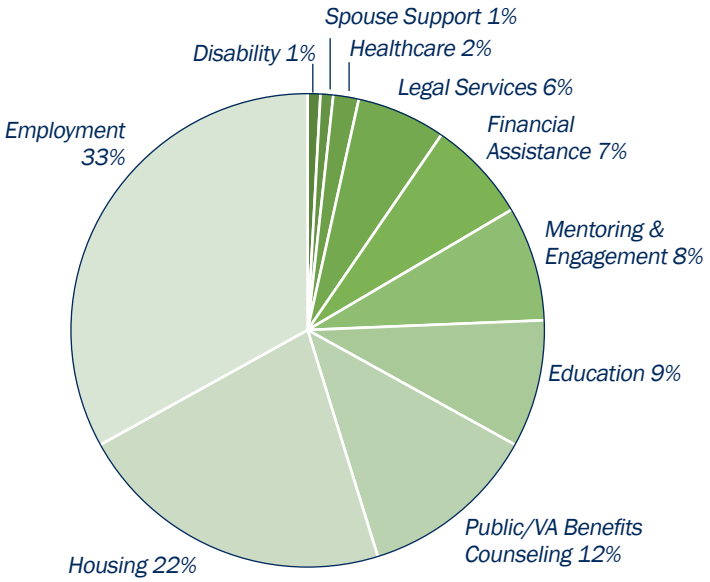
By identifying ... measurement standards, a coordinated network can demonstrate the performance of its collective efforts, identify areas for improvement, set and monitor targets and goals, and increase trust and transparency through regular reporting to service providers and funders.

Unite US. Along with Unite US, the IVMF has also partnered with Metis Associates/ Gotham Culture to provide a third party evaluation of the pilot network's overall effectiveness, impact, and customer satisfaction. Though still in its early phases, this complementary assessment is underway and will help to inform improvements in the NYCServes and future networks' processes and practices.

NYCServes demonstrated a remarkable intake of veterans demanding services in the first quarter (Q1) of 2015. While this is presently the network's first and only snapshot in time, the Q1 data, summarized in a real-time dashboard (Figure 9), reveals an intake of 218 unique veterans served across the network. Beyond these basic inputs, the individual data collected (with informed consent) provide rich detail of demographic characteristics (e.g., gender, service era, branch of service, type of discharge, etc.) of the veterans accessing the network.

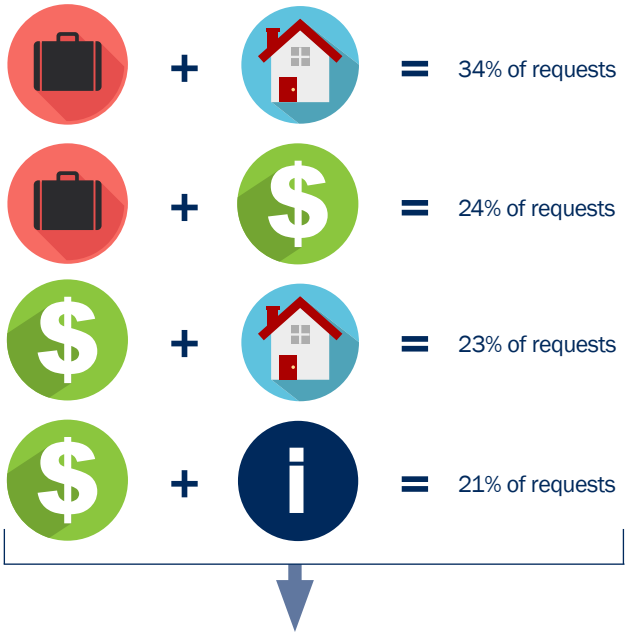
Figure 10. Demand for Services (Q1, 2015)

By analyzing the data collected through the NYCServes portal, we are able to identify service domains in greatest demand, which informs future network growth and expansion planning for additional providers.



(Percentages based on successful referrals for services)

We also noticed recurring correlations in service requests, which further informs planning for increasing services to veteran members.



A majority of veterans who seek employment services also request housing or financial assistance. Those who seek financial assistance appear to also request housing or mentoring and engagement services.

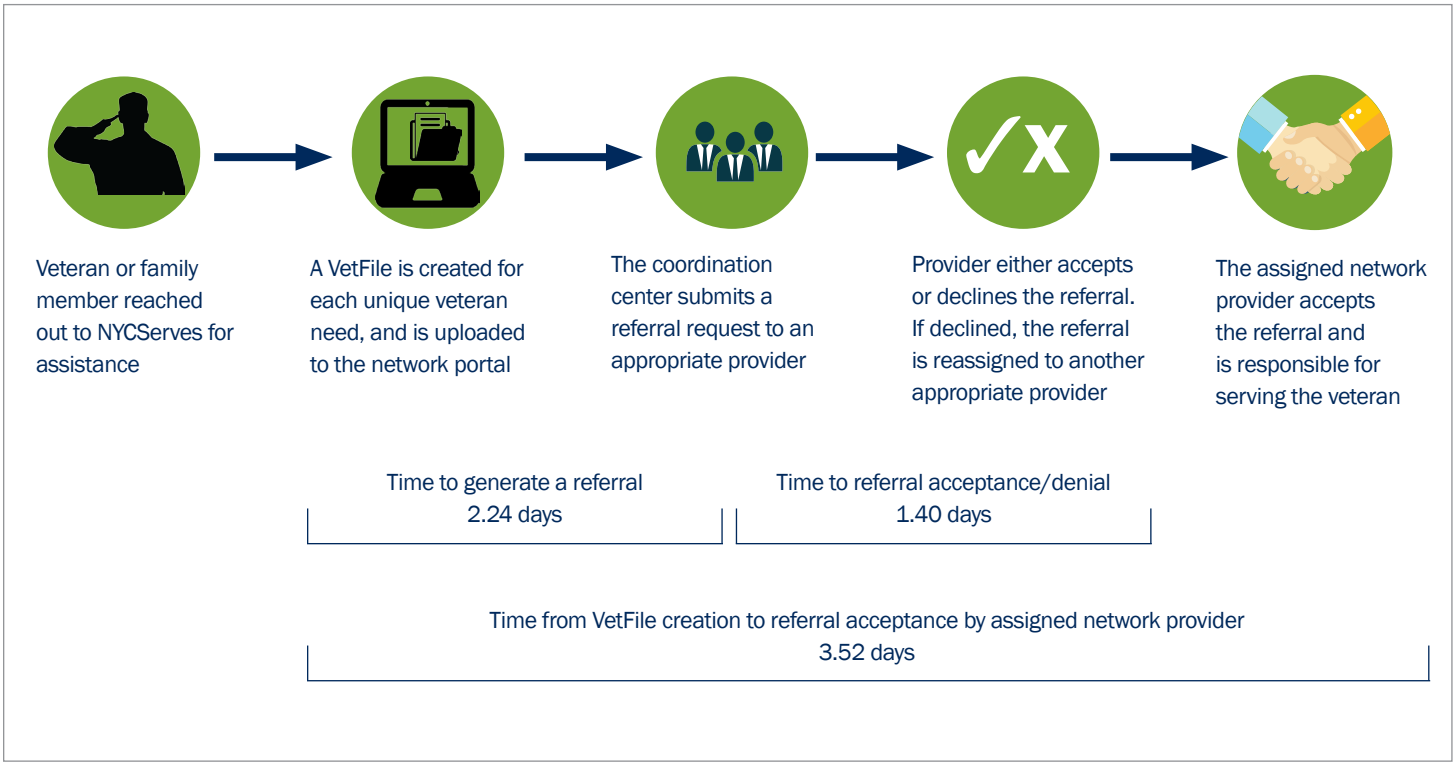
Importantly, data on referral requests by type, service provider, and referral duration elevate peer-to-peer and external transparency and accountability in ways that differentiate NYCServes from other collaborative models in veterans' services. Finally, data on referral demand (Figure 10) and network efficiency (Figure 11) inform the network's ongoing coordination and referral (re)assignment as well as its planning for future growth or change based on historical demand. For example, employment and housing were the two greatest requests for assistance in Q1 (more than half), however, more than a third of participants requested help with both (Figure 10).

In addition, IVMF continues to identify leading practices and standards that are essential to building a strong foundation for a coordinated collaborative network of services, resources, and care for veteran families. One of the most critical activities that became evident as new providers joined the initiative was to clearly outline and map their qualifications—e.g., their geographical coverage, portfolio of services or programs, and certifications and accreditations. This process takes time. However, the information has already proven vital to help providers better understand how they fit into the network's ecosystem, reinforce their commitment and confidence to provide consistent high quality services to veteran families, and demonstrate their value and credibility as a network participant (and the network's collective value) to funders and the veteran families they serve.

SCALING SUCCESS: CHARLOTTE, NORTH CAROLINA AND PITTSBURGH, PENNSYLVANIA

The standard established by NYCServes

Figure 11. Network Efficiency (Q1, 2015)



and its high-aiming goals have sparked attention and support from philanthropic organizations and community interests in North Carolina and southwestern Pennsylvania. Enabled by initial funding from the Heinz Endowments in Pittsburgh and the Walmart Foundation North Carolina, providers from the public and private sectors in these communities are embracing their responsibility to better address the needs of veteran families, while utilizing local funding more efficiently and effectively through the creation of coordinated provider networks similar to NYCServes. North Carolina (NCServes) and Pennsylvania (PAServes), two new peer models of collective impact under the AmericaServes banner, are now developing strategies that are tailored to their local communities' needs and are set to launch in summer 2015. In addition to the communities outlined here that have initiated community-based, collectively organized networks, a number of communities across the nation are also investigating the opportunity to replicate this model and preparing to launch planning efforts within the next 18 months.

The IVMF, in conjunction with its strategic partners in Unite US and Accenture, has propelled new collective models of services, resources, and care into communities across the United States that value ongoing learning and commitment to continuous improvement for the betterment of the veteran populations they serve. Importantly, while time will tell, these models are already showing early signs that collective impact, as an organizing framework, may be a missing piece to addressing the apparent gaps between public, private, and nonprofit organizations.

Conclusion: The Case for Collective Impact in Veterans Services Provision

Despite vast generosity and laudable effort (Copeland & Sutherland, 2010), our nation's approach to fulfilling the moral obligation to its veterans has some inherent shortfalls (CJCS, 2014; IVMF & INSCT, 2012). As this paper has highlighted throughout, research points to a greater need for addressing the social determinants of health and wellbeing in the communities in which people live, work, and play. While this is true for all Americans, it must be the nation's North Star on which to orient our ways and means toward advancing the lives of our veterans and their families.

The status quo and its barriers—fragmented, uncoordinated, and siloed approaches—demand the nation's immediate attention if we are to improve the course of post-military life for our transitioning service members and their families. If ever there was a sector screaming for more collective activity, it is the veteran nonprofit sector. Nearly 45,000 nongovernmental, nonprofit entities are largely going it alone in their efforts to address the needs of returning veterans and their families. Some are collaborating, but it is unclear the extent to which they are doing so with any greater efficiency or impact. Most communities are organizing efforts with little or no understanding of how to deliver high quality, personalized models of services, resources, and care that match veterans' needs.

As this paper outlines, the collective impact approach is one way to do so. Collective impact offers great potential and promise for how the nation can better support its veterans and their families. It provides clear, direct benefit to a population in need of integrated, holistic services. Moreover, in light of the explosive growth in health care costs, collective impact initiatives—which enhance wellness (i.e., reduce disease and illness) through various social factors—offer enhanced resilience and potential savings to a national health care system under great strain. Because they are necessarily community- and evidence-based by design, collective impact initiatives present public and private sector funders opportunity for smarter and more efficient use of resources and a better alternative to advance veteran wellness compared to supporting individual programs or organizations of various quality and impact.

Finally, policymakers looking to improve how our nation provides for its veterans and their families should explore funding and other means to incentivize increased community-based service provider coordination and participation in collective impact initiatives. Empowering the VA to invest in and increase collective impact initiatives at the community level should be strongly considered. The philanthropic community must also coalesce around the idea of driving local collaboration and coordination by funding networks as opposed to individual organizations. All stakeholders must do more to support strong measurement and evaluation approaches among providers as well.

Through AmericaServes, the IVMF is leveraging its resources to empower and support communities in their quest to deliver more inclusive, holistic, and impactful services to veterans and family members via coordinated, evidenced-based service delivery networks. Ultimately, AmericaServes' value is rooted in providing unprecedented access to a technology-supported network of high-quality service providers and resources. As this paper argues, this model is based in decades of public health research on the social determinants of health and innovations in public sector collaboration and health care management. Even so, this is only one innovative example of how communities can transform how they care for veterans and their families. Each community must ultimately determine whether and how to improve coordination of services. This paper should at least provide ample motivation to do so, for recognizing that, in spite of generous government-provided benefits, it still takes a community to serve a veteran and their families well.

About the Authors

NICHOLAS J. ARMSTRONG, PH.D.

Nick Armstrong is the senior director for research and policy at the Institute for Veterans and Military Families (IVMF) at Syracuse University. Before joining the IVMF, Armstrong served for six years as a research fellow at Syracuse University's Institute for National Security and Counterterrorism (INSCT). Armstrong is also a seven-year veteran of the U.S. Army, and served in Iraq, Afghanistan, and Bosnia. Armstrong is a graduate of the U.S. Military Academy at West Point (B.S.) and the Maxwell School of Citizenship and Public Affairs at Syracuse University (Ph.D., M.P.A.).

COLONEL JAMES D. MCDONOUGH JR., USA (RET.)

James McDonough is the managing director of community engagement and innovation at the Institute for Veterans and Military Families at Syracuse University (IVMF). Before joining the IVMF, McDonough served as senior fellow for veterans affairs at the New York State Health Foundation; president and CEO of the Rochester, New York-based Veterans Outreach Center Inc.; and director of the New York State Division of Veterans' Affairs. He is a 26-year veteran of the U.S. Army, including service in Germany, Korea, and Kuwait in support of Operation Iraqi Freedom.

DANIEL SAVAGE, M.P.P.

Daniel Savage is senior director of community engagement and innovation at the Institute for Veterans and Military Families at Syracuse University (IVMF). A U.S. Army veteran, Savage served for five years as an infantry officer, including service overseas in Iraq, Kuwait, Egypt, and Germany. Savage serves as a fellow with the Truman National Security Project and the New Leaders Council and as a past fellow in the office of Chicago Mayor Rahm Emanuel. Savage is a graduate of the U.S. Military Academy at West Point (B.S.) and the John F. Kennedy School of Government at Harvard University (M.P.P.).

References

ENDNOTES

1. *Berglass and Harrell (2012, p. 14) define "veteran wellness" as "the satisfactory and sufficient conditions permitting individuals to function as necessary. Physical and psychological well-being are each informed by four dimensions: social/personal relationships, health, fulfillment of material needs and purpose. These dimensions are interrelated and mutually supporting."*

2. *A February 2, 2015, basic search of the GuideStar USA nonprofit database returned 44,623 organizations using the term "veterans" and another 1,132 using the term "military family," though there is some degree of intersection between these two figures. Source: http://www.guidestar.org/.*

3. *See http://www.collectiveimpactforum.org/.*

4. *Though the principles in this figure are not described explicitly in the text, they are all addressed to various degrees in this section.*

5. *See, for example, https://uniteus.com/.*

Agranoff, R., & McGuire, M. (2001). Big Questions in Public Network Management Research. *Journal of Public Administration Research and Theory, 11*(3), 295-326.

Agranoff, R., & McGuire, M. (2003). *Collaborative Public Management: New Strategies for Local Governments.* Washington, DC: Georgetown University Press.

Altarium Institute. (2015). Veterans Community Action Teams Mission Project. Ann Arbor, MI. from http://altarum.org/our-work/veterans-community-action-teams-mission-project

Alter, C., & Hage, J. (1993). *Organizations Working Together.* Newbury Park, CA: SAGE Publications.

Arkin, E., Braveman, P., Egerter, S., & Williams, D. (2014). *Time to Act: Investing in the Health of Our Children and Communities: Recommendations from the Robert Wood Johnson Foundation Commission to Build a Healthier America.* Princeton, NJ: Robert Wood Johnson Foundation.

Asch, S. M., McGlynn, E. A., Hogan, M. M., Hayward, R. A., Shekelle, P., Rubenstein, L., . . . Kerr, E. A. (2004). Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample. *Annals of Internal Medicine, 141*(12), 938-945.

Auerbach, D. I., Weeks, W. B., & Brantley, I. (2013). *Health Care Spending and Efficiency in the US Department of Veterans Affairs*. Santa Monica, CA: RAND Corporation.

Augusta Warrior Project. (2015). Our Model. Retrieved February 8, 2015, from http://augustawarriorproject.org/our-model/

Austin, J. E., & Seitanidi, M. M. (2012). Collaborative Value Creation: A Review of Partnering between Nonprofits and Businesses. Part 2: Partnership Processes and Outcomes. *Nonprofit and Voluntary Sector Quarterly, 41*(6), 929-968.

Bartley, M., & Plewis, I. (2002). Accumulated Labour Market Disadvantage and Limiting Long-Term Illness: Data from the 1971–1991 Office for National Statistics' Longitudinal Study. *International Journal of Epidemiology, 31*(2), 336-341.

Bel, G., Brown, T., & Marques, R. C. (Eds.). (2015). *Public-Private Partnerships: Infrastructure, Transportation and Local Services.* Oxfordshire, UK: Routledge.

Berglass, N. (2010). *America's Duty: The Imperative of a New Approach to Warrior and Veteran Care.* Washtington, DC: Center for a New American Security.

Berglass, N., & Harrell, M. C. (2012). *Well after Service: Veteran Reintegration and American Communities.* Washington, DC: Center for a New American Security.

Berkman, L. F., & Syme, S. L. (1979). Social Networks, Host Resistance, and Mortality: A Nine-Year Follow-up Study of Alameda County Residents. *American Journal of Epidemiology, 109*(2), 186-204.

Bingham, L., & O'Leary, R. (2008). *Big Ideas in Collaborative Public Management.* Armonk, NY: M.E. Sharpe.

Bingham, L., O'Leary, R., & Carlson, C. (2008). Frameshifting: Lateral Thinking for Collaborative Public Management. In L. Bingham & R. O'Leary (Eds.), *Big Ideas in Collaborative Public Management* (pp. 3-16). Armonk, NY; London: M.E. Sharpe.

Brown, T. L., Potoski, M., & Van Slyke, D. (2013). *Complex Contracting: Government Purchasing in the Wake of the U.S. Coast Guard's Deepwater Program.* Cambridge, UK: Cambridge University Press.

Burnam, M. A., Meredith, L. S., Tanielian, T., & Jaycox, L. H. (2009). Mental Health Care for Iraq and Afghanistan War Veterans. *Health Affairs, 28*(3), 771-782.

Byrne, T., Culhane, D., Kane, V., Kuhn, J., & Treglia, D. (2014). *Predictors of Homelessness Following Exit from the Supportive Services for Veteran Families Program.* Philadelphia, PA: VA National Center on Homelessness Among Veterans, U.S. Department of Veterans Affairs.

Calman, N., Hauser, D., Lurio, J., Wu, W. Y., & Pichardo, M. (2012). Strengthening Public Health and Primary Care Collaboration through Electronic Health Records. *American Journal of Public Health, 102*(11), e13-e18.

Carter, P. (2012). *Upholding the Promise: Supporting Veterans and Military Personnel in the Next Four Years.* Washington, DC: Center for a New American Security.

Carter, P. (2013). *Expanding the Net: Building Mental Health Care Capacity for Veterans.* Washington, DC: Center for a New Amercian Security.

Castro, C. A., Kintzle, S., & Hassan, A. (2014). *The State of the American Veteran: The Los Angeles County Veterans Study.* Los Angeles, CA: Center for Innovation and Research on Veterans and Military Families, University of South California School of Social Work.

Chairman of the Joint Chiefs of Staff (CJCS) Office of Reintegration. (2014). After the Sea of Goodwill: A Collective Approach to Reintegration. Washington, DC: U.S. Department of Defense, Joint Staff.

Chaney, E. F., Rubenstein, L. V., Liu, C.-F., Yano, E. M., Bolkan, C., Lee, M., . . . Uman, J. (2011). Implementing Collaborative Care for Depression Treatment in Primary Care: A Cluster Randomized Evaluation of a Quality Improvement Practice Redesign. *Implementation Science, 6*(1).

Chomitz, V. R., Corliss, J., Arsenault, L., Chui, K., Garnett, B. R., & Economos, C. (2012). *A Decade of Shape Up Somerville: Assessing Child Obesity Measures 2002-2011.* Somerville, MA: Shape Up Somerville.

Copeland, J. W., & Sutherland, D. W. (2010). Sea of Goodwill: Matching the Donor to the Need. Washington, DC: Office of the Chairman of the Joint Chiefs of Staff, Warrior and Family Support.

Demers, A. (2011). When Veterans Return: The Role of Community in Reintegration. *Journal of Loss and Trauma, 16*(2), 160-179.

Donais, T. (2009). Empowerment or Imposition? Dilemmas of Local Ownership in Post-Conflict Peacebuilding Processes. *Peace & Change, 34*(1), 3-26.

Edmondson, J., & Hecht, B. (2014). Defining Quality Collective Impact. *Stanford Social Innovation Review, 12*(4), Sponsored Supplement: Collective Insights on Collective Impact, 6-7. http://www.ssireview.org/articles/entry/defining_quality_collective_impact

Elliott, L., McBride, T. D., Allen, P., Jacob, R. R., Jones, E., Kerner, J., & Brownson, R. C. (2014). Peer Reviewed: Health Care System Collaboration to Address Chronic Diseases: A Nationwide Snapshot from State Public Health Practitioners. *Preventing Chronic Disease, 11.*

Emerson, K., Nabatchi, T., & Balogh, S. (2012). An Integrative Framework for Collaborative Governance. *Journal of Public Administration Research and Theory, 22*(1), 1-29.

Freedman Consulting LLC, & Bloomberg Philanthropy. (2013). *The Collaborative City: How Partnerships between Public and Private Sectors Can Achieve Common Goals.* New York, NY: Freedman Consulting.

George W. Bush Institute (GWBI), & Institute for Veterans and Military Families (IVMF). (2015). *Leading Practices among Veteran and Military Family Serving Organizations: A Thematic Case Study Analysis.* Dallas, TX: George W. Bush Institute.

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative Care for Depression: A Cumulative Meta-Analysis and Review of Longer-Term Outcomes. *Archives of Internal Medicine, 166*(21), 2314-2321.

Goldsmith, S., & Eggers, W. D. (2004). *Governing by Network: The New Shape of the Public Sector*. Washington, DC: Brookings Institution Press.

Hanleybrown, F., Kania, J., & Kramer, M. (2012). Channeling Change: Making Collective Impact Work. *Stanford Social Innovation Review,* 1-8. http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work

Hill, D. (2014). *A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health: Examining the Interaction between Social Environment and the Health of Low-Income Populations in Oregon.* Princeton, NJ: Robert Wood Johnson Foundation.

Hogue, C. (2013). *Government Organization Summary Report: 2012.* Washington, DC: U.S. Census Bureau.

Institute for Veterans and Military Families (IVMF), & Institute for National Security and Counterterrorism (INSCT). (2012). *A National Veterans Strategy: The Economic, Social, and Security Imperative.* Syracuse, NY: Syracuse University.

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: The National Academies Press.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health, 19*(1), 173-202.

Kania, J., & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review, 1*(9), 36-41.

Kania, J., & Kramer, M. (2013). Embracing Emergence: How Collective Impact Addresses Complexity. *Stanford Social Innovation Review.* http://www.ssireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity

Kawachi, I., & Berkman, L. F. (2003). *Neighborhoods and Health.* Oxford; New York: Oxford University Press.

Keiser, L. R., & Miller, S. M. (2013). Collaboration between Government and Outreach Organizations. In IBM Center for the Business of Government (Ed.), *Collaboration Across Boundaries Series.* Washington, DC: IBM Center for the Business of Government.

Kizer, K. W., & Dudley, R. A. (2009). Extreme Makeover: Transformation of the Veterans Health Care System. *Annual Review of Public Health, 30*(1), 313-339.

Klijn, E.-H., Edelenbos, J., & Steijn, B. (2010). Trust in Governance Networks: Its Impacts on Outcomes. *Administration & Society, 42*(2), 193-221.

Mansuri, G., & Rao, V. (2004). Community-Based and -Driven Development: A Critical Review. *The World Bank Research Observer, 19*(1), 1-39.

Marmot, M. (2006). Introduction. In M. G. Marmot & R. G. Wilkinson (Eds.), *Social Determinants of Health* (2nd ed., pp. 1-5). Oxford: Oxford University Press.

Marmot, M., & Wilkinson, R. G. (2006). *Social Determinants of Health* (2nd ed.). Oxford; New York: Oxford University Press.

Mays, G. P., & Scutchfield, F. D. (2010). Improving Public Health System Performance through Multiorganizational Partnerships. *Preventing Chronic Disease, 7*(6), A116.

McGuire, M. (2006). Collaborative Public Management: Assessing What We Know and How We Know It. *Public Administration Review, 66*(December-Special Issue), 33-43.

McLaughlin, C. P., & Kaluzny, A. D. (2006). *Continuous Quality Improvement in Health Care* (3rd ed.). Sudbury, Mass.: Jones and Bartlett.

Medicare.gov. (2015). Accountable Care Organizations. Retrieved February 15, 2015, from http://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.html

Mettessich, P. W., & Rausch, E. J. (2013). *Collaboration to Build Healthier Communities: A Report for the Robert Wood Johnson Foundation Commission to Build a Healthier America.* Minneapolis, MN: Wilder Research.

Minkler, M., & Wallerstein, N. (2008). *Community-Based Participatory Research for Health: From Process to Outcomes* (2nd ed.). San Francisco, CA: John Wiley & Sons.

Moser, K. A., Fox, A. J., & Jones, D. (1984). Unemployment and Mortality in the OPCS Longitudinal Study. *The Lancet, 324*(8415), 1324-1329.

National Association of Veteran-Serving Organizations (NAVSO). (2015). Home. from http://www.navso.org/

Nevada Department of Veterans Services. (2015). Green Zone Network. Carson City, NV. from http://www.greenzonenetwork.org/

Oliver, A. (2007). The Veterans Health Administration: An American Success Story? *The Milbank Quarterly, 85*(1), 5-35.

Osborne, S. P. (2000). *Public Private Partnerships: Theory and Practice in International Perspective.* London; New York: Routledge.

Pace, L., & Edmondson, J. (2014). *Improving Student Outcomes through Collective Impact: A Guide for Federal Policymakers.* Cincinnati, OH: Knowledge Works.

Points of Light. (2015). Community Blueprint. Atlanta, GA. from http://www.pointsoflight.org/programs/military-initiatives/community-blueprint

Provan, K. G., Beagles, J. E., & Leischow, S. J. (2011). Network Formation, Governance, and Evolution in Public Health: The North American Quitline Consortium Case. *Health Care Management Review, 36*(4), 315.

Provan, K. G., & Kenis, P. (2008). Modes of Network Governance: Structure, Management, and Effectiveness. *Journal of Public Administration Research and Theory, 18*(2), 229-252.

Provan, K. G., Veazie, M. A., Staten, L. K., & Teufel & Shone, N. I. (2005). The Use of Network Analysis to Strengthen Community Partnerships. *Public Administration Review, 65*(5), 603-613.

Robert Wood Johnson Foundation (RWJF). (2011). *Health Care's Blind Side: The Overlooked Connection between Social Needs and Good Health. Summary Findings from a Survey of America's Physicians.* Princeton, NJ: Robert Wood Johnson Foundation.

Robert Wood Johnson Foundation (RWJF). (2014). Robert Wood Johnson Foundation Awards $16 Million to Health Leads to Help Health Care Providers Address Social Factors. Retrieved January 29, 2015, from http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2014/04/robert-wood-johnson-foundation-awards--16m-to-health-leads-to-he.html

Roberts, A. R., & Yeager, K. (2006). *Foundations of Evidence-Based Social Work Practice.* Oxford; New York: Oxford University Press.

Schell, T. L., & Tanielian, T. (2011). *A Needs Assessment of New York State Veterans: Final Report to the New York State Health Foundation.* Santa Monica, CA: RAND Corporation.

Smith, H. (2005). Ownership and Capacity: Do Current Donor Approaches Help or Hinder the Achievement of International and National Targets for Education? *International Journal of Educational Development, 25*(4), 445-455.

Stansfeld, S. A., & Marmot, M. G. (2002). *Stress and the Heart: Psychosocial Pathways to Coronary Heart Disease.* London: BMJ Books.

Tanielian, T., Farris, C., Epley, C., Farmer, C. M., Robinson, E., Engel, C. C., . . . Jaycox, L. H. (2014). *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families.* Santa Monica, CA: RAND Corporation.

Tanielian, T., Martin, L. T., & Epley, C. (2014). *Enhancing Capacity to Address Mental Health Needs of Veterans and Their Families.* Santa Monica, CA: RAND Corporation.

The Elizabeth River Project. (2015). About the Elizabeth River Project. Retrieved January 31, 2015, from http://www.elizabethriver.org/#!about-the-elizabeth-river-project/c226v

The White House, Executive Office of the President. (2013). The Fast Track to Civilian Employment: Streamlining Credentialing and Licensing for Service Members, Veterans, and Their Spouses. Washington, DC: The White House., p. 7. from https://www.whitehouse.gov/sites/default/files/docs/military_credentialing_and_licensing_report_2-24-2013_final.pdf

Together4Health. (2015). Together4health. from http://www.t4hillinois.org/

Turner, S., Merchant, K., Kania, J., & Martin, E. (2012). Understanding the Value of Backbone Organizations in Collective Impact: Part 2. *Stanford Social Innovation Review* - Blog. http://www.ssireview.org/blog/entry/understanding_the_value_of_backbone_organizations_in_collective_impact_2

University of Southern California, Center for Innovation and Research on Veterans & Military Families (USC-CIR). (2015). Los Angeles Veterans Collaborative. Retrieved February 8, 2015, from http://cir.usc.edu/community-engagement/la-vet-collaborative

U.S. Department of Defense. (2015). Armed Forces Strength Figures for January 31, 2015. Retrieved March, 2015, from https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp

U.S. Department of Veterans Affairs. (2013). Trends in the Utilization of VA Programs and Services. Retrieved January, 2015, from http://www.va.gov/vetdata/docs/quickfacts/Utilization_trends_2012.pdf

U.S. Department of Veterans Affairs. (2014a). Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans Cumulative from 1st Qtr FY 2002 through 3rd Qtr FY 2014 (October 1, 2001 – June 30, 2014). http://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2014-qtr3.pdf

U.S. Department of Veterans Affairs. (2014b). National Center for Veterans Analysis and Statistics. VetPop 2014, FY2014 Estimate. http://www.va.gov/vetdata/Veteran_Population.asp

U.S. Department of Veterans Affairs. (2014c). Veterans Affairs Secretary McDonald Updates Employees on MyVA Reorganization Plans. Retrieved January, 2015, from http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2657.

U.S. Department of Veterans Affairs. (2014d). *Veterans Health Administration Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System.* Retrieved January, 2015, from http://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf

U.S. Department of Veterans Affairs. (2014e). *FY2014-2020 Strategic Plan.* Retrieved March, 2015, from http://www.va.gov/op3/docs/strategicplanning/va2014-2020strategicplan.pdf

U.S. Department of Veterans Affairs. (2015). Veterans Health Administration. Retrieved January 27, 2015, from http://www.va.gov/health/

U.S. Government Accountability Office (GAO). (2013). *Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness.* Washington, DC: GAO.

U.S. Government Accountability Office (GAO). (2014a). *Better Understanding Needed to Enhance Services to Veterans Readjusting to Civilian Life*. Washington, DC: GAO.

U.S. Government Accountability Office (GAO). (2014b). *VA Lacks Accurate Information About Outpatient Medical Appointment Wait Times, Including Specialty Care Consults.* Washington, DC: GAO.

Vangen, S., Hayes, J. P., & Cornforth, C. (2014). Governing Cross-Sector, Inter-Organizational Collaborations. *Public Management Review,* 1-24.

Weaver, L. (2014). The Promise and Peril of Collective Impact. *The Philanthropist, 26*(1).

Wenger, E. (1998). *Communities of Practice: Learning, Meaning, and Identity*. Cambridge, UK; New York: Cambridge University Press.

Wenger, E. (2015). *Learning in Landscapes of Practice: Boundaries, Identity, and Knowledgeability in Practice-Based Learning.* Oxford; New York: Routledge.

Wenger, E., McDermott, R. A., & Snyder, W. (2002). C*ultivating Communities of Practice: A Guide to Managing Knowledge.* Boston, MA: Harvard Business School Press.

West, D. M. (2004). E-Government and the Transformation of Service Delivery and Citizen Attitudes. *Public Administration Review, 64*(1), 15-27.

Wilkinson, R. G., & Marmot, M. (Eds.). (2003). *Social Determinants of Health. The Solid Facts* (2nd ed.). Copenhagen, Denmark: World Health Organization.

Wizemann, T., & Thompson, D. (2014). *The Role and Potential of Communities in Population Health Improvement*. Paper presented at the The Role and Potential of Communities in Population Health Improvement, Los Angeles, CA.

World Health Organization (WHO). (2015). Social Determinants of Health. from http://www.who.int/social_determinants/en/

Zero8Hundred. (2015). Home. San Deigo, CA. from http://www.zero8hundred.org/Home.aspx

Zahner, S. J., Oliver, T. R., & Siemering, K. Q. (2014). The Mobilizing Action toward Community Health Partnership Study: Multisector Partnerships in US Counties with Improving Health Metrics. *Preventing Chronic Disease,* 11.

About

THE INSTITUTE FOR VETERANS AND MILITARY FAMILIES (IVMF)

The IVMF is the first interdisciplinary national institute in higher education focused on the social, economic, education and policy issues impacting veterans and their families post-service. Through our focus on veteran-facing programming, research and policy, employment and employer support, and community engagement, the institute provides in-depth analysis of the challenges facing the veteran community, captures best practices and serves as a forum to facilitate new partnerships and strong relationships between the individuals and organizations committed to making a difference for veterans and military families.

ABOUT NEW YORK STATE HEALTH FOUNDATION

The New York State Health Foundation (NYSHealth) is a private, statewide foundation dedicated to improving the health of all New Yorkers. We strive to be focused and purposeful in our work; establish and adhere to clear goals and strategies; and measure our progress. We are committed to making grants, but also to making a difference beyond our dollars: informing health care policy and practice, spreading effective programs to improve the health system, serving as a neutral convener of health leaders across the State, and providing technical assistance to our grantees and partners.

The NYSHealth Initiative for Returning Veterans and Their Families seeks to underscore that the health care, mental health, and social services issues returning veterans and their families face are not solely military issues, but public and community health issues that should be addressed by local and national government agencies, community-based organizations, and health funders.

ABOUT ACCENTURE

Accenture is a global management consulting, technology services and outsourcing company, with approximately 319,000 people serving clients in more than 120 countries. Combining unparalleled experience, comprehensive capabilities across all industries and business functions, and extensive research on the world's most successful companies, Accenture collaborates with clients to help them become high-performance businesses and governments. The company generated net revenues of US $30.0 billion for the fiscal year ended Aug. 31, 2014. Its home page is www.accenture.com.

STAY IN TOUCH

p 315.443.0141
f 315.443.0312
e vets@syr.edu
w vets.syr.edu

IVMFSyracuseU

SYRACUSE UNIVERSITY
INSTITUTE FOR VETERANS AND MILITARY FAMILIES
JPMorgan Chase & Co., Founding Partner