Department of Veterans Affairs
Office of Inspector General

Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program

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VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The Office of Inspector General conducted an evaluation of the Veterans Health Administration Homeless Grant and Per Diem (GPD) Program to determine whether: (a) homeless veterans received appropriate clinical services, (b) VA and GPD providers engaged in performance improvement activities, (c) VA teams inspected GPD facilities annually, (d) VA managers provided adequate oversight of program operations, and (e) fiscal controls were in place. We also followed up on deficiencies identified during a previous review of the GPD Program. The review covered various aspects of program operations from October 2002 through January 2006.

The GPD Program was authorized to establish alternative housing programs for homeless veterans through partnerships with non-profit or local Government agencies. We visited 8 VA Medical Centers with GPD programs that offered a combined total of 730 beds and 1 stand-alone Service Center.

While we found many programs that were clinically strong, appropriately administered, and fiscally sound, we also identified some program areas that required attention.

- Records did not always contain documentation of clinical activities.
- Completeness and accuracy of discharge data were not assured.
- Northeast Program Evaluation Center data was not reviewed or discussed with GPD providers.
- GPD proposal goals were not adequate, monitored, or followed up.
- GPD inspection deficiencies were not always corrected.
- VA-GPD liaisons did not provide sufficient oversight of program operations.
- Financial reviews were not sufficient to prevent overpayments to GPD providers.
- Corrective actions from a previous GPD review were insufficient.
- The National GPD Program Office did not provide adequate oversight of GPD operations.

We made recommendations to improve:

- Documentation of clinical activities and outcomes.
- Monitoring of GPD program performance.
- Follow-up of inspection deficiencies.
- Liaison oversight of GPD operations.
- Quality of financial reviews.
- Follow-up of corrective actions from a previous GPD assessment.
- Oversight provided by the National GPD Program Office.

The Acting Under Secretary for Health agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on all planned actions until they are completed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Acting Under Secretary for Health

SUBJECT: Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Offices of Healthcare Inspections and Audit conducted an evaluation of the Veterans Health Administration (VHA) Homeless Grant and Per Diem (GPD) Program. The purpose of the evaluation was to determine whether: (a) homeless veterans received appropriate clinical services, (b) VA and GPD providers engaged in performance improvement activities, (c) VA teams inspected GPD facilities annually, (d) VA managers provided adequate oversight of program operations, and (e) fiscal controls were in place. We also followed up on corrective actions taken by the National GPD Program Office in response to previous reviews of the GPD Program.

Background

Homelessness is a condition in which an individual "lacks a fixed, regular, and adequate nighttime residence; and… has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations…, (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."[1]

Homelessness is generally believed to be the result of lack of affordable housing, reduction in the availability of public assistance benefits and medical/mental health treatment services, high unemployment rates, and low wages for those that are employed.[2]

[1] Stewart B. McKinney Act, 42 United States Code § 11301, et seq. (1994).
[2] National Coalition for the Homeless, *Why Are People Homeless?*, June 2005. www.nationalhomeless.org.

While low income is clearly a risk factor associated with homelessness, middle income households may also be at risk. A recent study published in *Parade* magazine on April 23, 2006, which surveyed 2,200 American households earning between $30,000 and $99,000 a year, found that 66 percent of these middle-income Americans reported that they tend to live paycheck to paycheck. This lack of reserve resources demonstrates the vulnerability of many Americans to unexpected events, such as loss of wages due to injury, or catastrophic events, such as Hurricane Katrina, which could render them homeless.

While estimates regarding the number of homeless people vary depending on the data collection method used, the demographics of homelessness among single adults have not substantially changed in the past 15 years. VA estimates that about one-third of the adult homeless population is comprised of veterans, with about 200,000 homeless veterans living on the streets or in shelters on any given night, and possibly as many as 400,000 veterans homeless at some time during the course of a year.[3] This estimate does not include those fringe or marginally homeless veterans who double up with family or friends and whose tenuous housing arrangements could end at any time.

VA Homeless Program

In 1987, VA first authorized services to house and treat homeless veterans. Today, VA offers the largest integrated network of homeless treatment and assistance services in the country. The VA Health Care for Homeless Veterans (HCHV) Program was established to serve homeless veterans with limited resources and who suffer from severe psychiatric and substance abuse problems.[4] HCHV is an umbrella program that includes multiple specialized programs and services offering a continuum of care to homeless veterans. Those programs provide:

- Aggressive outreach to veterans living in shelters or on the streets.
- Clinical assessment and referral to medical, psychiatric, and substance abuse services.
- Residential treatment, transitional housing, case management, and rehabilitation.
- Employment assistance and linkage to income sources and benefits.
- Supported permanent housing.[5]

The HCHV Program served 63,283 veterans in its various homeless programs in fiscal year (FY) 2004;[6] final FY 2005 data is not yet available.

[3] vaww1.va.gov/homeless It should be noted that information referenced from vaww1.va.gov or vaww.va.gov websites are from VA intranet sites not available outside the VA system.
[4] Health Care for Homeless Veterans (HCHV) Programs: 18th Annual Report (4/15/05), Chapter 1, pps. 1–3. vaww.nepec.mentalhealth.med.va.gov.
[5] NEPEC 18th Annual Report, Chapter 1, pps. 1–3.
[6] NEPEC 18th Annual Report, Executive Summary, page ii.

GPD Program

In the early 1990s, the GPD Program was authorized by Public Laws 102–590[7] and 104–110[8] to establish alternative housing programs for homeless veterans through partnerships with non-profit or local Government agencies. Since 1994, VA has offered grants totaling $108 million for construction and renovation of buildings and $193.9 million for service provision to homeless veterans. The principal mission of the GPD Program is to promote the development and provision of supportive housing and/or supportive services to homeless veterans for up to 2 years.

The term "GPD provider" refers to the public or private organization that was funded to offer GPD services to homeless veterans. Some GPD providers, such as the Salvation Army, receive funding for and operate several GPD programs, often in different buildings. While some GPD providers offer an extensive array of supportive services addressing substance abuse, mental health, medical, and social issues, other GPD providers offer minimal onsite services and refer veterans to other community social service agencies. Some GPD providers were funded as Service Centers and offer basic services such as showers and meals in a low-demand environment for homeless veterans.

National GPD Program Office

VHA's National GPD Program Office located in Tampa, Florida, is the operational center of the GPD Program. Five National GPD Program Office employees disburse funds, review initial and annual inspection files and fiscal documents, draft policies and other guidance, and hold monthly conference calls to educate VA Medical Center (VAMC) and community GPD providers about GPD Program functions, enhancements, and changes. The National GPD Program Office, along with other grant review panel members, also evaluates grant proposals submitted by community homeless providers seeking GPD funding to serve veterans.

Northeast Program Evaluation Center

The Northeast Program Evaluation Center (NEPEC), located on the West Haven campus of the VA Connecticut Healthcare System, has played a major role in designing, implementing, and evaluating innovative mental health programs since 1987.[9] NEPEC evaluates VA projects budgeted at almost $300 million annually and provides informational support in the areas of quality assessment, cost-effectiveness, and health system organization and finance. One of NEPEC's primary evaluation efforts focuses on performance and outcomes of specialized treatment programs for homeless veterans. NEPEC collects data and issues quarterly and annual performance reports.

[7] Public Law 102–590, *The Homeless Veterans Comprehensive Service Programs Act of 1992.*
[8] Public Law 104–110, *An Act to amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to carry out certain programs and activities, and for other purposes.*
[9] www.nepec.org.

NEPEC's annual reports show that in 1998, there were 44 GPD programs with 866 beds; in 2004, there were 267 GPD programs with a total of over 7,000 beds[10] that accommodated 13,509 program admissions.[11] As of February 2006, National GPD Program officials reported 309 operational GPD programs including 14 stand-alone Service Centers.[12] Because of the GPD Program's explosive growth, our review focused almost exclusively on this program.

Scope and Methodology

Prior to initiating our review, we visited the National GPD Program Office and reviewed GPD proposals and inspection reports to better define the universe of GPD programs. We selected eight VAMCs with GPD programs that comprised a mix of facility sizes, geographic locations, and Veterans Integrated Service Networks (VISNs). The 8 VAMCs had agreements with 22 GPD providers that operated 32 GPD programs; the GPD programs offered a combined total of 730 beds and 1 stand-alone Service Center. We visited the facilities from June 20, 2005, through January 27, 2006. The review covered various aspects of program operations from October 2002 through January 2006.

SITE DEMOGRAPHICS 2005

VAMC	# of GPD Funded Recipients	# of GPD Programs Reviewed	Total GPD Beds	2005 Costs	VA-GPD Liaison Assignment**
A	1	1	60	$111,112	PT
B	3	3	112	710,339	PT
C	1	1	12	59,084	PT
D	4	4	73	558,728	PT
E	1	3	180	1,493,309	PT
F	4	10	145	1,230,698	PT
G	3	3	38	271,184	PT
H	5	7*	110	895,939	FT
TOTAL	**22**	**32**	**730**	**$5,330,393**	

* *Includes one Service Center*
** *Full-time (FT) or part-time (PT) at the time of our visit*

At the eight VAMCs visited, we interviewed the following VA personnel to determine program policies, procedures, and controls: HCHV coordinators, VA-GPD liaisons, social workers, facility management staff, police officers, contracting staff, and Fiscal Service staff. At the community GPDs, we interviewed executive directors, clinical staff, accountants, and some resident veterans. We reviewed *The Homeless Veterans Comprehensive Service Programs Act of 1992*, Public Law 102–590; Title 38, Code of Federal Regulations (CFR), Sections 17.700–17.731 and 61.0–61.82; Office of

[10] *Ibid*.
[11] NEPEC 18th Annual Report, Executive Summary, page iii.
[12] Stand-Alone Service Centers are funded separately from GPDs providing housing.

Management and Budget (OMB) Circulars A-110, A-122, A-133; VHA Directive 2002-072, *Health Care for Homeless Veterans Homeless Providers Grant and Per Diem Program; VA's Homeless Providers Grant and Per Diem Program Liaison Guide* (GPD Liaison Guide, dated March 16, 2004), and the newly issued VHA Handbook 1162.01, *Grant and Per Diem Program*, dated March 1, 2006. We also visited NEPEC in West Haven, Connecticut.

To assess the VHA Homeless GPD Program, we:

- Examined VA medical records and GPD program files of veterans receiving care at selected GPD facilities to evaluate whether the care needs of homeless veterans were being adequately addressed and whether documentation supported discharge and outcome data reported to NEPEC.

- Interviewed VA and GPD program managers to determine whether sub-par performance, as noted in NEPEC reports, was discussed by VA and GPD officials and if data were used to improve program services.

- Compared program goals as identified in the initial GPD proposals with current performance results to determine whether program goals were being met.

- Reviewed GPD inspection files to assess compliance with VHA guidelines and determine whether deficiencies identified in previous inspections were corrected. We also toured each of the community GPD facilities to evaluate current conditions of the properties and buildings.

- Interviewed VA-GPD liaisons and collected data to determine whether liaison requirements and functions were met as defined by VHA guidelines.

- Analyzed the GPD providers' financial data to assess whether costs were reasonable, allocable, and allowable.

- Traced VAMC incurred costs for FYs 2003–2005 to the GPD providers' general ledgers and audited financial statements to determine if the per diem rates were correct.

- Reviewed GPD provider invoices, payment vouchers, and supporting documentation to determine if the providers' invoices were certified prior to being paid.

- Followed up on corrective actions taken in response to deficiencies identified during a 2002 review of financial aspects of the GPD Program to determine if those actions were implemented and effective.

We discussed our findings, interpretations, and suggestions with the responsible VAMC managers and community GPD providers. National GPD Program Office staff participated in exit briefings during seven of our eight site visits.

We conducted the evaluation in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results and Conclusions

VHA's Homeless GPD Program provides an array of traditional medical, mental health, and social services to homeless veterans through its many community GPD providers. In addition, the Program has actively sought to fund GPD proposals that offer creative and non-traditional services to homeless veterans. Some unique programs we visited offered gardening and horticulture, assistance in purchasing small businesses, paid employment in a GPD provider's chocolate business, and jobs renovating apartments which then became the veterans' homes.

We found that VA staff assigned to the HCHV and GPD Programs were knowledgeable about homelessness and had developed the necessary community networks to ensure that homeless veterans had access to both VA and community services. Community GPD staff members were also knowledgeable and committed as demonstrated through their creative programming, personal attention to each veteran's special needs, and donation of time above and beyond traditional business hours.

Homelessness is a particularly challenging condition often characterized by high relapse and recidivism rates, low to moderate treatment compliance, and difficult follow-up. Successes are often measured in incremental steps, with stable, mainstream housing a distant goal. Yet, during our site visits, we found numerous cases of formerly homeless veterans who, with the help of the GPD Program's treatment and social services, quit using drugs and alcohol, entered training, became employed, rented apartments, and became productive and contributing members of their communities. Several GPD providers had hired some of their "graduates" into para-professional and facility support positions.

While we found many programs that were clinically strong, appropriately administered, and fiscally sound, we also identified some program areas that required attention.

Clinical Services

The objectives of the clinical services component of the review were to determine whether (a) homeless veterans received appropriate assessment and treatment services and (b) data submitted to NEPEC were supported by VA medical records or GPD provider documentation. To evaluate these measures, it is important to understand the

process for GPD assessment and treatment and the assignment of clinical responsibilities thereof.

VAMCs usually have HCHV Programs staffed by VA nurses, social workers, and substance abuse counselors who provide a broad range of services to homeless veterans, and the GPD Program is just one element in this continuum of care. VAMCs have oversight responsibility for GPD programs in their jurisdictions. Some VAMCs have small GPD Programs with 1 provider while other VAMCs have large programs with more than 15 GPD providers; 1 VAMC has 24 GPD providers. Each VAMC is required to assign a VA employee as a GPD liaison (referred to as the VA-GPD liaison) to ensure that clinical and administrative aspects of the program are operating effectively.

GPD providers operate programs that typically have social workers, nurses, and substance abuse counselors who provide the actual treatment and services to enrolled veterans. GPD providers usually have primary responsibility for case management of veterans and VA employees are responsible for clinical oversight to ensure that veterans are receiving appropriate services as defined in their treatment plans. There is no established standard for the frequency of VA-GPD liaison oversight visits to the GPD provider programs; however, VHA program officials told us that, ideally, VA-GPD liaisons would visit GPD providers weekly, work collaboratively with GPD provider staff to improve operations, and know the veterans enrolled in the programs.

NEPEC evaluates VA mental health treatment programs, including HCHV and GPD, and issues quarterly and annual performance reports that are used by VAMCs and GPD providers to improve service delivery. VA clinicians document baseline demographics for homeless veterans and complete preliminary assessments and treatment plans on Form Xs, NEPEC's data collection tool. Once a veteran is admitted to a GPD program, primary responsibility for the case usually transfers to the GPD provider's clinical staff. Most GPD clinicians reassess each veteran's needs and document new treatment plans at the times of admission. In the GPD Program, Form Xs should be completed within 3 days of a veteran's admission to a GPD facility. Upon a veteran's discharge, VA or GPD clinicians knowledgeable about the veteran's discharge disposition and status complete Form Ds, NEPEC's data collection tool that focuses on outcomes. Form Ds should be reviewed and the accuracy of the data verified by the VA-GPD liaison or designee. Form Xs and Form Ds should be forwarded to NEPEC by the 10th of each month.

Issue 1: Some Clinical Functions Were Not Performed

NEPEC provided us with admission, assessment, discharge, and cost data for those veterans admitted to and discharged from the community GPD programs in the 2 years immediately preceding our site visits. At the 8 VAMCs included in our review, 2,918 unique veterans had 3,713 episodes of GPD care during the 2-year period. The average GPD veteran was male (97 percent), 48 years old, and served during the Vietnam or post-Vietnam eras (90 percent). One of the sites we visited told us that they had served three

homeless combat veterans who were deployed in the Persian Gulf in 2003–2004; one of those veterans remained in a community GPD program as of March 2006.

We also selected 259 veterans from the NEPEC database (of 2,918 unique veterans) and reviewed their VA and GPD records while at each GPD site. These record reviews allowed us to follow an individual veteran's progress from initial contact through assessment, treatment, and discharge. Some of the 259 records were excluded from review in selected areas, most often because of short lengths of stay that did not offer opportunity for adequate assessments, treatment plans, referrals, or progress updates.

Issue 1a: Records Did Not Always Contain Adequate Documentation of Clinical Activities

Homeless veterans frequently have multiple and complex problems that take months or years to address. The NEPEC data we reviewed, which generally covered FYs 2003–2005, revealed that VA clinicians identified the following problems in homeless GPD veterans:

- Medical problems (74 percent).
- Alcohol abuse (70 percent).
- Mental illness (69 percent).
- Drug abuse (63 percent).
- Income less than $500 per month (59 percent).
- Unemployment (31 percent).

As these conditions are highly associated with homelessness, it is imperative that clinicians provide comprehensive assessment, treatment, and referral services to help these veterans meet therapeutic goals and achieve independence. We noted the following deficiencies:

Assessments were not always complete or current. The NEPEC database did not reflect that all veterans admitted to GPD programs were consistently assessed using the Form X. Of the 3,713 episodes of care provided at the 32 GPD program sites, 394 (11 percent) Form Xs were not submitted to NEPEC. In addition, 130 (4 percent) of the 3,319 Form X assessments that were in the NEPEC database were more than 2 years old when the veterans were admitted to a GPD program. VHA guidelines require VA-GPD liaisons to ensure the collection and submission of participant data to NEPEC in a timely manner. While we could not find written guidelines, GPD Program officials told us that Form Xs should be updated, at a minimum, every 2 years for veterans receiving VA HCHV services.

As Form Xs are not always current, and clinicians often use the assessment process to learn about the veteran and engage the veteran in services, GPD clinicians usually conduct their own assessments of each veteran's needs and document new treatment

plans at the times of admission. We reviewed 259 GPD provider records to determine whether GPD clinicians completed assessments upon admission, and in 40 (16 percent) of 251 applicable cases, we found the records did not contain new or revised assessments.

Treatment plans were not always complete. NEPEC data showed that in 2,981 (of 3,319) episodes of care with Form X assessments, veterans were initially assessed to need psychiatric or substance abuse treatment; however, 469 (16 percent) Form X treatment plans did not reflect psychiatric or substance abuse treatment services as goals. This discrepancy could mean that 469 veterans did not receive needed treatment services.

We also reviewed GPD provider records to determine whether their treatment plans, which should be more current than Form X treatment plans, were documented. We found that 45 (19 percent) of 241 applicable records did not contain any treatment plans.

Treatment plans were not always fully implemented. We reviewed VA medical records and GPD records to determine whether veterans actually received the needed treatment or were referred for services as described in their treatment plans. For each of the 259 cases, we focused on treatment planning goals (up to 5) as identified on the Form Xs. Some veterans had only one treatment planning goal identified, while others had several. We found no documented evidence that clinicians addressed or attempted to address 128 (15 percent) of 860 treatment plan goals identified.

As most GPD clinicians completed their own assessments and treatment plans when veterans were admitted to their programs, their records would reflect only those issues identified by the GPD clinician. However, if the VA clinician identified the need for a service that would not be provided by the GPD provider, then the VA clinician should have made arrangements for the service outside of the GPD program. Thus, all treatment plan elements should have been addressed and documented by GPD or VA staff, or the justification for not doing so should have been documented.

VA and GPD records did not always meet documentation standards. We reviewed progress notes completed by the primary case manager; in a majority of the cases, the GPD social worker had primary case management responsibilities for enrolled veterans. We reviewed VA and GPD quality, content, and frequency standards for documentation, and when none existed, asked clinical managers about their expectations for documentation. We applied the appropriate standard when evaluating each record. We found that:

- Fifty-four (22 percent) of 247 applicable records did not meet standards for frequency of documentation. Most providers required weekly documentation of client contact and progress in the early stages of GPD enrollment, to be scaled back as the veteran achieved more independence. Some records on newly placed veterans did not contain any progress notes for more than 3 months by either VA or GPD clinicians.

- Forty-three (21 percent) of 202 applicable records did not reflect treatment plan revisions based on the patient's changing needs or on a periodic basis (such as every 30 days).
- Forty-eight (20 percent) of 246 applicable records did not contain sufficient documentation of each veteran's status to determine their progress in meeting treatment goals or the need for additional services.

Although not a formal requirement, we noted that 154 (65 percent) of 238 applicable records did not contain evidence of interdisciplinary treatment planning.

VA and GPD records did not always reflect the appropriateness of veteran readmissions to the program. For the 2-year period prior to our visits, NEPEC data showed that 2,918 unique veterans accounted for 3,713 episodes of care in GPD programs included in our review. Further review showed that 585 veterans (20 percent) in our sample were admitted to community GPD programs 2 or more times and that these veterans accounted for 1,380 (37 percent) of 3,713 episodes of care. The GPD Program recognizes that relapse and recidivism are byproducts of homelessness and its associated social problems and allows for veterans to be readmitted to GPD programs when clinically indicated.

Eighty-two (32 percent) of the 259 veterans in our sample were readmitted to GPDs more than once in the 2 years preceding our visits. However, in 26 (32 percent) of 82 cases, we found no documented evidence that VA clinicians reviewed the cases to (a) assess the course of treatment during the first admissions and determine what treatment elements should change during the second admission to increase the chances for success or (b) determine whether GPD placements were appropriate a second or third time. For example, if a veteran was dismissed from a GPD program for relapse on drugs or alcohol, readmission to the GPD program may be contingent upon the veteran completing a detoxification or rehabilitation program, or he may be required to participate in Alcoholics or Narcotics Anonymous meetings. To maximize resources and the likelihood for success, it is important for clinicians to consider the veteran's needs and what GPD has to offer and make adjustments to the veteran's treatment plan to improve the chance for positive outcomes. Without clinical review, some veterans could be placed repeatedly in GPD programs with treatment plans that have been unsuccessful in the past.

Issue 1a Conclusion

Assessments and treatment plans are fundamental elements of service provision; they should be accurate and comprehensive documents that adequately assess and address clinical and social problems so as to ensure appropriate continuity of care. In cases where assessed needs cannot or will not be addressed, such as when the veteran declines services, the VA medical record or GPD provider records should document this

justification. Without complete and up-to-date assessments and treatment plans, providers could not be assured that services were targeting current needs of veterans.

Additionally, clinicians should document each veteran's conditions and progress frequently enough that other care providers can determine the overall status of the veteran and provide appropriate continuity of services, as needed. Interdisciplinary treatment planning is often used in medical and social service settings as a means to enhance client outcomes. When veterans are readmitted to GPDs, clinicians should document that the placements were clinically indicated so as to avoid duplication of previously unsuccessful placements and treatment plans.

Recommended Improvement Action 1. The Acting Under Secretary for Health should require VHA to ensure that:

a. VA-GPD liaisons or designees complete and submit Form Xs to NEPEC in a timely manner.

b. National GPD Program Office staff monitor Form X completion rates by VAMCs and require consistently underperforming sites to take corrective actions.

c. VA and GPD provider employees adequately assess each veteran's needs, devise treatment plans to meet those needs, and document the case records to reflect these services.

d. Clinicians comply with documentation standards regarding frequency of notes, treatment planning revisions, and veteran progress in the program to provide involved staff with an accurate depiction of the veteran's status.

e. Clinicians conduct and document interdisciplinary treatment planning.

f. VA clinicians review and document agreement with placements and treatment plans for those veterans with multiple readmissions.

Issue 1b: Completeness and Accuracy of Discharge Data Were Not Always Assured

NEPEC reported 3,713 episodes of GPD care during 2003–2005 for the 8 VAMCs included in our review, and each episode had corresponding discharge data. Each time a veteran is discharged from a GPD program, a clinician completes a NEPEC Form D cataloguing a number of outcomes, including the type of discharge, living situation, and employment or benefits status. Additionally, clinicians document changes in the veteran's clinical status in five categories at the time of discharge and note follow-up arrangements for continued treatment, if needed. Our analysis of NEPEC outcome data for these veterans revealed the following:

- Forty-seven percent successfully completed the program.
- Forty-four percent moved to an apartment, room, or house.
- Twenty-seven percent were employed full- or part-time.
- Sixty-eight percent had improvement in their alcohol problems.
- Sixty-seven percent had improvement in their drug problems.
- Fifty-five percent had improvement in their mental health problems.
- Fifty-five percent had improvement in their social or vocational skill deficits.
- Fifty percent had improvement in their medical problems.

However, it was not clear from our review whether the outcome data accurately reflected veteran status.

NEPEC Form D discharge data was not always consistent or supportable. Our review of VA and GPD records found that in 61 (24 percent) of 251 applicable cases, the clinical records did not fully support the responses documented on the Form Ds. In some cases, there was not enough information in the clinical record to substantiate the Form D data. In other cases, progress notes provided a different, or even contradictory, picture of the veteran's discharge status; these Form Ds usually upgraded the clients' levels of success in the program. By upgrading a veteran's discharge status, staff could artificially inflate performance outcomes of individual GPD programs or of a VAMC's aggregate performance. Program success in meeting or exceeding performance goals is considered during the annual inspection and grant renewal process. The following examples illustrate our concerns about inaccurate discharge coding and lack of supporting documentation:

- Progress notes at one GPD provider's program indicated a veteran missed curfew and failed to return to the GPD. Staff documented their suspicion that the veteran relapsed on drugs. The veteran was admitted to a VAMC the following day, and physicians documented that the veteran acknowledged using crack cocaine the previous day. GPD case managers completed the Form D, indicating that the veteran was discharged for "rule violations"; however, VA social workers had changed the answer to indicate the veteran became "too ill to participate," presumably because he was admitted to a psychiatry ward for substance abuse and depression. The change in Form D information was misleading.

- GPD case managers completed Form Ds, frequently recording that veterans were discharged to independent living in an apartment, room, or house, thus meeting criteria for "housed at discharge." However, we reviewed multiple records, primarily from one GPD facility, where progress notes documented that veterans did not return from pass or simply left the facility, and the GPD had no information as to their whereabouts. The GPD case manager told us that if the veteran signed out for a visit to a friend or family member's home, they assumed that he was staying with that person and coded that the veteran was housed. This

practice falsely increased the GPD performance measure of "housed at discharge" because staff could not be certain of this.

- One veteran was arrested for illegal drug use, but his Form D was coded as "substantial improvement" in addressing his drug problems.

- One veteran was discharged, and later arrested, for assault on staff and other residents, yet his Form D was coded as "some improvement" in mental health and social deficits.

In 47 (19 percent) of 252 applicable cases, we found no evidence that the VA-GPD liaison or designee reviewed or verified that the information on the Form Ds was correct at the time of the veteran's discharge. While VA clinicians are required to complete Form X assessments, GPD clinicians may complete Form D discharge and outcome reports. In such cases, VA-GPD liaisons or their designees are responsible for reviewing and verifying Form D data before submission to NEPEC. In some cases, the liaison's name was typed on the form as having verified the data, but there was no signature or initials, nor was there a progress note indicating that they reviewed and verified the discharge data. At one site, it appeared that the GPD clinician simply signed the liaison's name to all of the Form Ds. At the sites where liaisons were not verifying Form D information, staff confirmed that this practice should be improved.

The NEPEC Form D had some limitations. The subjective nature of the Form D allows clinicians to interpret the questions and answers as they deem appropriate, which may lead to inconsistent and unreliable answers. "Success" and "improvement" mean different things to different people, and when dealing with the often intractable problems associated with homelessness, clinicians (usually social workers) are apt to code a discharge status from a "strengths perspective," meaning to focus on the strengths and accomplishments rather than the weaknesses and failures. Consider the case of a veteran who has a long history of substance abuse with no significant period of sobriety that manages to remain drug and alcohol free for 4 months while in the GPD program. To the knowledgeable clinician, this sobriety may represent a major victory; however, coding this veteran's drug problems as "improved" after he relapses and disappears from the GPD may be somewhat misleading. Given the same treatment and discharge scenario, two social workers assigned to GPD oversight told us that they also would have coded this outcome as "improved"; one of them justified his response by saying that the veteran now had more resources to deal with his addiction. They both acknowledged, however, that other social workers might code this outcome differently.

VA-GPD liaisons are responsible for ensuring that necessary documentation, primarily Form X and Form D data, is accurate and provided timely to NEPEC. NEPEC managers told us that they must "trust the professional process" and operate on the premise that answers on the Form D are accurate, unbiased, and supported by documentation. NEPEC

has no authority over the GPD Program to require data validation; staff only aggregate and report the information received.

Issue 1b Conclusion

The Form D is NEPEC's method of capturing discharge and outcome data, which is used as a measure of program performance and effectiveness. As VHA Homeless Program managers use NEPEC data to make national program decisions and changes, the validity of Form D information is paramount, and veterans' clinical records should accurately reflect and support data submitted to NEPEC.

Recommended Improvement Action 2. The Acting Under Secretary for Health should require VHA to ensure that:

a. VAMCs implement systems whereby VA-GPD liaisons or their designees verify that Form D data is accurate and supported by medical record or GPD program documentation prior to submission to NEPEC.

b. VA and GPD staff members receive guidance and training on the meaning of Form D questions and the acceptable range of interpretations.

Issue 2: Performance Improvement Activities and Oversight Were Inadequate

The objectives of the performance improvement component of the review were to determine whether (a) facilities evaluated substandard performance of their housing programs and took actions to improve conditions, and (b) individual GPD programs achieved program goals as defined in their initial proposals. We identified the following conditions requiring management attention.

NEPEC Data Was Not Reviewed or Discussed With GPD Providers

VA-GPD liaisons did not routinely share and discuss NEPEC performance data with individual GPD providers; thus, GPD providers did not develop and implement action plans, as appropriate, to address areas where program performance fell below national averages. NEPEC publishes quarterly performance data specific to each community GPD site. NEPEC reports rank site-specific performance in comparison to other VHA HCHV Programs in "critical monitor" areas such as housing, employment, and sobriety measures. NEPEC states that the average performance of all GPD sites is used as the norm for evaluating performance at individual sites. Following is a table which is a compilation of data presented in NEPEC's *Health Care for Homeless Veterans Programs: Eighteenth Annual Report*, dated April 15, 2005, which covered FY 2004 (hereafter referred to as the 2004 NEPEC annual report). The table shows the percentage of successful discharges from individual GPD programs in VISN 21, as well as the site

median and national average for successful discharges—the benchmark by which performance is measured. In this example, Vet House 1 and Vet House 4 fell well below the national average for successful discharges, a condition which should prompt performance improvement initiatives and follow-up by GPD providers.

VISN and National Data for Successful Program Completion

VISN	Site Name	State	Program Name	No. of Discharges	No. of Successful Discharges	% Successful	National Data- Successful Completion of the Program
21	A	CA	Vet House 1	15	4	26.7	Site Median 52.22% National Average 48.20%
21	A	CA	Vet House 2	231	178	77.1	
21	A	CA	Vet House 3	53	30	56.6	
21	A	CA	Vet House 4	94	37	39.4	
21	A	CA	Vet House 5	20	11	55.0	

We selected nine evaluation measures as reported in the 2004 NEPEC annual report:

1. Successful discharge.
2. Discharge for a violation.
3. Housed in an apartment, room, or house.
4. Employed full-time or part-time.
5. Unemployed.
6. Improved alcohol problems [at discharge].
7. Improved drug problems [at discharge].
8. Improved mental health problems [at discharge].
9. Improved medical problems [at discharge].

Two GPD programs were too new to have reportable outcomes and another was a Service Center that was not required to report data to NEPEC.[13] Additionally, evaluation data for programs that were co-located in the same building were sometimes reported together. Thus, we were able to review 2004 NEPEC annual report evaluation data for 26 GPD programs.

Of the 234 evaluation measures (9 measures x 26 programs), 63 (27 percent) fell below national performance averages by more than 5 percentage points. VA-GPD liaisons should have reviewed and discussed NEPEC results with GPD providers, who in turn should have implemented corrective actions or documented the reasons that actions were not indicated. However, we found no documented evidence of discussions or corrective actions relative to 56 (89 percent) of the 63 sub par measures.

[13] The goal of the Service Centers is to provide services to the hard-to-reach homeless population in a low-demand, non-intrusive environment; there are no uniform reporting requirements.

In fact, 13 (59 percent) of 22 GPD providers[14] interviewed told us that they did not review or discuss quarterly NEPEC data with VA-GPD liaisons, and many were unaware that this evaluation data was available. The VA-GPD Liaison at one site was unaware that NEPEC data include GPD program-specific information related to clinical measures; she thought that the data was aggregated by facility and VISN.

National GPD Program officials and HCHV program managers told us that because GPD programs differ widely in their approaches to serving homeless veterans, and many tailor services to meet specific needs (that is, the program may be designed to serve chronically mentally ill homeless people and does not focus on employment), NEPEC data may not always be comparable across programs because of the divergent focuses and populations. However, the data could be useful for individual GPD providers to track their own performance across previous quarters and years and to take corrective actions as needed. A basic tenet of performance improvement requires benchmarking, either against similar programs or against oneself, if no similar program exists.

GPD Proposal Goals Were Not Adequate, Monitored, or Followed Up

VHA Directive 2002-072 requires that VHA officials ensure that GPD funded community providers are operating the programs as outlined in the original GPD grant proposals that were funded. VHA has defined several important goals in its efforts to eradicate homelessness in the veteran population and requires GPD applicants to address these goals in their applications for funding. VHA's top three goals for GPD providers are to (1) promote greater self-determination of participants, (2) increase the skill level and/or incomes of the participants, and (3) enhance residential stability of the participants. Each GPD proposal identifies program-specific activities and performance measures in support of these goals. We identified the following weaknesses:

<u>GPD provider goals were not always realistic, consistent, or measurable</u>. Some GPD providers were challenged with self-imposed but unachievable goals. The following cases illustrate the need to revise and update some providers' proposal goals:

- One GPD provider who specialized in substance abuse services had a goal to "Provide follow-up case management and support services, in the form of home visits, emergency services and intervention, counseling, peer group activities, and other programmatic services, for 100 percent of all former residents, during the first year after a resident moves to their next permanent residence." Given the nature and complexity of homelessness, it is unlikely that this goal could be achieved.

- Another GPD provider had three grants that all detailed different goals to achieve residential stability, increased income/skills, and greater self-determination.

[14] Some GPD providers, such as the Salvation Army, operated multiple GPD sites; however, the management team was the same for all sites.

However, the provider operated the program as a continuum across grants and facilities. Given the fluid nature of veteran movement across the continuum, monitoring of goals and outcomes was virtually impossible.

- A third GPD provider identified a goal stating that the program would "Assist the veterans to locate and secure approved apartment, community residential care homes and/or boarding homes…" but did not define the number or percentage of veterans to be referred, the time frame for doing so, or the anticipated number of veterans expected to be housed.

One drawback of the proposal and funding process is that, once funding is approved, GPD providers are committed to the scopes of service and performance goals outlined in their proposals. From a grant management perspective, this is a valid expectation. However, GPD programs work with a fluid and evolving population—primary problems of 3 years ago may no longer be issues because of changing demographics or improved community services. Likewise, performance goals that were reasonable then may not be achievable now (for example, a reliable community employer of GPD veterans may have gone out of business). On occasion, GPD providers may need to modify the scope of service and performance goals of their programs to respond to the changing needs of homeless veterans.

The National GPD Program Office staff told us that scope changes were rare because the scope of the services and the associated performance goals, among other criteria, were used to determine where the GPD provider ranked nationally with their proposal, which in turn impacted whether the grant request was funded. Approval for changes in scope is contingent upon the application ranking remaining high enough after the approved change to have been competitively selected for funding in the year the application was selected. This caveat reflects the complexity of securing approval for changes in scope. To minimize the number of GPD providers needing changes in scope, National GPD Program Office staff should carefully review proposal goals before funding is approved.

Neither VISN, VAMC, nor community GPD managers routinely monitored GPD providers' performance in relationship to the original grant proposal goals. The GPD Liaison Guide, issued in March 2004, states that, "Each year by regulation the awardee as part of your inspection provide you with a review of how they are meeting their goals and objectives as stated in the grant (38 CFR 61.80 (14) (c)). Your Network Homeless Coordinator (CNHC) was sent a project management database. This database contains the goals, objectives, and measures that awardees proposed to ascertain their project success. It is the individual CNHC and liaison's job to maintain the database."

None of the CNHCs or VA-GPD liaisons we talked to were maintaining a project management database of GPD goals and performance measures as required, and six of eight VA-GPD liaisons confirmed that they did not monitor their GPD programs' performance goals. While the VA social workers conducting the annual GPD inspections

occasionally referenced the GPDs' goals, the inspection files generally did not contain documentation supporting performance results. Usually, the social workers simply stated that the GPD programs were able to provide the services as listed in their grant proposals.

All of the GPD executive directors interviewed told us that they monitored their performance goals, but we found that most providers only tracked basic data, including admissions, discharges, or the number of homeless veterans who secured jobs. Although we included 32 GPD programs in our sample, several of those programs were co-located with and shared performance goals with "sister" programs operated by the same GPD provider. In addition, one GPD program was too new to have measurable outcomes. Thus, we were able to review performance goals for 27 GPD programs. Of these, 17 (63 percent) GPD providers could not provide us with performance reports that specifically tracked each of the activities and goals outlined in their proposals. One GPD clinical manager told us that he had not read the grant proposals, stating that the proposals were written before he took his position. Another GPD executive director told us that he "…never looked at the goals in reality to the services…" and never rewrote the goals from the original grant request, which dated back to 1998.

GPDs did not initiate corrective actions when they failed to meet performance goals. We evaluated the performance and outcomes of the 10 programs that could provide evidence of performance monitoring. Each program had defined from one to three goals related to the core objectives of self-determination, increased skill level/income, and residential stability. We found that 24 (35 percent) of the 69 goals reviewed were not achieved during the rating period; in 22 (92 percent) of the 24 cases, we found no evidence of performance improvement activities to enhance outcomes.

Issue 2 Conclusion

VAMC staff and GPD providers did not participate in basic activities to improve program performance. NEPEC performance data was not routinely shared with or reviewed by the GPD providers, so substandard performance was not identified and addressed. Additionally, VA and GPD employees did not consistently monitor whether GPDs were meeting their performance goals as defined in their original grant proposals.

Performance monitoring is the basis for performance improvement; when performance is not meeting established goals, corrective actions may be indicated. Without performance monitoring and improvement, clinical managers have no assurance that veterans are receiving appropriate services in accordance with program guidelines. Additionally, VA GPD staff could not be assured that GPDs were providing all of the services for which they were funded.

Recommended Improvement Action 3. The Acting Under Secretary for Health should require VHA to ensure that:

a. VA-GPD liaisons share and review NEPEC data with GPD providers quarterly and document discussions and corrective action plans accordingly.

b. National GPD Program Office managers should ensure that technical assistance on how to write measurable and achievable goals is available to GPD providers.

c. VA-GPD liaisons or designees ensure that GPD providers are monitoring performance in relation to proposal goals and require GPDs to develop performance improvement activities to enhance outcomes.

Issue 3: GPD Inspection Deficiencies Were Not Always Corrected

GPD providers served veterans in facilities encompassing a broad range of new construction, recently renovated, or never renovated buildings. Some GPDs were in well-designed structures with new furnishings and artwork; others were in older buildings with structural deficiencies and donated furniture. Four GPDs operated beds and services in leased buildings on VAMC campuses, and a majority of the remaining GPD programs were located within a 10-mile radius of the VAMC of jurisdiction. Four GPD programs were 40 miles or more from the VAMC; one of those GPDs was about 250 miles from the VAMC.

Overall, we found that VAMCs complied with CFR guidelines and VHA Directive 2002-072, requiring VAMC officials to conduct GPD facility inspections upon initiation of GPD contracts and yearly thereafter. There were 32 GPD programs in our sample; however, we only reviewed inspection reports for 28 GPD facilities because some programs were co-located in the same building. At 27 of 28 facilities, inspections were completed within the past 12 months, and the inspections were usually conducted by appropriate interdisciplinary team members, as required. A majority of the GPD programs visited were clean and well maintained. However, we noted that follow-up of identified deficiencies required VAMC management attention, as follows:

VAMC inspection team members and other responsible employees did not routinely ensure that GPD inspection deficiencies were corrected. According to inspection reports, inspection team members identified environmental deficiencies in 20 (71 percent) of 28 GPD facilities. We toured all 28 GPDs to determine whether the cited deficiencies were corrected and to assess the current conditions of the buildings and grounds. During our tours, we found that of the 20 GPDs where deficiencies were cited, 9 (45 percent) GPD providers had not corrected all of the conditions identified in the most recent inspection survey. In fact, five GPD providers told us that they were unaware of some or all of the deficiencies, as no one on the inspection team had communicated the findings to them.

In one GPD, we found significant deficiencies dating back to 1999 that had not been corrected at the time of our site visit in 2005. The GPD provider leased a building on the VAMC campus. The building, built in 1910, required significant structural repairs and upkeep, many of which were identified during the initial walk-through inspection in 1999 conducted by VAMC and GPD managers. The VAMC and the GPD spent 6 years debating who had primary responsibility for repairing sagging floors, loose and missing tiles, broken and leaking showers, and steam heat and ventilation problems. During our tour, we observed that these conditions still existed and also noted standing water in the basement and one bedroom that had been closed due to mold from a steam leak. We notified VAMC managers of our concerns, and corrective actions were initiated.

VAMC staff did not adequately address deficiencies identified by a contractor completing fire safety inspections. At one VAMC, contractors completed most of the fire safety inspections for the VA Inspection Team. The VAMC's Safety Officer told us that he reviewed and approved all inspection reports submitted by the contractor before sending them to the Inspection Team leader for processing. The contractor completed five of six[15] inspections in 2005, and often noted non-compliance with some fire safety standards as outlined on the VA's *Safety Inspection Report for Existing Small Residential Board and Care Facilities*.[16] During one inspection, the contractor used a check sheet to cite deficiencies that included lack of sprinkler systems, insufficient fire drills, and inadequate smoke partitions. Despite this, the VAMC Safety Officer did not question anything in the contractor's report as he attached his own memorandum, indicating that "No life safety code deficiencies were noted." The Safety Officer confirmed that he should have reviewed the report more carefully before endorsing its contents.

VAMC staff did not always monitor current environmental conditions and ensure that deficiencies were corrected. While VA Inspection Teams only visit GPD facilities annually, VAMC staff usually visit facilities weekly or monthly. This schedule allows the VA-GPD liaison or VA social worker to observe environmental conditions in the facilities on a regular basis and ensure that GPD managers promptly correct deficiencies rather than waiting for the next annual inspection. At the times of our site visits, we found environmental conditions that could have placed veteran health or safety at risk. In addition to the environmental concerns found at the VAMC-based GPD noted above, we also found the following conditions at different facilities:

- Mold on restroom ceilings, missing electrical face plates in a ladies restroom/shower, a missing drain grate and standing water in the drain, broken ceiling and floor tiles, and unclean conditions in the kitchenette area.

[15] The VAMC had oversight responsibility for seven GPD programs; however, one program was co-located in the same building and required just one inspection.
[16] National Fire Protection Association (NFPA) 101–2003.

- Outdated dry goods in the pantry (July 2003—more than 2 years old) and some expired items in the refrigerator, including milk 14 days past expiration.

- Deteriorating ceilings in two bedrooms that were at risk for falling.

- A leaking water heater, a hanging smoke detector, and a light dangling from the ceiling.

Issue 3 Conclusion

In general, the GPD facilities we visited were clean and comfortable. While VAMC inspection teams completed inspections as required, several of the VAMCs had not established procedures to follow up on deficiencies and ensure that corrective actions were taken in a timely manner. Because VA is frequently a primary oversight body for GPD facilities, the inspection process is critical to the safety and well being of the resident veterans.[17] We notified VAMC managers and GPD providers of these uncorrected deficiencies during our site visits so that they could take appropriate actions.

Recommended Improvement Action 4. The Acting Under Secretary for Health should require VHA to ensure that:

a. All deficiencies identified by inspection teams are corrected and that inspection files reflect these actions.

b. Inspection team members communicate their findings and recommendations to GPD providers.

c. VAMC staff monitor and follow up on the inspection work of contractors.

d. VA-GPD liaisons or their designees conduct environmental rounds during their regularly scheduled site visits to identify obvious hazards or other deficiencies which could be addressed promptly.

Issue 4: VA-GPD Liaisons Did Not Provide Sufficient Oversight of Program Operations

VA-GPD liaisons did not always perform functions, as required, to ensure proper oversight of clinical care, grant compliance, administrative operations, and fiscal controls. VHA Directive 2002-072 outlines specific operational and staffing requirements for the GPD Program. The VA-GPD liaison is designated by the VAMC Director to function as the point of contact between the programs in the field and the National GPD Program Office. The VA-GPD liaison monitors GPD program functions

[17] Additional entities that might inspect GPD facilities could include local fire and health departments.

to ensure that GPD providers are administering the programs as outlined in their grant proposals.

We found that the single most important factor in the quality and success of individual GPD programs was the knowledge, involvement, and oversight of the VA-GPD liaison and the relationship he or she had built with the GPD provider. Seven of the eight VA-GPD liaisons interviewed were assigned part-time to GPD activities, with primary or collateral duty assignments for the remainder of their time. According to National GPD Program Office staff, in the past 2 years, VHA has approved funding for 92 full-time VA-GPD liaisons, but approximately half of those positions have not been filled. We found that while some VA-GPD liaisons we spoke to were clearly knowledgeable about their roles, others appeared uninformed about program and role expectations. VHA Homeless Program officials acknowledged that the quality of the VA-GPD liaison's oversight varies greatly from site to site.

In previous sections of this report, we discuss deficiencies and make recommendations to ensure that VA-GPD liaisons consistently:

- Collect, verify, and submit Form X and Form D information to NEPEC.
- Review and discuss NEPEC outcome data with GPD providers.
- Monitor GPD providers' program goals.

In addition, we noted the following conditions:

Confidential financial disclosures were not always completed. Three of eight liaisons told us that they had not filed annual confidential financial disclosures (CFDs). CFDs are filed by select VA employees to minimize the potential for conflicts of interest arising from employee financial interest in public or private corporations.

The accuracy of GPD provider per diem invoices was not verified. Some VA-GPD liaisons did not verify the accuracy of GPD providers' per diem invoices. We found errors in per diem invoices from 26 (81 percent) of the 32 programs reviewed. Errors included both understatement and overstatement of the number of bed days of care provided and computational mistakes. These conditions occurred because the VA-GPD liaisons only conducted cursory reviews of per diem invoices and did not verify the computational accuracy of the invoices or the number of days claimed by comparing per diem invoices to sign-in logs. VA policy requires VA-GPD liaisons to verify admission and discharge dates and the eligibility of program participants along with certifying per diem invoices for accuracy based on supporting documentation. According to 4 (50 percent) of the 8 VA-GPD liaisons, they did not always verify per diem invoices for accuracy because they trusted the GPD providers would comply with guidelines and applicable regulations. Our review found that 207 (24 percent) of the 864 per diem

invoices received during FYs 2003–2005, valued at about $13 million, had errors of which 68 ($48,000) were related to overpayments and 139 ($25,000) to underpayments. The total amount of errors attributable to inaccurate invoice certification was about $73,000 ($48,000 + $25,000), or less than 1 percent of the $13 million paid to the providers. While the amount is not material to the overall program costs, these errors demonstrated a lack of oversight by the VA-GPD liaisons. We also identified overpayments due to inaccurate establishment of per diem rates. (See pages 24–29 on financial review of GPD providers.)

Some incidents involving GPD veterans were not reported to VAMC management or the National GPD Program Office. The National GPD Program Office had not provided VA-GPD liaisons with guidance on how to report incidents involving GPD veterans, so most liaisons reported following their VAMC's incident reporting procedures. Overall, it appeared that the system worked adequately and that most incidents occurring in GPDs or involving GPD veterans were reported appropriately. However, we identified the following incidents that, in our opinion, should have been reported to VAMC management for follow-up, but were not.

- A resident with complex medical problems fell and hit his head at the GPD facility. He was taken to a local hospital where he remained in a coma until his death 1 week later. While it appeared that the GPD staff were in contact with the veteran's family immediately, VA social workers were not notified of the accident until 3 days later. At least two VA social workers and a VA transfer nurse knew about the incident, but no one reported the case to the VAMC Quality Manager.

- A GPD resident with a history of violent outbursts threatened a VA social worker to the point of chasing her to her car where she locked herself in. Police arrested the veteran. The VAMC Quality Manager was notified of the incident but told the social work staff that since the event did not occur on VA property and no one was harmed, an incident report was not indicated. While perhaps technically accurate, the event should have at least been reviewed by the VAMC's Disturbed Behavior Committee to determine whether action was needed.

Incident reporting is an important function as it: (1) ensures that appropriate clinicians and managers are made aware of significant incidents involving veterans, (2) allows for individual and aggregate reviews which can lead to improved services and processes, and (3) is an integral part of a facility's risk management strategy.

Issue 4 Conclusion

VA-GPD liaisons play a critical role in the day-to-day management of the GPD Program. We determined that some VA-GPD liaisons were not adequately performing all of their

administrative and quality assurance functions, resulting in less than optimal data integrity, fiscal controls, and performance improvement.

Recommended Improvement Action 5. The Acting Under Secretary for Health should require VHA to ensure that:

a. All VA-GPD liaisons file CFDs annually.

b. VA-GPD liaisons appropriately certify invoices prior to payment.

c. Incidents involving GPD veterans are reported to VAMC and National GPD Program officials.

Financial Controls

Community GPD providers are awarded per diem funding to offset operational costs, including salaries of program employees. Per diem payments may not exceed the VA State Home daily rate for domiciliary care, which at the time of our review was $29.31.

The National GPD Program Office has overall responsibility for program operations and approves GPD providers' per diem rates based on assessments of their accounting systems and estimated costs by VAMC fiscal staff. The National GPD Program officials distribute per diem funds to VAMCs quarterly for disbursement to community GPD providers. The VA-GPD liaisons are to verify GPD providers' invoices prior to making per diem payments.

The objective was to determine whether VAMC management was providing appropriate monitoring and oversight of GPD programs as required by the OMB Circulars A-87, A-122, and A-133; and VHA Directive 2002-072 and Handbook 1162.01. We also reviewed the GPD providers' administration of the program to determine whether:

- Per diem rates were appropriate.

- Accounting systems properly accumulated, segregated, and reported costs under the GPD program.

- Costs incurred were eligible for reimbursement under Federal regulations and applicable cost principles.

We found that the accounting systems for the GPD providers we reviewed generally met OMB requirements regarding accounting for program funds and allocations of costs. While we did not test transactions in detail, we did find that the categories of cost

included in the per diem rate calculations appeared appropriate and necessary.[18] However, GPD providers' per diem rates were frequently overstated because accounting data was not properly used in computing their per diem rates. We found some GPD providers did not report all non-VA revenue, or their estimated costs were significantly higher than prior year actual costs. VAMC staff did not identify these errors because they were not knowledgeable about OMB Circulars A-87, A-110, and A-133 or the requirements to perform reviews of GPD providers' financial management accounting systems and financial and budgetary data. We also found that some GPD providers were not knowledgeable about how to complete the Funds Assurance Letters (FAL) and supporting schedules.[19]

Issue 5: Overstated GPD Providers' Per Diem Rates Resulted In Overpayments

Per diem rates were overstated because the GPD providers either did not deduct non-VA revenue from their programs' expenses, understated revenue, or overestimated their program costs when submitting their requests to the National GPD Program Office for per diem rates. As a result, we found that the 32 programs we reviewed were overpaid about $1.5 million or about 11.2 percent of the $13 million paid to the 32 programs during FYs 2003–2005. The overpayments of per diem reimbursements for some GPD providers went undetected because National GPD Program officials did not have procedures in place, prior to March 1, 2006, to conduct incurred cost reviews of GPD providers. VAMC staffs responsible for assessing GPD providers' requests for per diem and their financial data did not identify miscalculations or inaccurate estimates when conducting their reviews. Also, procedures for reviewing per diem rates during the annual renewal process frequently did not ensure that all non-VA revenue was reported or significant variances between estimated and actual expenditures were detected.

During FYs 2003–2005, the GDP Program officials awarded about $128.5 million in per diem payments to GPD providers that operated 309 different programs. Per diem payments and reviews of the GPD providers' financial information were the responsibility of 95 different VAMCs. During our review, we visited 8 VAMCs and reviewed 32 programs operated by 22 GPD providers that received about $13 million in per diem payments during FYs 2003–2005.

In performing the review, we analyzed the GPD providers' FALs, which documented their estimated program operating costs that were the basis for their per diem rates, to determine whether the approved per diem rates were correct. We compared the FALs

[18] Invoices and journal entries supporting costs reported in the audit financial statements were not tested. However, we compared total amounts in the financial statements to the total amounts in the general ledgers and trial balances to determine if they agreed.

[19] FAL and supporting schedules are GPD Program documents that identify estimated and actual project revenue and costs used to determine the recipient's per diem reimbursement rates.

and supporting schedules to the GPD providers' independently audited financial statements to determine whether estimated costs in the FALs were consistent with the actual costs incurred. Using the actual costs from audited financial statements, general ledgers, and trial balances, we recalculated the per diem rates to determine if GPD providers' established per diem rates were accurate.

Our analysis found that per diem rates for 20 (63 percent) of 32 programs were overstated by an average of $8.75, ranging from $.25 to $22.25. As a result, these programs were overpaid approximately $1.5 million,[20] ranging from $1,024 to $291,726 per program. Overpayments to 5 of the 20 programs totaled more than $100,000 each. The following table shows the number of programs monitored by each VAMC and the number of GPD providers overpaid.

Summary of GPD Provider Overpayments					
Supervising VAMC	**Programs Supervised**	**Programs Overpaid**	**Amount Paid**	**Amount Overpaid**	**Percent Overpaid**
A	1	1	$ 669,354	$ 120,753	18.0%
B	3	1	2,251,705	51,165	2.3%
C	1	0	187,811	0	0.0%
D	4	0	1,169,535	0	0.0%
E	3	3	3,104,368	394,279	12.7%
F	10	9	2,707,204	507,008	18.7%
G	3	2	607,923	26,544	4.4%
H	7	4	2,322,727	353,635	15.2%
Total	**32**	**20**	**$ 13,020,627**	**$ 1,453,384**	**11.2%**

The following are examples of the conditions identified:

- A GPD provider submitted a FAL for FY 2004 showing non-VA revenue of $27,500, but the Schedule A to the FAL showed estimated non-VA revenue of $146,442. VAMC fiscal staff did not detect this error when reviewing the request for per diem, resulting in the per diem rate being $5.37 ($26.95 – $21.58) higher than what should have been awarded. This caused the GPD provider to be overpaid about $137,000.

- A second GPD provider allocated about $1.5 million in costs for employment, legal, and supportive services to the GPD Program and other non-VA programs; however, in FY 2005 the GPD provider did not deduct $1.4 million in revenue attributable to these programs. As a result, about $160,000 in costs were inappropriately allocated to the GPD Program. The GPD provider used this same methodology in their previous per diem submissions. During the period July 2003 through September 2005, the GPD provider was overpaid about $292,000, most of which was attributed to the misallocation of these costs. In conducting the annual review, VAMC fiscal review

[20] Underpayments were negligible.

staff should have determined whether this revenue had been appropriately applied to the benefiting programs.

- A third GPD provider's cost estimate ($535,050) for their FY 2004 per diem rate was 48 percent higher than their actual FY 2003 expenditures ($361,231) with no increase in services or beds. In analyzing the various elements of cost for FYs 2003 and 2004, we found that the GPD provider included $44,029 for food and $133,946 for client assistance. However, actual expenses for these items totaled only $22 and $4,155, respectively. During FYs 2003 and 2004, this GPD provider was overpaid about $121,000. The difference between the overestimates and overpayments is attributed to cost increases in other elements of expense. VAMC fiscal review staff should have identified the significant differences between estimated and actual expenses when performing the annual review.

- A fourth GPD provider submitted a FAL for FY 2005 without showing all non-VA revenue. The GPD provider estimated $134,811 in non-VA revenue, while their FY 2004 income statement showed actual non-VA revenue of $444,320. In reviewing the FY 2005 audited income statement, we found the actual non-VA revenue was $447,145. The GPD provider under reported non-VA revenue by about 300 percent for FY 2005. This resulted in the GPD provider being paid a per diem rate of $27.19 instead of $9.63, causing an overpayment of about $81,000. The GPD provider also did not deduct the appropriate amount of non-VA revenue for FYs 2003 and 2004, which resulted in an overpayment of about $51,800. VAMC fiscal review staff should have identified the additional non-VA revenue not reported on the FAL supporting schedule when performing the annual review.

These overpayments resulted from the GPD provider not deducting non-VA revenue from their program expenses, understating revenues, or overestimating their program costs. However, these overpayments were not detected because the National GPD Program officials and VAMC fiscal officers, who supervise the fiscal review staffs, did not ensure adequate reviews of the GPD providers' accounting data were conducted during the initial and subsequent annual inspections. Discussion with VAMC fiscal officers disclosed that some fiscal review staffs were not familiar with OMB Circulars A-122 and A-133 audit procedures and did not have the expertise to perform these types of assessments. According to National GPD Program officials, they rely on VAMC fiscal review staffs to ensure the accuracy of the FALs.

Annual assessments by VAMC staff of FALs and comparisons of actual costs incurred to approve per diem rates have not been effective. VAMC fiscal review staffs were not properly trained or supervised to perform the annual assessments. Most VAMC fiscal officers we interviewed saw these responsibilities as ancillary duties that stretched their limited fiscal staff resources. Assessments were cursory in nature and usually performed in only 1 or 2 days. Some fiscal officers told us that their staffs were not familiar with

OMB requirements. One assistant fiscal officer stated that the OMB circulars were like reading "Greek" and that his staff was not qualified to conduct the annual assessments.

We also interviewed VAMC fiscal review staffs that conducted the annual assessments and found they generally could not explain the methods they used in evaluating the GPD providers' accounting systems and how they determined whether the requested per diem rates were appropriate. Five of the eight fiscal review staffs did not maintain work papers documenting their assessments.

A new VHA GPD handbook was issued. Prior to March 1, 2006, the VA's GPD Program Liaison Guide was the primary guidance provided to VAMC fiscal officers concerning their oversight responsibility of homeless providers. The guide requires that the VAMC fiscal staffs annually review GPD providers to ensure that their accounting systems meet generally accepted accounting principles and that they properly segregate costs to the appropriate cost centers, projects, or awards.

On March 1, 2006, VHA distributed a GPD Handbook which formally issued the Fiscal Review Guide[21] to VAMC staffs, which replaced the interim guide. The new guidance requires a comparison of current budget and actual costs for the previous year's operation and is more detailed than previous guidance. In addition, the new guidance instituted an incurred cost review requirement that GPD providers submit actual costs for the fiscal year. The actual costs will be compared to the estimated costs used to approve the per diem rates. If the actual costs result in per diem rates that are less than the approved rates, the GPD providers will be required to reimburse the overpayments to VA.

According to National GPD Program officials, under this new guidance, VAMC fiscal review staffs will be responsible for conducting assessments of FALs and completing incurred cost reviews of GPD providers. In our opinion, the inadequate assessment of the FALs identified in our review raises serious questions about VAMC fiscal review staffs' ability to adequately conduct incurred cost reviews. In order to properly conduct incurred cost reviews, the fiscal review staffs should be trained on how to perform audits of the GPD providers' financial statements and related ledger accounts and trial balances.

In January 2005, training was provided on the draft Fiscal Review Guide during the Fiscal Officers Annual Training Conference in Nashville, TN. In January 2006, the VISN Fiscal Quality Assurance Managers (FQAM) received training on their responsibilities to ensure that VAMC fiscal review staffs adequately assess FALs and conduct incurred cost reviews of non-profit organizations. None of the training was specific to the steps required to perform reviews of the FALs or the incurred costs reviews that the new guidance requires. Also, according to National GPD Program officials, the Fiscal Review Guide training is provided to VISNs on an "as requested"

[21] The GPD Program Liaison Guide included guidance that was similar but not as detailed as the Fiscal Review Guide.

basis. As of March 2006, only five VISNs had received the training, eight VISNs were scheduled for training this FY, and the remaining eight VISNs had not been scheduled. Consequently, there are no assurances that VAMC fiscal review staffs in these VISNs will ever be trained to perform effective reviews of the FALs and incurred costs reviews.

Issue 5 Conclusion

VAMC monitoring and oversight of GPD providers was inadequate. Financial assessments were not properly conducted and did not identify errors in the computation of approved per diem rates. Assessments did not identify all non-VA sources of revenue or detect significant differences between estimated and actual costs, resulting in GPD providers being overpaid. We found 20 (63 percent) of the 32 programs we reviewed were overpaid approximately $1.5 million. Failure to identify inaccurate information in the FALs during the per diem approval process can result in the GPD provider being overpaid. This could, in turn, result in the program ceasing operations and the veterans having to be placed elsewhere.

These errors occurred because VAMC fiscal review staff were not familiar with OMB requirements, and according to some fiscal officers, they were not qualified to conduct annual assessments. In our opinion, in order to ensure that per diem rates are accurately established and incurred cost reviews are properly conducted, financial oversight of GPD providers should be centralized to an appropriate office whose staff is trained and competent to audit GPD providers. This action would ensure accurate establishment of per diem rates and consistent oversight of GPD providers. However, because of VHA concerns about centralization, we agreed that VHA could take other measures to correct the problem.

Recommended Improvement Action 6. We recommend the Acting Under Secretary for Health:

a. Review the financial oversight of GPD providers to ensure that per diem rates are accurately established and incurred cost reviews are properly conducted.

b. Consult with General Counsel to determine the appropriateness and cost-effectiveness of initiating collection actions on overpayments.

Issue 6: Corrective Actions Following a Previous GPD Assessment Were Insufficient

In 2002, the OIG initiated an investigation of an allegation that a former VA-GPD Liaison was simultaneously the Chief Executive Officer for a non-profit organization (recipient) receiving VA grant and per diem payments (*Audit of the VA Homeless Veterans Transitional Housing Grant to Tampa-Hillsborough Action Plan, Inc., Tampa,*

Florida, Report No. 02-03372-101, issued March 8, 2006). As part of the investigation, the OIG conducted a review to determine if overall GPD management controls were adequate and operating to ensure that VA grant and per diem assistance were used by the recipient to provide transitional housing to homeless veterans. The OIG review identified nine areas where the management controls of the GPD Program needed strengthening to adequately safeguard program resources. Additionally, during the investigation, VHA assembled a Management Improvement Team (MIT) compromised of VHA officials, including the VHA Chief Financial Officer, Financial Assistance Office, and the GPD Program Office. The MIT examined the organizational structure and fiscal and program accountability of the GPD Program and identified 27 control weaknesses and system deficiencies. The deficiencies identified by the OIG and MIT occurred because GPD Program managers had not provided clear guidance to the recipient concerning their operational responsibilities and accountability for GPD funds; also they did not manage the program in compliance with OMB Circulars A-110, A-122, and A-133. As a result, the GPD Program overpaid the recipient almost $600,000 for costs that were not allowable or were not incurred.

To avoid compromising the criminal investigation, OIG did not issue a report at that time. Nevertheless, the OIG and VA's MIT brought many of the deficiencies identified in this review to the attention of VA and GPD Program management. The results of the OIG and MIT reviews were discussed with GPD managers during an October 2002 meeting in Washington, DC, that included the VA Homeless Coordinator, senior VHA HCHV Program officials, and representatives from General Counsel, the MIT, and OIG. Subsequently, GPD Program managers reported taking corrective actions to strengthen management controls. However, we determined during our current review that, while some actions taken were appropriate, other actions were not properly implemented or were otherwise ineffective in resolving the conditions, as follows:

- **Action Taken According to GPD Officials:** Specific instructions have been included in the application package that explain the difference between donations and discounts and the regulations that apply to each.

  OIG Assessment of Action Taken: Specific instructions were not added to the grant capital application package (First and Second Submissions) specifically addressing the difference between donations and discounts and the regulations that apply to each. The GPD provider evaluated during our 2002 OIG review used price discounts (applicable credits) which are specifically prohibited by OMB Circular A-122 instead of donations (services received) to meet their matching requirements for the acquisition and rehabilitation of property to be used to house homeless veterans (grant funding). Purchase discounts offset or reduce expense items that are allocable to awards as direct or indirect cost and should be credited to the Federal government either as a cost reduction or cash refunds. While our review did not focus on grant funding, the difference between donations and discounts can have a significant impact

on determining the GPD provider's matching requirement for the acquisition and rehabilitation of property to be used for transitional housing or service centers. Therefore, specific instructions should have been included in the application package that explain the difference between donations and discounts and the regulations that apply to each.

- **Action Taken According to GPD Officials:** An auditor was hired to review grant applications and per diem budgets, train VAMC fiscal staff to perform audits of GPD providers' financial and payroll records, verify the GPD providers' indirect cost allocation methodologies, and perform onsite GPD provider audits.

  OIG Assessment of Action Taken: The National GPD Program Office hired an auditor in May 2003 to assist with the assessment of FALs and incurred cost reviews. However, the National GPD Program officials delegated the primary responsibility of conducting FALs and incurred costs review assessments to the VAMC staffs. Reviews conducted by the VAMC staffs have not been effective as evidenced by the overpayments we identified. We were informed by VAMC fiscal management officials that the VAMC fiscal staffs have not been adequately trained nor are they qualified to conduct assessments of FALs or incurred cost reviews. (See pages 24–29 on financial review of GPD providers.)

- **Action Taken According to GPD Officials:** A tracking system has been implemented to ensure that GPD providers have annual audits and that National GPD Program staff compares the financial information in those audit reports with the per diem budgets submitted to the National GPD Program Office.

  OIG Assessment of Action Taken: During our review, we found that the GPD providers had annual audits of their financial statements. However, the National GPD Program officials delegated the primary responsibility of conducting FALs and incurred costs review assessments to the VAMC staffs. Reviews conducted by VAMC staffs have not been effective as evidenced by the overpayments we identified. (See pages 24–29 on financial review of GPD providers.)

- **Action Taken According to GPD Officials:** Training seminars have been developed for VA-GPD liaisons, VAMC staff, and GPD provider staff.

  OIG Assessment of Action Taken: The National GPD Program Office has not developed an integrated training program to ensure that all staff having oversight responsibility for the program have been properly trained. We found only limited training had been provided to VAMC staff on how to perform annual assessment of FALs and incurred costs reviews.

- **Action Taken According to GPD Officials:** VA-GPD liaisons are required to submit annual financial disclosure statements and receive annual ethics training.

OIG Assessment of Action Taken: The GPD Liaison Handbook has a provision that requires the VA-GPD liaison to submit Form 450, Confidential Financial Disclosure Report, to the Office of General Counsel. Our review found that VA-GPD liaisons usually received annual Ethics training, but did not always submit the required financial disclosures. (See pages 21–24 for VA-GPD liaison responsibilities.)

- **Action Taken According to GPD Officials:** The GPD Liaison Handbook was rewritten to include a checklist for initial and annual inspections, along with procedures to ensure that all rehabilitation work was actually completed.

  OIG Assessment of Action Taken: The GPD Program Liaison Handbook does include a checklist for initial and annual inspections. However, there are no procedures to ensure that all rehabilitation work was actually completed.

- **Action Taken According to GPD Officials:** The MIT has performed onsite audits at nine GPD homeless veteran transitional housing projects nationwide and has additional audits scheduled through the end of FY 2003.

  OIG Assessment of Action Taken: According to the National GPD Program Office, onsite reviews have been performed at about four to six GPD providers. The MIT conducted the audits of the GPD providers during their evaluation of the GPD Program. However, the evaluation was not issued because the office was reorganized.

Issue 6 Conclusion

Although National GPD Program officials had been informed of control weaknesses and system deficiencies through VA's MIT assessment and OIG work, they did not fully implement corrective actions to resolve identified conditions. In several instances, the corrective action was initiated, but National GPD Program officials did not follow through to ensure that: (a) VAMC staff were trained and qualified to perform the necessary fiscal functions, (b) revised policies and guidelines addressed all of the corrective action elements, and (c) systems were in place to ensure that GPD site audits would continue after the MIT's reorganization.

Recommended Improvement Action 7. We recommend that the Acting Under Secretary for Health require the National GPD Program officials:

a. Fully address deficiencies identified by internal and external reviews.

b. Track corrective actions through resolution.

c. Evaluate the effectiveness of those actions.

Issue 7: The National GPD Program Office Did Not Provide Adequate Oversight of GPD Operations

While not a specific objective of our review, VHA oversight of the GPD Program is a critical component of effective operations. We determined that VHA's National GPD Program Office did not provide adequate oversight of some GPD operations, nor did it provide timely and consistently accurate guidance to VAMC GPD staff at the eight VAMCs we visited. Many of the deficiencies identified at the individual VAMC and GPD levels could be traced back to inadequate oversight, guidance, and in some cases, enforcement of existing policies by the National GPD Program Office. The following matrix shows deficiencies outlined in previous sections of this report and the National GPD Program Office's role in obviating or correcting the conditions.

Deficiency	National GPD Program Office Role
Form Xs were not always completed and forwarded to NEPEC.	Enforcement of requirement to adequately complete all evaluation forms.
NEPEC data was not reviewed or discussed with GPD providers.	Follow-up with VA-GPD liaisons whose GPDs are performing below national averages.
Proposal goals were not always realistic, consistent, or measurable.	Thorough review of proposals to assure appropriateness of performance goals; provision of technical assistance to grant writers on how to write meaningful program goals.
VISN and VAMC staff did not monitor proposal goals.	Provide the project management database to appropriate staff, educate them on its use, and ensure that GPDs not meeting performance targets are reviewed for quality improvement purposes.
VAMC staff did not ensure that all inspection deficiencies were corrected.	Require VA-GPD liaisons to certify that inspection deficiencies are corrected within an established period of time.
VA-GPD liaisons did not perform all administrative or quality assurance functions.	Issue guidance and provide training on all aspects of the VA-GPD liaison's responsibilities.
Corrective actions from a previous GPD review were not initiated or were not effective.	Implement corrective actions in a timely manner and follow up on conditions to ensure that actions were effective.
Overpayments of per diem reimbursements for some GPD providers went undetected because the National GPD Program Office did not have procedures in place to conduct cost-incurred reviews.	Review VAMC fiscal staff assessments of the FALs to ensure that they were properly conducted.

In addition, we found that the National GPD Program Office allowed a GPD provider to change the scope of their program and offer short term lodging (30 days) to GPD veterans, contrary to the GPD Program mission to provide transitional housing.

The National GPD Program Office granted a change of scope to a GPD provider but did not adequately document the rationale for the approval, which appeared inconsistent with the GPD mission. The GPD was originally funded to provide 12 transitional housing beds with appropriate social services. However, VA clinical managers had requested that the GPD designate eight of these beds as "detoxification beds,"[22] where veterans enrolled in VA's outpatient Substance Abuse Treatment Center (SATC) could stay for 30 days pending completion of SATC treatment. These veterans were then referred to community halfway house programs where beds may or may not be available. SATC clinical staff provided the treatment and case management services; the GPD did not provide any clinical services. In January 2000, a member of the National GPD Program Office staff conducted a site visit at the request of the GPD provider because of concerns about the program's structure. The National GPD Program official informed VA personnel that the GPD program was "…not designed to create 'boarding beds' exclusively for VA use…"; rather, it was for transitional housing and services. The program official outlined several options to address these issues. Shortly thereafter, the GPD provider requested a change of scope that proposed providing eight beds to veterans for a "…shorter period of time, usually 3–5 days."

The National GPD Program official approved the change of scope,[23] despite this change being contrary to the GPD mission to provide transitional housing for up to 2 years. We found three cases where veterans successfully completed SATC (and 30 days in the GPD), yet the discharge summaries referenced the need of those veterans to seek employment, address legal issues, and/or live with relatives pending halfway house placement. These are the types of psychosocial issues that would normally be addressed during transitional housing placement. Also, the original proposal goals were never changed to match the new service approach, nor were the per diem payments altered to reflect the reduction in clinical services for veterans residing in the eight short-term detoxification beds.

This is significant because we noted during our site visits that many GPD providers have initiated a "phased" approach to service provision similar to the GPD site noted in the above example. Specifically, providers may offer a 10-day drug detoxification program to be followed by a 30-day residential treatment component. This approach, however, would only meet GPD Program guidelines if residential treatment were followed by a transitional housing placement for up to 2 years. The National GPD Program Office needs to ensure that GPD programs are operated and services are delivered in a manner that supports the GPD mission.

[22] They only provided room and board in a substance-free environment.
[23] Approved April 4, 2004, via facsimile.

Issue 7 Conclusion

The National GPD Program Office did not provide adequate guidance or oversight to VAMCs with GPD programs, did not enforce existing policies, nor did it ensure that VA GPD staff had the necessary training and resources to perform their administrative and clinical functions. The GPD Program has grown significantly over the past 12 years, from 44 programs in 1994 to 309 programs in 2006, yet the 5-person composition of the National GPD Program Office has remained virtually the same. It appears that the existing National GPD Program Office infrastructure has been unable to support the program growth. While the sizable increase in GPD beds has undoubtedly furnished homeless veterans with more housing and treatment services, the lack of clear guidance and oversight in some areas placed those same veterans, as well as GPD programs, at risk for poor outcomes that may have been preventable.

Recommended Improvement Action 8. The Acting Under Secretary for Health should require VHA to ensure that the National GPD Program Office meets the operational and oversight requirements of this rapidly expanding program.

Comments

VHA Comments

VHA responded that it agreed with the OIG report findings and concurred with all recommendations. Although VHA agreed that GPD per diem rates should be accurately established and incurred cost reviews should be properly conducted (Recommendation 6.a.), they stated that a final plan to address this issue is dependent on the outcome of a review of possible alternatives.

VHA said they are finalizing a statement of work for solicitation of an expert consultant to evaluate the current GPD program/process—especially as it relates to financial oversight. The solicitation will include a requirement for the development of alternative options for program management. They further stated that the timetable for the availability of the final VHA plan is dependent on the responses to the solicitation. However, they stated that they would propose that the deliverable (the options document) be completed within 6 months after award, with the timetable for implementation to be dependent on the strategy selected.

The Acting Under Secretary for Health's memo stated that the National GPD Program is not accountable for all aspects of care for homeless veterans, but primarily with providing transitional housing and supportive services associated with psycho-social issues related to the patient's homelessness. The National GPD Program Office provides guidance to medical centers through VHA policy documents, training, conference calls, designated intranet sites, site visits, and teleconferences, with the Northeast Program Evaluation

Center charged with providing a global evaluation of the needs of homeless veterans, supporting program accountability, assessing program effectiveness, and identifying ways to improve program outcomes.

VHA's position is that since the GPD Program represents a diverse group of programs that have a common goal of providing flexible housing and supportive services to meet the needs of homeless veterans in their communities, local oversight is imperative to promote program quality and coordination. In response, VHA's Office of the Associate Chief Consultant for Homeless and Residential Rehabilitation and Treatment Programs will monitor the implementation of corrective actions planned in addressing the remaining recommendations in this report and provide OIG future reports of that assessment.

In their action plan, VHA further stated that it would conduct a comprehensive assessment of the effectiveness of follow-up action items by February 2008. In addition, VHA will conduct an assessment of the program's resource needs and begin making any needed adjustments in resources by October 1, 2006.

The Acting Under Secretary for Health's response is included in its entirety as Appendix A, beginning on page 37.

OIG Comments

We will follow up on all planned actions until they are completed. With regard to the issue of Recommendation 6.a., concerning the issue of accurately establishing GPD per diem rates and properly conducting GPD incurred cost reviews, we recognize that VHA cannot specify the timetable or completion date until they have selected a strategy from among those submitted by the consultant. We will follow up on Recommendation 6.a. until the strategy has been selected and implemented.

(original signed by Dana Moore, Deputy Assistant Inspector General for Healthcare Inspections for:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Acting Under Secretary for Health's Comment

Department of Veterans Affairs **Memorandum**

Date: August 17, 2006

From: Acting Under Secretary for Health (10)

Subject: **Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program, Project Number 2004-00888-HI-0102**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report, and I concur with the report and recommendations. Although VHA agrees that development and implementation of a plan to ensure accurate per diem rates and properly conducted cost reviews are needed, a final plan to address this issue is dependent on the outcome of a review of possible alternatives.

2. Nonetheless, I appreciate your efforts in highlighting the array of services VHA's GPD Program provides to homeless veterans through its many community GPD providers. VA's partnership with these organizations is an important part of what is, overall, the largest integrated network of homeless assistance programs in the country. During the past 10 years, over 6,000 transitional housing beds have been created in partnership with more than 200 non-profit organizations or local government agencies. Progress is being made, but as your report outlines, there is more work to be done to ensure appropriate operation and oversight of the growing GPD Program. In response to the recommendations, the attached action plan outlines several actions to be implemented, with others deferred until further assessment by VHA is completed.

3. The report indicates that some basic care activities, provided to homeless veteran patients in the collaborative operations with community providers, was less than optimal, and that further guidance may be needed to clearly define responsibility for these key aspects of care. As outlined in the attached action plan, VHA will take immediate steps to define these responsibilities, and initiate the necessary action to assure that the integrated care is well coordinated by the Grant and Per Diem Liaisons responsible for program oversight.

4. Your review assigned most program oversight responsibility to the National GPD program. However, it should be noted that the National GPD Program is not accountable for all aspects of care for homeless veterans, but primarily with providing transitional housing and supportive services associated with psycho-social issues related to the patient's homelessness. The National GPD Program Office provides guidance to medical centers through VHA policy documents, training, conference calls, designated intranet sites, site visits, and teleconferences, with the Northeast Program Evaluation Center (NEPEC) charged with providing a global evaluation of the needs of homeless veterans, supporting program accountability, assessing program effectiveness, and identifying ways to improve program outcomes.

5. Further, the report implies that centralized monitoring of the basic patient care activities and quality of local programs is problematic. Given that the GPD Program represents a diverse group of programs that have a common goal of providing flexible housing and supportive services to meet the needs of homeless veterans in their communities, local oversight is imperative to promote program quality and coordination. In response, VHA's Office of the Associate Chief Consultant, Homeless and Residential Rehabilitation and Treatment Programs will monitor the implementation of corrective actions planned in addressing the remaining recommendations in this report, and provide OIG future reports of that assessment.

6. VHA will continue to assess the oversight and resource needs necessary to support the rapidly growing Grant and Per Diem Program. Thank you for the opportunity to respond to this report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 565-7638.

(original signed by:)
Michael J. Kussman, MD, MS, MACP

Attachment

Acting Under Secretary for Health's Comments to Office of Inspector General's Report

The following Acting Under Secretary for Health's comments are submitted in response to the recommendations in the Office of Inspector General's Report:

Action Plan in Response to: OIG Draft Report, Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program (EDMS 353706)

Project No.: 2004-00888-HI-0102

Date of Report: May 18, 2006

Recommended Improvement Action 1. The Acting Under Secretary for Health should require VHA to ensure that:

a. VA-GPD liaisons or designees complete and submit Form Xs to NEPEC in a timely manner.

Concur

GPD Liaisons currently submit Form Xs to NEPEC on a monthly basis. Effective immediately, NEPEC will track all missing Form Xs on a monthly basis and will notify the GPD Liaison and the VISN Homeless Coordinator when a form is incomplete or missing. NEPEC will track all missing Form Xs until they are received.

In process	July 1, 2006 and on-going

b. National GPD Program office staff monitor Form X completion rates by VAMCs and require consistently underperforming sites to take corrective actions.

Concur

VHA concurrence is qualified, since, as noted in 1a, compliance with Form X completion will be monitored by NEPEC on a monthly basis. Monitoring of compliance with program evaluation tools is the responsibility of NEPEC, and not the GPD Program. NEPEC currently generates a quarterly report to the GPD

Liaisons and the Network Homeless Coordinator. This report provides aggregate data on the percentage of Form Xs completed for each GPD Program in their Network.

Effective immediately, the NEPEC quarterly report will be sent to the VISN Quality Management Office for review and action. Those Medical Centers that fall below a pre-established threshold for timely Form X completion will be required to submit a corrective action plan that address deficiencies. The corrective action plan will be submitted through the Medical Center Director to NEPEC and the GPD Office. Repeated under- performance with Form X completion will be identified by NEPEC and will be further addressed through a letter from the Associate Chief Consultant, Homeless and Residential Rehabilitation and Treatment Services to the VISN Director, the Medical Center Director, and the Network Homeless Coordinator where the under performance is occurring that will request an outline of actions to be taken to bring up performance.

In process October 1, 2006

c. VA and GPD provider employees adequately assess veterans' needs, devise treatment plans to meet those needs, and document the case records to reflect these services.

Concur

VHA concurs with clarification. For those veterans who are case managed by VA GPD Liaisons, it is imperative that a homeless veteran in the GPD Program have an initial evaluation, a treatment plan and timely documentation as clinically indicated. Documentation must address needs and ongoing documentation of progress related to services provided. VHA further clarifies that Form X is not a formal assessment or treatment plan. It is a program evaluation tool designed by NEPEC to collect baseline contact information from homeless veterans within the VHA Healthcare for Homeless Veteran Program (HCHV). Form X's may be completed on a veteran prior to admission to a GPD program by VA staff conducting outreach. Veterans' needs identified during outreach may differ from their needs at the time of admission to the program; therefore, it is within reason that the Form X assessment and the treatment plan are discrepant.

GPD Liaisons are required to comply with medical center policy and procedures within the liaison's discipline, scope of practice, and clinical service line and/or

other clinical guidelines related to assessment, treatment planning, and documentation. This documentation is entered into the VA electronic medical record. Responsibility for monitoring quality and timeliness of documentation is the responsibility of the local medical center.

According to GPD regulations (38 CFR 61.0), Community providers (Grant recipients) are held to standards as put forth in their application; consequently, VHA cannot hold GPD community providers accountable to clinical standards beyond what is required by this regulation without mutual consent. The GPD Liaison and the VA treatment providers will solicit the community provider's participation in VA treatment planning, with every effort made to coordinate the treatment process between the VAMC and the GPD community provider.

VHA will enhance the initial and annual inspection authorization and documentation to clearly establish responsibility for the provision of services and record keeping that includes assessment, treatment plans, and documentation of requirements performed by the GPD community provider and the VA liaison. This agreement will be signed and approved by the Medical Center Director in coordination with the GPD Office. The Medical Center Director will be held accountable for ensuring that the community based GPD provider offers quality services that are in compliance with existing laws, regulations, and standards. The National GPD Program Office and the Homeless Network Coordinators are available as key resources to facilitate this process. The GPD inspection forms have been revised for 2006 requiring the Medical Center Director's signature.

The VHA GPD office recently hired a clinical manager who will, in consultation with the field staff, the Council of Network Homeless Coordinators, and Patient Care Services, develop, a Clinical Pertinence Review Tool to be utilized by medical centers to monitor liaison compliance with documentation standards.

The program office will develop an USH Information Letter that emphasizes new requirements will be sent to the Network Director, Medical Center Directors, Network Homeless Coordinators, and liaisons emphasizing new requirements.

In process September 1, 2006

d. Clinicians comply with documentation standards regarding frequency of notes, treatment planning revisions, and veteran progress in the program to provide involved staff with an accurate depiction of the veteran's status.

Concur

VHA agrees that treatment planning is necessary and essential for veterans care. GPD liaisons or their designees are required to comply with medical center and regulatory agency documentation requirements. The quality monitoring of the documentation is the responsibility of the medical center. The quality management office at the local medical center is a primary resource to assure compliance with local documentation policies and accreditation standards related to the frequency and quality of the documentation.

While VHA supports timely and consistent documentation and recognizes that documentation is an essential tool for promoting integrated and coordinated services, VHA cannot hold GPD community providers to be accountable to clinical standards outside of what is required by GPD regulations (38 CFR 61.0). To help ensure providers are operating programs in accordance with their proposals, inspection forms have been revised for 2006 to include a requirement that providers submit documentations on progress towards meeting their goals and objectives as put forth in the grant application. As noted in 1c, VHA will develop a Clinical Pertinence Review Tool and send an USH Information Letter to GPD Liaisons and Network Homeless Coordinators emphasizing new requirements.

In process October 1, 2006

e. Clinicians conduct and document interdisciplinary treatment planning.

Concur

VHA concurs with qualification. VHA will encourage that GPD liaisons participate in interdisciplinary treatment planning and care at their local VA medical centers when diagnosis or conditions warrant care that requires interdisciplinary involvement, and whenever possible and appropriate. Care plans will be developed by individual clinicians when interdisciplinary care plans are not warranted. VHA clinical documentation is completed in CPRS and in accordance with medical center policy and procedures.

Presently, GPD providers frequently do not have interdisciplinary staff and requiring the provider to add interdisciplinary staff to meet this recommendation would be both costly and unnecessary. Treatment planning in the community based program needs to occur in accordance with specifications noted in the grant application or an authorized change of scope.

As noted in 1c and d, VHA will develop a Clinical Pertinence Review Tool and send and USH Information Letter to GPD Liaisons and Network Homeless Coordinators emphasizing new requirements.

In process October 1, 2006

f. VA clinicians review and document agreement with placements and treatment plans for those veterans with multiple readmissions.

Concur

VHA Handbook 1162.01 states that the Grant & Per Diem Liaison must review and approve or deny a waiver (for those veterans who have had three or more episodes) based on their best clinical assessment of the individual case. All readmissions require review and these reviews will be documented in the clinical record. The review will include documentation of clinical reasons contributing to the need to readmit the veteran. A memorandum for the record stating that a waiver has been granted must be forwarded to the GPD office, and recorded in the computerized medical record system (CPRS).

In addition, NEPEC will monitor waiver compliance and ensure that a waiver exists for homeless veterans admitted to GPD programs four or more times. If a waiver is not on file, NEPEC will notify both the medical center and the GPD office for corrective action.

In process October 1, 2006

Recommended Improvement Action 2. The Acting Under Secretary for Health should require VHA to ensure that:

a. VAMCs implement systems whereby VA-GPD liaisons or their designees verify that Form D data is accurate and supported by medical record or GPD program documentation prior to submission to NEPEC.

Concur

VHA agrees that it is good clinical practice for GPD staff to document client outcomes at the time of discharge in CPRS, and that this documentation should be consistent with what has been reported on the Form D. Homeless veterans enrolled in the GPD program, who are also under VA care (e.g., case management while in the HCHV Program) should have relevant information concerning the GPD episode entered in their clinical medical center record.

The Form D was designed by NEPEC to describe basic characteristics of the veteran's episode of care in the GPD program including cost, as well as several outcomes of program participation such as employment status, housing status, and clinical improvement. It is not intended to be a discharge note. The GPD Liaison is primarily responsible for accuracy of the discharge report (Form D) data. NEPEC requires that each Form D be signed by the individual completing the form, and that the GPD Liaison or other VA clinician familiar with the client's care in the GPD program (e.g. another HCHV program clinician) review the Form D and indicate concurrence with accuracy of the review by signing the Form. It is NEPEC policy to return the unsigned forms to the originating medical center liaison.

An Information Letter will be sent to the VISN Directors, Medical Center Directors, Network Homeless Coordinators and Medical Center Liaisons emphasizing the importance of documentation in the medical record will be generated. A Clinical Pertinence Review Tool will be developed and sent with the above mentioned letter to assist facilities with monitoring of staff documentation requirements.

In process October 1, 2006

b. VA and GPD staff members receive guidance and training on the meaning of Form D questions and the acceptable range of interpretations.

Concur

NEPEC currently provides training on evaluation procedures for all GPD liaisons and GPD community providers. Training is conducted via teleconference, and an evaluation procedure manual is provided to both GPD liaisons and GPD community providers. A primary component of the training is the review of the Form D, and the acceptable range of interpretations of Form D responses. When GPD providers complete Form Ds, Liaisons will be responsible for training the providers on Form D completion, and ensuring that providers meet acceptable standards for Form D completions. Additional training from NEPEC is available at the request of the GPD Liaisons. Additional training is often required and provided due to staff turnover.

VHA recognizes the importance of training staff and has initiated a focused training for new liaisons related to VHA-GPD Handbook 1162.01 on the GPD Program. Each VISN has participated in the training and to date, 136 new liaisons

have each received 1.5 days of training. The GPD Office is also working with the VA Employee Education Service (EES) to develop a web-based training that will provide critical training information related to the rules, regulations, and operating principles for the GPD program. GPD will continue the training, with web-based training released to the field in December 2006. All liaisons in the GPD program will be required to complete this training. EES is developing a specific evaluation tool to be implemented in 2007 to monitor the effectiveness of their training, including the effectiveness of their web based training.

In process January 31, 2007

Recommended Improvement Action 3. The Acting Under Secretary for Health should require VHA to ensure that:

a VA-GPD liaisons share and review NEPEC data with GPD providers quarterly, and document discussions and corrective action plans accordingly.

Concur

VHA agrees that NEPEC program evaluation data can be used at times to assist providers' programs in improving performance. VHA Handbook 1162.01 notes under the GPD Liaison training and duties section that a primary responsibility of the Liaison is to "monitor periodically throughout the year for compliance to ensure the GPD program is being administered as outlined in the grant proposal." This monitoring must include performance reviews. At a minimum, the liaison must use NEPEC data, as well as the goals and objectives put forth by the provider in the grant application, as benchmarks for grant recipient program performance. The performance reviews must be documented and the program improvement actions, based on these reviews, must be implemented.

To further promote the implementation of performance based activities within the GPD, the liaison will be required to submit a copy of the performance reviews that were conducted during the annual inspections to the Medical Center Quality Management Office. The Quality Management Office will track the recommendations and ensure that they are addressed in subsequent reviews. If GPD providers continue to under-perform, the liaison and quality management office will notify the Medical Center Director who will establish a correction plan to address deficiencies. Corrective action plans may include recommendation to suspend funding. A copy of this plan will be forwarded to the GPD and the

Network Homeless Coordinator. Proposed VHA enhancement will be added to the GPD Handbook, December 2006.

In process December 31, 2006

b. National GPD Program Office managers adequately review proposals for measurable and achievable goals prior to funding approval.

Concur

VHA is currently authorized by law to award funds to organizations that offer technical assistance and has awarded technical assistance grants to community providers that assist homeless veterans. The awardees of these grants have been providing technical assistance to potential and current GPD providers on how to write measurable program goals. The GPD office has documentation related to the dates and times of these trainings.

Recent training completed June 5, 2006 On-going

c. VA-GPD liaisons or designees ensure that GPD providers are monitoring performance in relation to proposal goals and require GPDs to develop performance improvement activities to enhance outcomes.

Concur

VHA Handbook 1162.01 includes a requirement in the Clinical Review portion of the yearly inspection for the clinical member of the inspection team to ensure an ongoing assessment of the supportive services needed by the residents and the availability of such services; and ensure an assessment report addressing the providers ability to meet the goals, objectives, measures, and special needs as set forth in the application is completed by the provider and submitted with the annual GPD inspection report. These new inspection procedures are in place for 2006.

VHA recognizes the importance of providing quality transitional housing and supportive services for homeless veterans. In the VHA Handbook 1162.01, GPD provider compliance is the assigned responsibility of the medical center director. As stated in section 8.b. of the Handbook, "it is the responsibility of the VAMC Medical Center Director to ensure programs are operating as stated and designed in the original GPD proposal. Additionally, the VAMC inspection team is required on an annual basis to ensure that the provider submits an assessment

report addressing their ability to meet the goals, objectives, measures, and special needs as set forth in their application."

The GPD Office will monitor enhanced inspection procedures and provide timely feedback to those sites that are out of compliance.

In process January 1, 2007

Recommended Improvement Action 4. The Acting Under Secretary for Health should require VHA to ensure that:

a. All deficiencies identified by inspection teams are corrected, and that inspection files reflect these actions.

Concur

VHA concurs that all deficiencies identified by inspection teams must be corrected and inspection files must reflect these actions. The need for enhanced inspection procedures was previously identified by the National GPD Program Office and these enhanced procedures for corrective actions and due processes have been specified in the VHA Handbook 1162.01. These procedures give guidance to medical centers on notification of program deficiencies and necessary corrective actions.

The GPD Liaison will be required to submit a copy of the inspection reports that include deficiencies to the medical center Quality Management Office. The Quality Management Office will track the deficiencies and ensure that they are addressed in a timely manner. Once deficiencies have been addressed, the Quality Management Office will forward a report of completion to the National GPD Program Office.

In process January 1, 2007

b. Inspection team members communicate their findings and recommendations to GPD providers.

Concur

VHA addressed this recommendation in VHA Handbook 1162.01, in the section, "Program Inspections". VA FORM 10-0361c, VA Homeless Providers Grant and Program Inspection Package Checklist, provides the opportunity for the GPD Liaison and other inspection team members to communicate findings and

recommendations to the medical center director as well as the GPD provider staff. The report is then filed with the National GPD Program Office.

VA-GPD Liaisons will be instructed to submit copies of the inspection report documents to the GPD provider after these reports have been approved and signed by the medical center director. An addendum will be included in the VHA Handbook 1161.01, December 2006.

In process January 1, 2007

c. VAMC staff monitor and follow up on the inspection work of contractors.

Concur

VHA concurs that all deficiencies identified by inspection teams must be corrected and inspection files must reflect these actions. Procedures for corrective actions and due processes have been specified in the VHA Handbook 1162.01. These procedures give guidance to VAMCs on notification of program deficiencies and necessary corrective actions.

In process January 1, 2007

d. VA-GPD liaisons or their designees conduct environmental rounds during their regularly scheduled site visits to identify obvious hazards or other deficiencies which could be addressed promptly.

Concur

VHA concurs with qualification. We recognize the importance of care being provided in a safe environment. If a liaison identifies an environmental hazard as part of the routine visit to the program, it is his responsibility to inform the GPD provider regarding the safety concern. It should be noted that it is also the liaison's responsibility to comply with medical center policy and procedures related to reporting safety, environmental hazards, other patient care concerns and or allegations of impropriety. A copy of this contact should then be documented to the GPD file.

GPD Liaisons will be reminded quarterly on the conference calls regarding the importance of reporting obvious hazards in accordance with their medical center policies.

In process October 1, 2006

Recommended Improvement Action 5. The Acting Under Secretary for Health should require VHA to ensure that:

a. All VA-GPD liaisons file CFDs annually.

Concur

VHA requires GPD Liaisons to file confidential financial disclosures (CFDs), as specified in VHA Handbook 1162.01, "As part of the initial designation and annual re-designation, the VA Liaison is required to comply with the provisions of "Confidential Filer" regulations and submit to the Office of General Counsel Form 450, Confidential Financial Disclosure Report, to ensure there is no actual or apparent conflict of interest between the liaison and the provider organization...." Regional Counsels are accountable to ensure GPD liaisons file these disclosures, and the liaisons are provided with the necessary accompanying training.

VHA will work with the 22 Regional Counsel offices to ensure that all GPD liaisons complete their annual CFD. The GPD Office will request that Regional counsels provide certification on an annual basis, that GPD liaisons have completed their CFD's if this is not deemed by OGC to be a violation of their confidential filer status.

In process October 1, 2006

b. VA-GPD liaisons appropriately certify invoices prior to payment.

Concur

VHA agrees that liaisons must appropriately certify invoices prior to payment. The VHA Handbook 1162.01 expands and further specifies the liaison's responsibilities with regard to establishing review billing documentation. It is under the authority and the responsibility of the medical center director to ensure these processes are in place.

Liaison training and web-base training will address this issue. Reminders will also be provided as needed on the Liaison Monthly Conference Call.

In process October 1, 2006

c. Incidents involving GPD veterans are reported to VAMC and National GPD Program officials.

Concur

VHA agrees that incidents involving GPD veterans should be reported to the VAMC and the national GPD program office. This issue is addressed in the recently published VHA Handbook 1162.01, under "Special Reporting Circumstances." The GPD Handbook recommends that medical centers incorporate GPD-funded programs into a critical incident reporting procedure. VHA policy requires that yearly data from these reporting procedures be submitted to the GPD Office for review. The medical center director or his designee is responsible for ensuring compliance with this procedure.

When the GPD Office becomes aware of failure to notification, the Associate Chief Consultant Homeless and Residential Rehabilitation and Treatment Services will send a letter to the medical center director for further follow up and review.

In process Immediately

Recommended Improvement Action 6. We recommend the Acting Under Secretary for Health:

a. Review the financial oversight of GPD providers to ensure that per diem rates are accurately established and incurred cost reviews are properly conducted.

Concur

VHA concurs in concept with the recommendation of developing and implementing a plan to ensure that per diem rates are accurately established and incurred cost reviews are properly conducted.

VHA is finalizing a statement of work for solicitation of an expert consultant to evaluate the current GPD program/process -- especially as it relates to the financial oversight. The solicitation will include a requirement for the development of alternative options for program management. The Office of Intergovernmental Affairs has been consulted and concurs with this approach.

The timetable for the availability of the final VHA plan is entirely dependent on the responses to the solicitation. VHA will certainly propose that the deliverable

(the options document) be completed within 6 months after award. The timetable for the implementation is dependent on the strategy selected.

b. Consult with General Counsel to determine the appropriateness and cost-effectiveness of initiating collection actions on the $1.4 million in overpayments.

Concur

The collection of the amount estimated by OIG must be validated through audit procedures established through the GPD and VA Office of Finance. Collection actions cannot be taken until the identified community providers are given an opportunity for due process. VHA will initiate appropriate action, as agreed upon by the Office of General Counsel, depending on the outcome of VHA validation and due process for community providers.

In process January 1, 2007

Recommended Improvement Action 7. We recommend that the Acting Under Secretary for Health require the National GPD Program officials:

a. Fully address deficiencies identified by internal and external reviews.

b. Track corrective actions through resolution.

c. Evaluate the effectiveness of those actions.

Concur

OIG notes in their report on page 30 that they did not provide a report of the review of the GPD program during a 2002 review of a non-profit organization, to avoid compromising a criminal investigation of the provider. An MIT review conducted at that time did result in seven observations, and 27 suggestions. Most of the MIT suggestions were accepted and those that warranted action were implemented. VHA acknowledges the value of addressing deficiencies, tracking corrective actions and evaluating the effectiveness of those actions. VHA agrees that quality planning, efficient quality control, and quality improvement are essential to offering effective services. VHA will address the comprehensive findings documented in this report by ensuring that actions are specified and tracked, and that evaluation systems are implemented. Target dates have been

established for policy clarification and enhancement, training and continuous monitoring. The Office of the Associate Chief Consultant, Homeless and Residential Rehabilitation and Treatment Programs will fully address the deficiencies identified and accepted in this report, establish a tracking system for corrective action of those deficiencies, and evaluate the effectiveness of all actions within one year of implementation. It should be noted that some actions will require policy changes and hiring additional staff, necessitating a longer period than usual for assessing the effectiveness of actions taken.

In process February 1, 2008

Recommended Improvement Action 8. The Acting Under Secretary for Health should require VHA to ensure that:

The National GPD Program Office meets the operational and oversight requirements of this rapidly expanding program.

Concur

VHA concurs with qualification. The OIG auditors assigned most program oversight responsibility to the National GPD Program Office; however, authority and responsibility for a significant portion of program oversight is assigned to the local medical centers, as delineated in the GPD Directive 2002-72 (rescinded), and further specified in VHA Handbook 1162.01 published March 2006. VHA does not agree that a significant policy change to assign most oversight functions to the National Program Office is in the best interests of homeless veterans or our community partners. Local oversight is imperative to promote program quality and coordination of the diverse group of programs providing services to homeless veterans in their community. Assigning most oversight functions to the National Program Office would result in more distant, and therefore, less effective management of quality patient care and program monitoring activities.

VHA will address the comprehensive findings documented in this report by ensuring that actions are specified and tracked, and that evaluation systems are implemented by the Office of the Associate Chief Consultant, Homeless and Residential Rehabilitation and Treatment Programs. Target dates have been established for policy clarification and enhancement, training and continuous monitoring. VHA will also conduct a comprehensive assessment of the effectiveness of follow-up action items by February 2008. In addition, VHA will conduct an assessment of the program's resource needs and begin making any needed adjustments in resources by October 1, 2006.

In process February 1, 2008

Appendix B

OIG Contact and Staff Acknowledgments

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Appendix C

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