VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of
the Homeless Providers
Grant and Per Diem Program

March 12, 2012
11-00334-115

ACRONYMS AND ABBREVIATIONS

GPDP	Grant and Per Diem Program
HUD-VASH	Housing and Urban Development-Veterans Affairs Supported Housing
NEPEC	Northeast Program Evaluation Center
NOFA	Notice of Funding Availability
OIG	Office of Inspector General
VHA	Veterans Health Administration

Report Highlights: Audit of VHA's Homeless Providers Grant and Per Diem Program

Why We Did This Audit

In November 2009, the VA Secretary announced a goal to end homelessness among veterans by 2015. We conducted this audit to determine whether community agencies receiving funds from the Grant and Per Diem Program (GPDP) are providing services to homeless veterans as agreed upon in their grant agreements or authorized changes of scope. We also examined whether program funding is effectively aligned with program priorities.

What We Found

The Veterans Health Administration (VHA) GPDP provides services to homeless veterans and has successfully assisted veterans to live independently in safe and affordable permanent housing. An incomplete grant application evaluation process, a lack of program safety, security, health, and welfare standards, and an inconsistent monitoring program impacted the program's effectiveness.

Additionally, VHA lacked an effective mechanism to assess and measure bed capacity, procedures to monitor the reliability of reported information, and sufficient training on program eligibility.

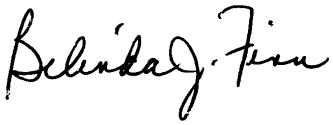
As a result, VHA's controls do not ensure homeless veterans consistently receive the supportive services agreed to in approved grants. Also, program funding is not effectively aligned with program goals and better assurance is needed that program goals are met.

What We Recommend

We recommend the Under Secretary for Health strengthen the grant application and evaluation process by publishing policies and standards, updating their inspection checklist, and implement procedures to ensure grant providers have the capability to deliver services. We also recommend the Under Secretary establish bed capacity goals, maintain program data, implement procedures to improve the reliability of program information, and provide training on program eligibility.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and provided appropriate action plans. We will follow up on the implementation of VHA's corrective actions.



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INTRODUCTION

Objective

This audit determined whether community agencies[1] receiving funds from the VA Homeless Providers Grant and Per Diem Program (GPDP) were providing services to homeless veterans as agreed upon in their grant agreement or authorized changes of scope. We also examined whether program funding was effectively aligned with program priorities.

VA's Goal to End Veteran Homelessness

In November 2009, the VA Secretary announced a goal to end homelessness among veterans by 2015. VA outlined six areas of focus: (1) outreach and education, (2) treatment, (3) prevention, (4) housing and supportive services, (5) income, employment, and benefits, and (6) community partnerships. In 2011 the Department of Housing and Urban Development released *The 2011 Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report*, which estimated 67,500 veterans were homeless on a single night in January 2011.

Grant and Per Diem Program

The Veterans Health Administration's (VHA's) Homeless Program is responsible for all homeless programs, to include the GPDP, and is aligned under the Deputy Under Secretary for Health for Operations and Management. The purpose of the GPDP is to provide funding to non-profit and government agencies to offer outreach, rehabilitative services, vocational counseling and training, and transitional housing assistance to homeless veterans.

The GPDP manages several types of grants. This audit focused on grants that were providing services to homeless veterans prior to March 31, 2011. See Appendix B for more information on the GPDP program and a description of the types of grants managed by the GPDP.

Program Funding

Annual funding for the GPDP increased from $92.2 million in FY 2007 to $217.6 million in FY 2011. VA requested $224.2 million and estimated creating capacity to serve approximately 20,000 veterans in 2012.

Other Information

Appendix A highlights veterans' concerns about recent Housing and Urban Development-Veterans Affairs Supported Housing policy changes. This issue was outside of our audit scope. Appendix B provides background information and Appendix C the audit's scope and methodology.

[1] Prior to approval of funding by VHA, community agencies are referred to as grant applicants or applicants. After VHA approves funding, grant applicants are referred to as GPDP providers.

RESULTS AND RECOMMENDATIONS

Finding 1 VHA Needs To Improve Delivery of Services to Homeless Veterans

VHA's GPDP provides vital services to homeless veterans and has successfully assisted many veterans to live independently in safe and affordable permanent housing. However, VHA needs to strengthen the oversight and management of the GPDP to ensure that safe transitional housing and sufficient supportive services are provided more effectively to homeless veterans. Specifically, VHA needs to provide greater clarity regarding program expectations to adequately ensure the safety, security, privacy and the health and welfare of homeless veterans.

Lapses in oversight and grants management occurred because of the lack of an application evaluation process that identified and analyzed risks associated with grant applications. In addition, the program lacked standards to ensure the safety, security, privacy and health and welfare of veterans in GPDP facilities, and inconsistent monitoring of the GPDP providers. As a result, VHA needs to improve their program management and oversight associated with providing safe transitional housing and effective supportive services to homeless veterans.

Safety, Security, and Privacy of Veterans

VHA did not consistently ensure the safety, security, and privacy of homeless veterans in transitional housing. VHA policy requires supervision and security arrangements for the protection of homeless veterans using GPDP housing. However, VHA does not define what specific supervision and security measures are expected for various homeless veteran populations, such as female, homosexual, and transgender veterans living in GPDP transitional housing.

Supported Populations Unclear

We found 8 (31 percent) of 26 applications selected for review did not clearly state the gender of veteran homeless populations the grant applicant proposed to support. Applicants must provide a project narrative, description of need, and an outreach targeting plan. The project narrative inadequately identified the gender of homeless veteran populations the applicant planned to support, such as female, male, or both. Often these same applications were written using gender-neutral terminology throughout the application, such as "veterans." Without a clear understanding of the homeless population to be supported, VA medical facilities cannot determine what risks are associated with the population and adequately monitor the provider's safety and security arrangements. Appendix B provides more information on the application process.

Safety, Security, and Privacy Risks Not Addressed

We found 8 (31 percent) of 26 GPDP providers[2] did not adequately address the safety, security, and privacy risks of veterans, especially female veterans. GPDP medical facility staff allowed providers to house female veterans in male-only approved facilities and multi-gender facilities for which security and privacy risks had not been assessed and mitigated. For example, we found the following risks.

- Bedrooms and bathrooms without sufficient locks
- Halls and stairs without sufficient lighting
- Female and male residents on the same floor without access restrictions

According to the National Center on Family Homelessness, multi-gender living arrangements can present risks of sexual harassment and assault to women and can invite perpetrator-victim relationships. In addition, the GPDP medical facility staff placed female veterans in female-only facilities that had inadequate security measures, such as insufficient monitoring and restricting of access to non-residents.

Previous OIG Report

During the course of this audit, the Office of Inspector General (OIG) advised VHA of serious female veteran safety, security, and privacy issues discovered during an OIG site visit that required immediate management attention.[3] Female residents shared bathrooms with male residents without secure locks and shared the same floor as male residents without adequate barriers restricting access to the female rooms. According to data provided by the Northeast Program Evaluation Center (NEPEC),[4] VA medical facility's GPDP staff had placed 22 homeless females in a GPDP male-only approved provider facility since FY 2002 without adequately addressing the safety, security, and privacy needs of the female veterans.

The VA medical facility staff's assessment documents were available for 10 of 22 female veterans who had resided at the facility since FY 2002. According to the 10 available clinical assessments, 7 (70 percent) of 10 female veterans had histories of sexual trauma and/or domestic violence. Further, some of the current male residents were assessed as having drug and alcohol problems and psychiatric issues, as well as criminal histories, such as assault and attempted homicide.

The provider's facility also had a history of documented instances of unprofessional behavior of resident managers, such as substantiated

[2] Grants were held by 16 providers at multiple locations.
[3] *Safety, Security, and Privacy for Female Veterans at a Chicago, IL Homeless Grant Provider Facility*, Report No. 11-00334-267, September 6, 2011
[4] The Northeast Program Evaluation Center conducts evaluations for several VHA programs including the GPDP, such as tracking care provided to homeless veterans from admission to discharge.

allegations of sexual harassment and an inappropriate relationship with a resident. Female veterans were housed in this facility because GPDP medical facility staff were unaware that the facility was approved as a male-only facility. After we discussed this situation with the director of the VA medical facility, the GPDP medical facility staff moved the two current resident female veterans to alternative housing.

Examples of Safety, Security, and Privacy Risks

The following are other illustrations of safety, security, and privacy risks that veterans encountered.

- In April 2011, a VA medical facility placed a homeless female veteran and her 18-month-old son in a GPDP provider's facility. This facility was approved without the provider clearly stating whether the facility would support homeless females, males, or both. In August 2011, the medical facility placed a homeless male veteran, who was a state registered sex offender, in the same provider facility. The female veteran and her son were on a different floor than the male veterans and had their own lockable room with separate bathroom facilities. The medical facility's homeless program coordinator acknowledged he did not conduct a formal risk assessment, such as verifying the offender's description of his past criminal history, prior to placing the male veteran in the provider facility. Before leaving the site, we discussed this issue with the VA medical facility director and recommended she assess the risk of the situation to determine if better alternatives existed. She determined that the male veteran could remain at the facility.

- The GPDP approved a grant that included support for a female-only facility that consisted of two buildings. The buildings were on a large campus that, according to the site director, also housed approximately 500 males collocated on the facility grounds. The entrances to the two buildings were not locked or electronically monitored, and female residents' rooms did not have locks. Provider staff were responsible for providing after-hour security services. Security consisted of a staff member positioned near the entrance of one of the three buildings. This same staff member also had responsibility for performing a walkthrough of the other buildings at certain times. This created security lapses, which left female residents concerned about their safety and security. The GPDP medical facility staff told us approximately 80 percent of the females housed at this provider's facility had experienced military sexual trauma.

- A GPDP provider housed female homeless veterans in a facility that did not specifically identify females as a supported population in the grant application. During our site visit, the facility was housing 6 female veterans in their own single room units and 32 males in mostly

double occupancy rooms on the same floor of the facility. All bedroom units had their own bathrooms. The female and male residents shared laundry and kitchen facilities and a common television room. One of the six female residents was receiving treatment for military sexual trauma and stated she had safety concerns about sharing common areas with male veterans. The only area she felt comfortable in was the kitchen, which had two security cameras. Female veterans also expressed privacy concerns with sharing laundry facilities and the television room with males. One female veteran stated some of her personal clothing items, such as underwear, were frequently missing from the shared laundry facility. Two female veterans stated they were not comfortable going to the television room where the males gathered.

After discussing our concerns about vague information in grant applications regarding homeless population descriptions and how safety and security issues would be managed, GPDP officials conducted an inventory of all GPDP providers to determine how many were serving the supported populations identified in their approved grant application. According to GPDP analysis of the inventory, 122 (20 percent) of 596 GPDP providers clarified or submitted a change to the gender of the population identified in their current grant agreement.

Program Application and Oversight Not Sufficient

VHA did not consistently address safety, security, and privacy concerns of homeless veterans because of an incomplete application evaluation process and insufficient program oversight. The application process lacked sufficient controls to ensure grant applicants clearly identified proposed supported populations and address safety, security, and privacy issues for homeless populations, such as females or multi-gender populations. Without requiring grant applicants to clearly identify specific populations in their applications, GPDP and the provider cannot address the security risks specific to those populations and have standards that VA medical facility GPDP staff can measure providers' performance.

Prior to any work or receipt of government funds, VHA requires any approved application for construction or rehabilitation of a facility to undergo a compliance review of various engineering codes, such as fire and building codes. However, VHA does not adequately require VA medical facility staff review veterans' safety, security, and privacy issues prior to government funds being awarded, such as access restrictions at multi-gender facilities. Additionally, VA medical facility staff do not review these issues during their annual inspections because they are not addressed on the GPDP inspection checklist.

VHA also lacked effective oversight of provider facilities. Although GPDP medical facility staff visited provider facilities regularly and were helping veterans achieve their program goals, the staff often overlooked the

monitoring of the providers' facilities including changing conditions to identify potential risks to resident veterans.

Safety, Security, and Privacy Risks Not Assessed or Mitigated

As a result of not completely addressing homeless veterans' safety, security, and privacy issues, VHA does not ensure that veterans are provided with an environment that enables them to overcome the complex issues of their homelessness. During the audit, it came to our attention that a female veteran reported she was sexually assaulted on two occasions by a male resident at a GPDP provider's facility not in our sample.[5] According to the VA medical facility's Patient Safety Manager, the female veteran participated in the program for 3 months, and after reporting the incidents, she left the program because she no longer felt safe. This occurred in an approved multi-gender facility that was annually inspected by VA medical facility staff, but they had not noted any security deficiencies.

After the sexual assault allegation, medical facility staff conducted a review of the GPDP facility and identified inadequate bathroom and window locks, insufficient lighting, inadequate security monitoring, and female and male residents residing on a common floor with unrestricted access to female living areas. According to the Patient Safety Manager, the remaining female veteran residents were later moved to a more secure facility. VHA needs to assess and mitigate risks associated with their current policies and procedures or more female veterans will likely risk becoming victims of sexual assault and harassment and not receive the supportive services needed to overcome homelessness.

Homeless Veterans Health and Welfare Needs Improvement

VHA needs to improve the environment of care for homeless veterans in GPDP-approved facilities. Eight (31 percent) of 26 providers had environment of care issue related to medication security and dietary care. Specifically, VHA did not ensure medications were appropriately stored and monitored, or that they had adequate meals and meals that met dietary needs. VHA policy requires annual inspections that would include review of medication storage and nutrition inspections of providers' facilities.

Medications Not Adequately Secured

Seven (27 percent) of 26 GPDP providers did not ensure safe storage of homeless veterans' prescribed medications, to include controlled narcotics such as oxycodone and Vicodin®. VHA does not provide guidance that addresses storage of homeless veterans' prescribed medications nor does VHA require grant applicants to address the management of medications as part of the application process. Therefore, GPDP providers had various procedures for the storage of prescribed medications.

[5] According to the Patient Safety Manager, local law enforcement chose not to initiate an investigation.

We observed the following situations at the provider facilities we visited. Generally, the provider facilities provided multi-occupant rooms or barracks-type environments with some minor variations of controls among providers for storage of prescribed medications.

- Each veteran kept prescribed medications, to include controlled medications, unlocked in their personal living area. The veteran self-administered their medications, to include controlled substances. No procedures were in place to ensure veterans safely managed their medications or safeguarded controlled medications from loss or misuse.
- Each veteran kept prescribed medications in a locked box in the veteran's personal living area. The veteran would self-administer their medications, to include controlled substances. No procedures were in place to ensure veterans safely managed their medications or safeguarded controlled medications from loss or misuse. During our walkthrough of the living areas, we found boxes containing prescribed medications, to include controlled substances, unlocked in open view.
- Veterans' medications were locked in a room with separate pill boxes for each resident. A responsible staff member provided the box to the veterans when requested. Veterans then self-administered medications. The provider maintained a log documenting specific dates each resident took his or her medication. Each day, the provider counted controlled medications and recorded an entry in a log.

Medication Controls Needs Improvement

Providers did not adequately control medications because VHA lacks standards on managing, storing and monitoring prescribed medications and does not include a review of the control of medications in their annual inspections. Additionally, VHA does not require applicants to address the control of veterans' medications as part of the application process.

Veterans' Health May Be Jeopardized

As a result of the lack of standards for managing, storing, and monitoring prescribed medications, veterans' health and rehabilitation may be jeopardized if needed medications are lost or stolen. In addition, misuse or overdose of medications, especially controlled medications, can adversely affect the health of veterans.

Dietary Needs of Homeless Veterans Not Met

VHA requires annual inspections and provides an inspection checklist, however VA medical facility nutritionists did not consistently ensure that those veterans requiring special meals for conditions, such as hypertension, high cholesterol, or diabetes were addressed effectively. We found that 3 (12 percent) of 26 GPDP providers were not ensuring dietary restrictions were met. More important, VHA lacked reasonable assurance that those veterans requiring special meals to address conditions, such as hypertension, high cholesterol, or diabetes were addressed consistently.

VHA policy states medical facility nutritionists must ensure that meals served as part of the community-based program design are nutritionally balanced and appropriate for the program participants. It also requires that inspections ensure residents with special dietary needs are provided meals or meal preparation facilities to meet their needs. Although the example that follows was the most egregious situation we found, it does illustrate oversight issues VHA needs to address.

One GPDP provider was not providing meals according to their published menu plan. The published meal plan for the evening meal was supposed to be oven fried chicken, whipped potatoes, spinach, and a whole wheat dinner roll. Instead the residents received a meal that consisted mostly of baked beans and a small thin hamburger patty with a bun, as shown in the photograph.

Photograph taken by OIG at GPDP facility

Additionally, special dietary meals were not provided to four residents who told us they had special dietary restrictions due to hypertension or diabetes. In January 2011, the VA medical facility's nutritionist reviewed and approved the menu plan and determined the provider was adequately meeting veterans' dietary needs. Residents told us the provider had never served the meals described in the plan or provided special dietary meals. The nutrition clinician stated she based her inspection on a review of the menu plan and discussion with the provider's facility manager. She also stated she did not interview veterans or the medical facility's GPDP staff or conduct subsequent visits to ensure the provider was following the approved menu plans or providing special dietary meals.

We also confirmed veterans' allegations that the provider did not serve three daily meals during the weekend. After discussing this issue with VHA program officials and the VA medical facility director, they told us the provider implemented significant remedies to address these issues, such as conducting weekly inspections of food service operations, providing three meals daily, and soliciting feedback from veteran residents.

Provider Dietary Plan Not Required In Providers' Grant Applications

The dietary needs of veteran residents were not met because GPDP application procedures do not require applicants to describe how they will provide meals or meet special dietary needs. According to VHA policy, the purpose of the annual inspections at provider facilities is to ensure providers carry out activities as detailed in their original application. However, when applicants do not have to describe how they will provide a nutrition program that provides adequate nutrition or meals or meets special dietary needs, VHA has little criteria to evaluate performance.

Risks of Not Meeting Dietary Needs

As a result of VHA not ensuring providers served adequate meals and meals that met dietary restrictions, veterans are at risk of not receiving their recommended dietary allowances of food. This may worsen veterans' nutritional deficiencies that may already exist because of their homelessness. Additionally, veterans' health is at risk if VA medical facility staff prescribes special dietary meals to control medical conditions and providers do not ensure special dietary requirements are consistently met, such as diets needed to address hypertension, high cholesterol, or diabetes.

Conclusion

VHA must strengthen GPDP controls, such as establishing clear program policies and standards, to ensure the safety, security, privacy, health, and welfare of veterans participating in the GPDP. Omissions that exist within the GPDP application process have created uncertainties on the abilities of some providers to deliver the supportive services described in their grant proposals. To minimize these risks, VHA needs to review the GPDP's application evaluation process and implement standards to ensure providers have the capability and mechanisms to deliver proposed services to homeless veterans, prior to awarding government funds.

Recommendations

1. We recommended the Under Secretary for Health publish standards to ensure the safety, security, and privacy of veterans in Grant and Per Diem Program facilities.

2. We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state the gender of the proposed homeless populations the provider intends to serve.

3. We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to manage veteran safety, security, and privacy issues.

4. We recommended the Under Secretary for Health publish standards on medication management to ensure the safe storage of medications in Grant and Per Diem Program facilities.

5. We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to address storage of medications.

6. We recommended the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to address veterans' nutritional and dietary issues.

7. We recommended the Under Secretary for Health establish policies to perform periodic unannounced visits to observe the storage and

preparation of food, serving of meals, and to ensure changing conditions are identified timely during the grant award.

8. We recommended the Under Secretary for Health update the Grant and Per Diem Program inspection checklist to ensure safe transitional housing and effective support services are provided to homeless veterans.

9. We recommended the Under Secretary for Health implement procedures to ensure providers have the capability and mechanisms to deliver proposed services to veterans, prior to funds being awarded.

Management Comments

The Under Secretary for Health agreed with our findings and recommendations, and plans to address our recommendations by January 31, 2013. The Under Secretary advised us that VHA is taking action to develop standards, revise the grant application, and revise the inspection checklist.

OIG Response

The Under Secretary provided a responsive action plan to address our recommendations. We will monitor the Department's progress and follow up on its implementation until all proposed actions are completed. Appendix D provides the full text of the Under Secretary's comments.

Finding 2 VHA Needs To Reassess Program Evaluation Procedures

VHA needs to improve GPDP evaluation procedures to ensure program funding is effectively aligned with program goals. Specifically, the GPDP did not do the following.

- Effectively assess bed capacity against funding priorities and underserved geographic areas
- Accurately report program outcomes
- Correctly determine veterans' eligibility to participate in the program

Lapses in program management occurred because program officials did not establish an effective mechanism to assess the GPDP's progress toward achieving sufficient bed capacity, define specific meanings to program outcomes, establish effective monitoring procedures to improve the reliability of reported information, and provide sufficient training on program eligibility requirements. As a result, VHA does not have reasonable assurance that their current evaluation procedures are providing adequate controls to achieve program goals.

Bed Capacity Not Effectively Managed

VHA did not adequately manage transitional bed capacity against their funding priorities and the needs associated with underserved geographic areas, such as female veterans and homeless veterans living in rural areas. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* states that organizations need to establish controls to monitor performance measures and indicators.

VHA annually announces the availability of GPDP funds for assistance, commonly referred to as Notice of Funding Availability (NOFA). The NOFA is published in the Federal Register and provides information on the application process, such as application requirements, selection methodology, and funding priorities. VHA establishes funding priorities to ensure geographical dispersion of support services, prevent duplicate services, and bolster capacity in underserved regions, such as rural areas. An example of a funding priority is women veterans and women veterans with care of dependent children, which VHA designated as their highest funding priority for the past 3 years.

VA's FY 2011–2013 Homeless Initiative Operating Plan identifies GPDP deliverables, such as creating an additional 1,500 transitional beds and serving approximately 18,000 veterans in FY 2011. However, the operating plan does not provide specific goals for increasing transitional bed capacity for their funding priorities. In addition, the GPDP did not maintain reliable

operational data that would enable GPDP officials to assess the program's effectiveness toward achieving sufficient bed capacity for their priorities or other specific homeless populations, such as homeless rural veterans. Reliable data on the gender of the population being served, the number of beds by gender, and geographical description (rural or non-rural) are necessary to compare and assess current transitional bed capacity with projected transitional bed needs for homeless women and rural veterans.

Housing Capacity Inadequately Assessed

This occurred because VHA had not established an effective mechanism to assess the GPDP's progress toward achieving sufficient bed capacity for funding priorities or specific homeless populations. Any mechanism should include identifying bed capacity goals and the operational data to measure progress toward those goals.

Risks of Lack of Bed Capacity Goals

As a result, VHA cannot make adequate assessments comparing the GPDP's transitional bed capacity goals with actual performance. It is also clear from the GPDP's inventory of VA medical facilities that not all providers are serving the homeless populations identified in their applications, thus increasing the risk of using unreliable data in future funding decisions. Without an effective mechanism to assess the program's progress toward achieving sufficient bed capacity, VHA cannot make sound policy adjustments to their NOFA priorities to reasonably ensure that bed capacity is funded for homeless populations and underserved geographic areas that need it most.

Program Outcomes Were Not Accurately Reported

The GPDP did not accurately report discharge outcomes of veterans from the program. Our audit reviewed two outcomes related to program success—the reason veterans ended residential treatment, and the veteran's living situation at the time of discharge. In our sample, 223 (26 percent) of 854 discharges had one or more errors that were inaccurately reported to NEPEC. This is a recurring issue identified in a previous OIG report.[6] That evaluation revealed that in 24 percent of the records reviewed, VHA could not support submitted discharge information, and in some cases provided a different or contradictory outcome.

VHA guidance states a clinician who has good knowledge of the veteran's care should complete the discharge form. A VA medical facility staff member must review the discharge information for completeness and accuracy before the information is sent electronically to NEPEC.

End of Residential Treatment

We found 110 (13 percent) of 854 case files inaccurately reported the reason a veteran ended residential treatment. When answering the question on the form, clinicians select from the following:

[6] *Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program* (Report No. 04-00888-215, September 20, 2006).

- Veteran successfully completed the program
- Veteran was asked to leave because of violation of program rules
- Veteran left the program by his/her own decision, without medical advice
- Veteran became too ill (mentally or physically) to complete the program
- Veteran is deceased
- Veteran was transferred to another residential treatment program for administrative reasons

The response most often answered incorrectly (57 of 110 errors) was "successful completion of the program." For example, one discharge form stated the veteran was removed from the GPDP for violating the provider's program rules. However, the NEPEC data reported the veteran successfully completed the program. We verified that the provider correctly filled out the form, but the medical facility's GPDP clinician entered the data incorrectly. In another case, the documentation revealed that the veteran left without completing the program. However, the NEPEC data reported the veteran had successfully completed the program.

Living Situation at Time of Discharge

We found 168 (20 percent) of 854 case files inaccurately reported the veteran's living situation at the time of discharge. When answering the question on the form, clinicians selected from the following choices:

- Homeless shelter or no residence
- Single room occupancy
- Residential treatment program
- Institution (hospital, nursing home, or domiciliary)
- Apartment, room, or house
- Veteran left program without giving indication of living arrangement
- Prison or jail

The response, "apartment, room, or house," was most often answered incorrectly (105 of 168 errors). For example, one GPDP grant had 12 instances where veterans completed their current rehabilitation program and were discharged to a supportive housing situation at a residential treatment program. The discharge form and NEPEC data stated the veterans had been discharged to an "apartment, room, or house" rather than the correct choice of "residential treatment program." According to a provider's

staff member, a prior medical facility GPDP clinician told him the correct response was "apartment, room, or house."

Discharge Outcomes Inaccurately Reported

VA medical facility GPDP clinicians did not report program outcomes accurately because NEPEC's data collection manual did not clearly define the meaning of the questions' choices. The lack of more specific definitions or elaboration of the terms used in the questions raises the potential risk of increased subjectivity and misinterpretation. For example, the NEPEC manual provided a limited definition of one discharge outcome as "apartment, room, or house." As a result, GPDP clinical staff had different interpretations for "apartment, room, or house."

The Homeless Operations Management and Evaluation System, a recently deployed online data collection system, has addressed this issue by providing more definitive meanings to possible outcome choices. Reporting of inaccurate program outcomes also occurred because of the lack of an effective monitoring system to improve the quality and reliability of information used for making policy decisions. We saw existing controls were weak. GPDP medical facility staff did not consistently validate information prior to entering it into the NEPEC database. Although, the Homeless Operations Management and Evaluation System has clarified discharge outcomes, VHA still needs to improve monitoring controls to ensure the reporting of accurate outcome data. The previous OIG report also identified the need to improve monitoring controls.

Data Quality and Reliability Needs Improvement

VHA captures discharge outcomes, which are measures of the program's performance and effectiveness. In their *Health Care For Homeless Veterans Programs: The Twenty-Fourth Annual Report*, March 31, 2011, NEPEC evaluated VHA's homeless programs, including treatment outcomes of the GPDP. The report stated 47 percent of FY 2010 treatments were successful and 53 percent of veterans acquired their own apartment, room, or house—the program's desired outcome. Because of the error rates found in our sample, the accuracy of the reported information is questionable. Without quality and reliable data, policy makers cannot effectively perform their oversight responsibilities to ensure that program funding is effectively aligned with program goals and that program goals are met.

Eligibility Requirements Not Consistently Met

For one GPDP grant, 40 (23 percent) of 173 veterans had not been homeless when admitted to the GPDP. To be eligible for the GPDP, VHA requires veterans to be homeless, and defines a "homeless" veteran as a person who lacks a fixed, regular, adequate nighttime residence and instead stays at night in a shelter, institution, or public or private place not designed for regular sleeping accommodations. We found that the 40 participating veterans temporarily left their homes to participate in the substance abuse program, to include veterans who had full-time employment or took leaves of absence to participate in the program.

Definition of Homeless Not Understood

Ineligible veterans were not identified because VA medical facility staff stated they believed the veterans were experiencing conditions which could lead to homelessness, such as substance abuse. Senior officials at the VA medical facility also stated they considered veterans who "were in danger of becoming homeless" qualified for the program.

Reduced Opportunities for Other Homeless Veterans

VHA incorrectly spent approximately $60,000 in a six-month period to provide housing to veterans who were not homeless or under the care of GPDP case workers. As a result, VA medical facility staff reduced the opportunity for eligible homeless veterans to receive supportive services that could improve their lives and end their homelessness.

Conclusion

The GPDP provides vital services to homeless veterans and has successfully assisted veterans to live independently and in safe and affordable permanent housing. However, improving VHA's program evaluation procedures will help ensure that program funding is effectively aligned with program goals and that program goals are met. Strengthening the GPDP's controls and VHA's oversight will provide better assurance that VA's homeless program funds are effectively used to deliver supportive services to homeless veterans.

Recommendations

10. We recommended the Under Secretary for Health establish an effective mechanism to ensure the Grant and Per Diem Program assesses progress toward achieving sufficient bed capacity for funding priorities or specific homeless populations.

11. We recommended the Under Secretary for Health establish specific goals in VA's Homeless Initiative Operating Plan to ensure that progress toward achieving transitional bed capacity goals is measurable.

12. We recommended the Under Secretary for Health establish a mechanism to maintain operational data to ensure the Grant and Per Diem Program monitors transitional bed capacity and measures progress toward achieving bed capacity goals.

13. We recommended the Under Secretary for Health implement monitoring procedures to ensure that quality and reliable information is provided to the Northeast Program Evaluation Center.

14. We recommended the Under Secretary for Health provide additional training on Grant and Per Diem Program eligibility requirements to VA medical facility staff tasked with grants management responsibilities.

Management Comments

On February 24, 2012, the Under Secretary for Health agreed with our findings and recommendations, and provided an action plan. We reviewed

the proposed action plan, and requested further clarification on planned actions for recommendations 10, 11, and 12. The Under Secretary then expanded upon his original comments submitting revised comments on March 5, 2012. The full text of the Under Secretary's revised comments and action plans are presented in Appendix D. We have also included the original letter signed by the Under Secretary, dated February 24, 2012, supporting his agreement with the report findings and recommendations. To avoid duplication of information, the original action plans dated February 24, 2012 are not included in this report since the Under Secretary just expanded his original action plan to address our recommendations.

The Under Secretary advised us VHA is taking action to develop a registry that tracks and monitors homeless program expansion, operation, and treatment outcomes. The registry has the capacity to track characteristics by geographic regions, and allows VHA to target resources to specific homeless populations. VHA is also providing additional training to field staff on documenting veterans' discharge data, and is exploring the feasibility of establishing a national contract to monitor results. Finally, VHA is providing additional training to field staff on the topic of veteran eligibility requirements.

OIG Response The action plan to address our recommendations was responsive. We will monitor the Department's progress and follow up on its implementation until all proposed actions are completed. Appendix D provides the full text of the Under Secretary's comments.

Appendix A Other Matters of Interest

Veterans' Concerns About Recent Policy Changes

During our audit, veterans' expressed concerns about recent Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) policy changes and its effect on veterans currently participating in the GPDP. The HUD-VASH program was not reviewed as part of this audit, and therefore we are not making any recommendations.

HUD-VASH provides housing voucher rental assistance for homeless veterans and their families with case management and clinical services provided by VA's medical facilities and the community. Beneficiaries are selected based on certain requirements including health care eligibility, homelessness status, income, and assessed need for case management services. During our meetings with veterans at the 26 provider sites, veterans were very supportive of the HUD-VASH program and saw it as a major incentive to successfully complete their personal rehabilitation plan. Although they had no assurance of obtaining a voucher, veterans saw HUD-VASH as the best means to obtain safe and affordable permanent housing. Medical facilities' GPDP staff also recognized the incentive value and would sometimes extend the veterans' participation in the program until the veteran obtained a HUD-VASH voucher.

GPDP Participants Pushed To Lower Priority

In September 2011, VHA changed their HUD-VASH program policy and made it a priority for vouchers to be given to veterans who are chronically homeless. Homeless veterans are not considered "chronically homeless" when their length of stay in a program, such as the GPDP, exceeds 90 days. According to NEPEC data, in FY 2010 the average length of stay in the GPDP was about 179 days. Although veterans could have a higher priority if clinically determined necessary, most veterans participating in the GPDP would be pushed to a lower priority and thus not receive HUD-VASH vouchers.

HUD-VASH Opportunities More Limited

As a result of this policy change, veterans we spoke with in the GPDP were frustrated and upset. These veterans felt that they worked hard toward making positive changes to their lives with the hope that they would be provided the opportunity to participate in the HUD-VASH program. For example, one veteran understood he was not considered "chronically homeless" since he resided in GPDP transitional housing for more than 90 days. In his frustration, he told us he would have a better chance of getting a HUD-VASH voucher if he relapsed, left the GPDP, and went to live under a bridge with the rest of the local homeless population.

Appendix B Background

Program Authority

The GPDP was authorized on November 10, 1992, by Public Law 102-590, the Homeless Veterans Comprehensive Service Programs Act. According to the program director, the GPDP has provided services and transitional housing for over 100,000 veterans since 1994. Programs exist in all states, the District of Columbia, Puerto Rico, and Guam through more than 600 operational projects providing approximately 14,000 transitional housing beds. These community-based projects are partially funded by VA and recipients utilize other revenue sources, such as Federal, state or local funding. These programs operate based on unique designs as stated in their grant application. Responsibility for management and operation of projects rests with the community provider as determined by statute and regulation, with local VA medical facilities providing oversight.

Program Oversight

Day-to-day oversight of the providers' operations is the responsibility of GPDP staff from the local VA medical facility. Referred to as GPDP liaisons, these individuals are appointed by the VA medical facility director and are typically social workers. As part of their oversight responsibilities, GPDP liaisons' duties normally include regular contact with veterans and providers. Additionally, GPDP liaisons coordinate annual inspections of the providers' facilities and provide annual performance reviews to the GPDP office. During the intake process, GPDP liaisons initially screen homeless veterans, verify their eligibility for the GPDP, and determine which homeless programs are most suitable for the needs of individual veterans. GPDP liaisons typically work with providers' case managers on a continuous basis developing treatment goals and plans for each veteran and assessing each veteran's progress in reaching those goals.

Types of Grants

The GPDP funds four different types of grants.

- Capital grants fund up to 65 percent of the cost of acquiring, renovating, or constructing facilities in order to provide supportive housing or service centers and to purchase vans for outreach and transportation.
- Per diem-only grants fund community-based organizations that do not need federal funding for the construction or renovation of facilities but are seeking funds to offset operational expenses.
- Technical assistance grants fund entities with expertise in preparing grant applications relating to assistance for homeless veterans.
- Special need grants fund operational costs for homeless veteran populations, such as women, the terminally ill, and the chronically mentally ill.

GPDP Grant Selection Processes

The GPDP office is responsible for preparing and publishing an annual NOFA in the Federal Register. The NOFA communicates the funding categories and funding priorities and sets deadlines for submission of applications. GPDP officials first review the applications to determine whether they meet basic threshold requirements. Applications that meet the basic threshold requirements are then reviewed by evaluation teams. Evaluators rate the applications and assign points based on how well the applicants meet scoring criteria. The applications are then grouped and ranked in categories according to the NOFA funding priorities. The highest ranked applications for which funding is available and within the highest priority funding category are conditionally selected. If funds are still available after selection of those applicants in the highest priority groups, VA will continue to conditionally select applicants in lower priority categories.

Appendix C Scope and Methodology

Audit Scope

We conducted our audit work from April 2011 through January 2012. To accomplish our objectives, we reviewed a statistical sample chosen from all operational grants and community agency providers under the VHA's GPDP that were receiving funds as of March 31, 2011.

Methodology

We identified and reviewed applicable Federal laws and regulations, previous OIG and U.S. Government Accountability Office audit reports, NOFA funding priorities, and GPDP policies and guidelines. Additionally, we interviewed VHA and GPDP officials and VA medical facility GPDP clinical staff and social workers. We also interviewed GPDP provider management and their staff, as well as veterans participating in the program.

To evaluate delivery of services, we selected a statistical sample of 26 GPDP grants that offered a total of 914 beds grouped under 8 VA medical facilities. We visited the medical facilities shown in Table 1 below from June 2011 through October 2011.

Table 1

Medical Facilities Selected			
Facility Name	**Facility Location**	**Grants Reviewed**	**GPDP Beds**
Jesse Brown VA Medical Center	Chicago, IL	3	59
VA New Jersey Health Care System	Lyons, NJ	3	103
Atlanta VA Medical Center	Atlanta, GA	4	176
Sheridan VA Medical Center	Sheridan, WY	2	26
Portland VA Medical Center	Portland, OR	3	87
Southeast Louisiana Veterans Health Care System	New Orleans, LA	4	110
Greater Los Angeles Healthcare System	Los Angeles, CA	4	187
Long Beach Health Care System	Long Beach, CA	3	166

Source: VA OIG

Grants were selected to reflect a variety of locations, sizes, and Veterans Integrated Service Networks. Provider grants were stratified within the eight sites selected. The first stratum consisted of grants that had 1 to 39 beds and the second stratum consisted of grants that had 40 or more beds. We did this to ensure both large and small grants were represented in our sample. Table 2 on the next page shows the samples selected from each medical facility and stratum.

Table 2

Stratification and Selection				
Medical Facility	**Stratum**	**Number of Grants**	**Number of Beds**	**Second-Stage Sample Size**
Atlanta VA Medical Center	1 – 39 beds	3	72	2
	> 39 beds	2	110	2
Jesse Brown VA Medical Center	1 – 39 beds	6	93	3
	> 39 beds	0	0	0
VA New Jersey Health Care System	1 – 39 beds	3	44	2
	> 39 beds	1	70	1
Long Beach Health Care System	1 – 39 beds	2	62	2
	> 39 beds	1	104	1
Southeast Louisiana Veterans Health Care System	1 – 39 beds	8	172	2
	> 39 beds	2	96	2
Sheridan VA Medical Center	1 – 39 beds	2	26	2
	> 39 beds	0	0	0
Portland VA Medical Center	1 – 39 beds	4	81	2
	> 39 beds	1	50	1
Greater Los Angeles Healthcare System	1 – 39 beds	25	481	2
	> 39 beds	9	641	2
	Totals:	**69**	**2,102**	**26**

Source: VA OIG

For each sampled provider, we reviewed VA medical records and GPDP files of veterans discharged between July 1, 2010, and December 31, 2010. To evaluate whether the needs of homeless veterans were adequately addressed, we reviewed approved grant applications to determine providers' program goals, performance measures, and services to be provided. We defined reporting errors when either a document in the case file contradicted the reported outcome, when information on the Form D did not match the electronic data sent to NEPEC, or documentation was not in a case file to support the reported outcome.

We also reviewed annual inspection reports of providers' facilities and GPDP correspondence, including any applicable scope changes. We walked through each GPDP facility to assess whether the providers were adequately addressing safety, health, and welfare issues of resident veterans.

Data Reliability

We used computer-processed data provided by NEPEC to identify veterans from each of our selected GPDP provider facilities who were discharged from July 1 through December 31, 2010. To test the reliability of this data, we compared the data in NEPEC reports to noted outcomes in veterans' provider files and medical facility clinical records. We concluded the data was not sufficiently reliable to determine veterans' actual discharge outcomes. As a result, we explained the condition and developed recommendations for improving management controls to ensure the reliability of data reported to NEPEC.

Government Audit Standards

Our assessment of internal controls focused on those controls relating to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix D Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: February 24, 2012

From: Under Secretary for Health (10)

Subj: Office of Inspector General, Office of Audits and Evaluations Draft Report, Audit of the Homeless Providers Grant and Per Diem Program (VAIQ 7200530)

To: Assistant Inspector General for Healthcare Inspections (52)

1. I have reviewed the draft report and concur with all the report's recommendations. Attached is the Veterans Health Administration's (VHA) corrective action plan for the report's recommendations.

2. VHA takes the welfare and safety of our homeless Veterans population very seriously, and as the action plan shows, VHA has already taken proactive steps to address the report's recommendations. In addition, VHA will exercise its authority to seek recovery of funds from any grant that is not operational, ceases to provide services for which the grant was intended, or withdrawn prior to period of services required by the grant.

3. As VHA explores changes in the Homeless Grant Per Diem program, changes to existing regulations may be required. If this results in changes to the action plan, VHA will communicate with the Office of Inspector General to revise the milestones and timelines for the action plan as needed.

4. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

Robert A. Petzel, M.D.

Attachment

Department of Veterans Affairs

Memorandum

Date: March 5, 2012

From: Under Secretary for Health (10)

Subj: Office of Inspector General, Office of Audits and Evaluations Draft Report, Audit of the Homeless Providers Grant and Per Diem Program (VAIQ 7200530)

To: Assistant Inspector General for Healthcare Inspections (52)

1. As the Office of Inspector General (OIG) requested, I have attached the Veteran Health Administration's (VHA) revised action plan, which provides additional clarification for recommendations ten, eleven, and twelve of the draft report.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Audit of the Homeless Providers Grant and Per Diem Program (VAIQ 7200530)

Date of Draft Report: February 6, 2012

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommend the Under Secretary for Health publish standards to ensure the safety, security, and privacy of Veterans in Grant and Per Diem Program facilities.

VHA Comments

Concur

Veterans Health Administration (VHA) Grant and Per Diem (GPD) National Program Office officials have recently provided guidance and technical assistance in an effort to ensure safety, security, and privacy of Veterans regarding gender-mix issues on nationwide conference calls and face-to-face trainings with Department of Veterans Affairs (VA) liaisons and community-based providers.

Completed

The GPD National Program Office distributed written guidance and clear program expectations to all GPD Liaisons regarding the special considerations that should be given to transitional housing facilities that serve mixed-gender populations where unrelated adults are cohabitating in the same facility.

Completed

The VHA GPD National Program Office will revise the GPD Handbook to reflect safety, security and privacy standards for Veterans in transitional housing.

In process January 31, 2013

The GPD National Program Office will provide training to VHA staff, as well as GPD-funded providers on the new standards once they are published, through a comprehensive education plan, utilizing multiple options for training.

In process January 31, 2013

Recommendation 2: We recommend the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state the gender of the proposed homeless populations the provider intends to serve.

VHA Comments

Concur

In August through November 2011, the GPD National Program Office conducted a nationwide inventory of all operational transitional housing projects to ascertain the gender-mix being served at each GPD-funded facility and the appropriateness of the scope of services available relative to the populations served. Of the 596 projects surveyed, 94 provided clarifications regarding the populations that could be appropriately served; 474 required no change to either clarify or change gender-mix; and 28 projects changed the scope of their projects.

Completed

The GPD National Program Office will revise the GPD grant application to require applicants to state the intended homeless population to be served by the grant (men, women, mixed-gender, or family with children). VHA must then submit the revised application to the Office of Management Budget (OMB) for concurrence and approval.

In process January 31, 2013

Recommendation 3: We recommend the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to manage Veteran safety, security, and privacy issues.

VHA Comments

Concur

The GPD National Program Office will revise the application process to ensure that applications clearly describe how prospective grantees will address the safety, security, and privacy issues of Veterans in their programs based on the physical configuration of each facility and populations served. VHA must then submit the revised application to OMB for concurrence and approval.

In process January 31, 2013

Because GPD-funded capital projects in development have up to 1 year to obtain site control and occasionally change sites from what was originally proposed in the grant application, the GPD National Program Office will update the GPD Handbook and inspection forms to ensure that these type of issues are reviewed by local VA medical center (VAMC) staff prior to approving placement of Veterans in a GPD-funded site.

In process January 31, 2013

Recommendation 4: We recommend the Under Secretary for Health publish standards on medication management to ensure the safe storage of medications in Grant and Per Diem Program facilities.

VHA Comments

Concur

The GPD National Program Office is developing an enhanced inspection process that will address standards for the safe storage of medications.

In process January 31, 2013

In addition, the GPD Handbook will be revised to include a section on medication monitoring and storage standard operating procedures based on the type of residential setting. VHA staff and GPD-funded providers will receive training and technical assistance regarding safe medication management and storage.

In process January 31, 2013

Recommendation 5: We recommend the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to address storage of medications.

VHA Comments

Concur

The GPD National Program Office will revise the GPD application to ensure applicants include the applicant's proposed plan to address the compliance with storage of medications standards. VHA must then submit the revised application to OMB for concurrence and approval.

In process January 31, 2013

Recommendation 6: We recommend the Under Secretary for Health revise the Grant and Per Diem Program application process to ensure providers clearly state plans to address Veterans' nutritional and dietary issues.

VHA Comments

Concur

The GPD National Program Office will revise the GPD grant application to require applicants to clearly state the plans to meet the needs of Veterans' nutritional and dietary needs. VHA must then submit the revised application to OMB for concurrence and approval.

In process January 31, 2013

Recommendation 7: We recommend the Under Secretary for Health establish policies to perform periodic unannounced visits to observe the storage and preparation of food, serving of meals, and to ensure changing conditions are identified timely during the grant award.

VHA Comments

Concur

The GPD National Program Office will work with VHA Deputy Under Secretary for Health for Policy and Services, and Nutrition and Food Service, to develop guidance for GPD liaisons to use during their environmental reviews of GPD grantee facilities. The guidance will include corrective actions the grantee must take to address any changing nutritional conditions found during the review. This guidance will be incorporated into the GPD Handbook.

In process January 31, 2013

The GPD National Program Office will provide training to VHA inspection team members once this guidance is established.

In process January 31, 2013

Recommendation 8: We recommend the Under Secretary for Health update the Grant and Per Diem Program inspection checklist to ensure safe transitional housing and effective support services are provided to homeless Veterans.

VHA Comments

Concur

The GPD National Program Office will revise the GPD inspections checklist to include specific safety and security standards for homeless in transitional housing settings. Any conditions not meeting the safety and security standards will require corrective action as

described in the GPD Handbook. The revised inspection checklist process will be incorporated into the GPD Handbook.

In process January 31, 2013

The GPD National Program Office will provide training to VHA staff and GPD-funded providers regarding the new standards. Monthly conference calls with VHA staff, as well as GPD-funded providers will be used as forums for the training on these new standards.

In process January 31, 2013

The National Homeless Program Office will explore the feasibility of a national contract to provide monitoring and compliance of these revised standards of care. If it is found that a contract is feasible, processes to implement a contract will be started. If a contract is not feasible, the GPD National Program Office will develop and implement other methods for monitoring and compliance with revised standards of care.

In process January 31, 2013

Recommendation 9: We recommend the Under Secretary for Health implement procedures to ensure providers have the capability and mechanisms to deliver proposed services to Veterans, prior to funds being awarded.

VHA Comments

Concur

The GPD National Program Office will revise the GPD application and inspection process to provide an enhanced review of the project during the initial inspection. Initial inspections occur prior to the activation of the project and place special emphasis on ensuring that the GPD-funded provider can provide supportive services as outlined in the grant application.

In process January 31, 2013

The GPD National Program Office will ensure that training and technical support will be provided to VHA staff and GPD-funded providers regarding the specifics of these standards that would be incorporated into the initial inspection process.

In process January 31, 2013

In addition to the standard approval processes, each capital project will be required to have a Pre-Disbursement Review by the local VAMC fire/safety/engineering department prior to incurring any costs. The change requiring a Pre-Disbursement Review will be added to the GPD Handbook. The Pre-Disbursement Review consists of a site visit conducted by the VAMC staff to ensure the scope of the project is reasonable, considering the funds requested, and that the plans submitted reflect the work that is to be accomplished.

In process January 31, 2013

Recommendation 10: **We recommend the Under Secretary for Health establish an effective mechanism to ensure the Grant and Per Diem Program assesses progress toward achieving sufficient bed capacity for funding priorities or specific homeless populations.**

VHA Comments

Concur

The National Center on Homelessness among Veterans is developing a comprehensive Homeless Registry, a data warehouse that tracks and monitors homeless program expansion, operation, and treatment outcomes. The Homeless Registry will allow "real-time" access to data by VA providers, program administrators, VAMC staff, as well as Veterans Integrated Service Network and VHA Central Office leadership to facilitate performance monitoring and decision-making.

The registry enhances VHA's capacity to utilize longitudinal programmatic and Veteran-specific data to better evaluate how programs function and how the system as a whole is progressing to end Veteran homelessness. The registry has the capacity to provide individualized reports on Veteran characteristics by geographic regions. This new capacity facilitates VHA ability to target resources (program funding and grant funding) to where the need is greatest. Examples include gender specific, age and service era data that inform decisions related to Supportive Services for Veteran Families (SSVF) and Department of Housing and Urban Development-Department of Veterans Affairs Supportive Housing (HUD-VASH) programs as well as GPD.

VHA has also realigned its data collection about homeless programs to be more consistent with those in HUDs Homeless Management Information System (HMIS) standards. VA bed capacity is now entered into the HMIS bed inventory section to achieve coordinated and complete data collection of VA resources in HMIS. VA and HUD have collaborated on a single reporting mechanism of Veteran homelessness the Veterans Annual Homelessness Assessment Report (VETAHAR). These modifications promote greater consistency in reporting prevalence of Veteran homelessness both inside and outside of the VA.

An analytic decision support tool that assists leadership in developing and managing fiscal resources has been developed. The tool has a regional component and includes data related to VA bed capacity and program efficiency for the core homeless programs. This tool was used to help inform the most recent VHA budget request, and it can be used to help inform where additional resources are needed to enhance VHA capability to end Veteran homelessness

VHA will develop a process to review and use the data in the development of future funding priorities.

In process October 31, 2012

Recommendation 11: We recommend the Under Secretary for Health establish specific goals in VA's Homeless Initiative Operating Plan to ensure that progress toward achieving transitional bed capacity goals is measurable.

VHA Comments

Concur

While VHA agrees that it is important to establish specific goals to ensure progress toward achieving measurable transitional bed capacity goals, it is VHA's position that these goals do not need to be incorporated in the Operating Plan to End Veteran Homelessness because a system is already in place to address this issue. The GPD National Program Office currently maintains bed capacity information on operating projects and projects in development and tracks occupancy rates for currently operating transitional housing projects nationally. GPD-funded projects with low occupancy rates have been contacted by the GPD National Program Office and have been requested to work with the local GPD liaison to develop a plan to increase occupancy and ensure efficient use of transitional housing resources. The required occupancy rate in the proposed regulations (see response to Recommendation 12) will be used in conjunction with existing monitoring to measure progress toward capacity goals.

Completed

In addition, the GPD National Program Office will be working with the National Center on Homelessness to determine future resource needs for transitional housing. Information available in the Homeless Registry and the analysis of homeless resources data available through the registry (which includes the availability of various VA homeless resources and demographic information), will be used by the GPD National Program Office to recommend priorities. The funding priorities, including number of targeted beds in the Notice of Funding Availability (NOFA) will be recommended by the National GPD office based upon this analysis and available funding

VHA will develop a process to review and use the data in the development of future funding priorities.

In process October 31, 2012

Recommendation 12: We recommend the Under Secretary for Health establish a mechanism to maintain operational data to ensure the Grant and Per Diem Program monitors transitional bed capacity and measures progress toward achieving bed capacity goals.

VHA Comments

Concur

The GPD National Program Office has written new regulations that set an occupancy rate goal of 75 percent for a prior 180-day period. The proposed regulations are presently in concurrence.

In process October 31, 2012

The responses to Recommendations 10 and 11 provide additional information pertinent to this recommendation.

Recommendation 13: We recommend the Under Secretary for Health implement monitoring procedures to ensure that quality and reliable information is provided to the Northeast Program Evaluation Center.

VHA Comments

Concur

On April 20, 2011, VHA began using the Homeless Operations Management and Evaluation System (HOMES) data tracking system for homeless Veterans in all VHA homeless programs. This system tracks homeless Veterans as they move through VA's system of care. VHA has provided training to VHA field staff for all homeless programs, and has developed a detailed manual for users of the system. The exit forms used for all homeless programs (including GPD) have been expanded to more clearly represent housing arrangements at discharge (21 categories now listed on the residential exit form as opposed to 7 categories).

Completed

The GPD National Program Office will provide additional training during the monthly GPD national calls on the discharge documentation in the clinical record.

In process April 30, 2012

The National Homeless Program Office will explore the feasibility of a national contract to provide a review of accuracy of program data reported in VHA's program evaluation system. If it is found that a contract is feasible, processes to implement a contract will be started. If a contract is not feasible, the GPD National Program Office will identify and implement other methods to ensure program data reported to the Northeast Program Evaluation Center is accurate.

In process January 31, 2013

Recommendation 14: **We recommend the Under Secretary for Health provide additional training on Grant and Per Diem Program eligibility requirements to VA medical facility staff tasked with grants management responsibilities.**

VHA Comments

Concur

The GPD National Program Office will include information about eligibility requirements during the orientation call for new GPD liaisons that is provided monthly.

In process October 31, 2012

The GPD National Program Office will develop and complete training for all VA GPD liaisons and GPD-funded providers using a variety of training and conference call options. The topic of eligibility will then be incorporated at least quarterly into the conference calls for VA GPD liaisons and GPD-funded providers.

In process October 31, 2012

The GPD National Program Office will also provide training on the topic of eligibility to Network Homeless Coordinators and various other VA homeless program staff during their monthly conference calls. The GPD National Program Office will continue to provide consultation to VA GPD liaisons and GPD-funded providers regarding eligibility questions.

In process October 31, 2012

Veterans Health Administration

March 2012

Appendix E Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Gary Abe, Director Maria Afamasaga Kevin Day Sophia Demco Chris Enders Todd Groothuis Marisa Harvey Tom Phillips Ron Stucky Steve Toom Nelvy Viguera Butler

Appendix F Report Distribution

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