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VETERANS HEALTH ADMINISTRATION

Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego

Administrative Investigation | 22-03076-65 | March 5, 2025

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Executive Summary

The Veterans Health Administration (VHA) Grant and Per Diem (GPD) program funds community-based transitional housing for veterans experiencing homelessness. The Office of Inspector General (OIG) conducted an administrative investigation to examine VHA's oversight of the Veterans Village of San Diego (VVSD), a GPD program grantee providing housing and supportive services to residents. The initial two-year investigative review period (fiscal years (FYs) 2021 and 2022) corresponds with the timing of allegations that VVSD did not maintain a safe environment for the veterans it served, as required, including a nonfatal drug overdose of a VVSD GPD program participant and several confirmed or suspected drug overdose deaths among residents not part of the VHA program who were co-located with GPD residents. The OIG's administrative investigation was prompted in part by an April 2022 OIG hotline complaint alleging unsafe conditions, drug use, and staffing shortages at VVSD, as well as a June 2022 inquiry from Congressman Mike Levin regarding what oversight would be done at VVSD following news reports from that month concerning issues such as drug use and dealing among VVSD residents. The OIG also performed a limited review of VHA's oversight of VVSD in FYs 2023 and 2024 to assess whether the oversight problems it identified during the initial review period had recurred or persisted.

The OIG found that staff at the VA San Diego Healthcare System (the VA facility) responsible for local oversight of VVSD were aware of problems that were increasing health and safety risks to veterans in 2021 and through most of 2022, including drug sales and drug use among residents, insufficient staffing, and other grant compliance issues pertaining to safety and security.[1] Despite this awareness, VA facility staff responsible for overseeing VVSD's GPD compliance did not adequately ensure VVSD abided by governing regulations and the terms of its grant—specifically those provisions that required VVSD to provide adequate staffing levels and appropriate care and services in an environment free from substance use that could threaten veteran safety. Federal law prohibits VA from making per diem payments to grantees for care that does not meet VA standards, including the requirements of GPD grants and regulations.[2] The OIG also determined that VA facility staff did not have meaningful support from the official assigned to assist in GPD oversight from the region's Veterans Integrated Service Network (VISN) and could have received more robust guidance from the GPD National Program Office.[3]

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[1] According to GPD policy and the organizational chart of personnel at the VA facility, staff at the facility who were involved in oversight of VVSD's GPD operations included (1) liaisons to VVSD; (2) the liaisons' supervisor, the facility's Healthcare for Homeless Veterans coordinator; (3) the chief of social work service; (4) the associate director of patient care services; and (5) the facility director. VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program*, November 17, 2020, pp. 4–11.

[2] 38 U.S.C. § 2012(b); 38 C.F.R. § 61.65.

[3] VHA has divided the nation into 18 Veterans Integrated Service Networks, or VISNs, which are "regional systems of care working together to better meet local health care needs and provides greater access to care." Veterans Integrated Service Networks (web page), VHA, accessed July 11, 2024, www.va.gov/HEALTH/visns.asp.

The OIG focused its administrative investigation on two critical areas of concern related to VHA oversight of VVSD: (1) drug use and dealing and (2) inadequate staffing. First, federal regulation requires that VHA ensure GPD grantees provide "a clean and sober environment that is free from illicit drug use or from alcohol use that could threaten the health and/or safety of the residents or staff."[4] Yet from late 2021 through mid-2022, drug use and dealing increased at VVSD, leading to overdoses among one GPD resident and several non-GPD residents. VA facility liaisons to VVSD and their supervisor, the then Healthcare for Homeless Veterans coordinator (facility coordinator 1) knew about this problem as it progressed.[5] They waited months, however, before asking the facility's security inspector to review the VVSD matter, which was after San Diego County, California, entities stopped referring individuals to VVSD and removed co-located residents funded by the state's Drug Medi-Cal program.[6] At the same time, the VA facility's inpatient and outpatient drug treatment programs were also steering their patients away from VVSD.

Despite awareness that other entities thought VVSD was not appropriate for referrals, the then VA facility director (VA facility director 1) did not halt GPD program admissions while the drug problem continued.[7] Facility staff told the OIG that GPD admissions were not halted during this period because staff relied on ongoing oversight efforts and open communication with VVSD to address the problem. Some VA staff also expressed concern that some veterans would end up on the street if they halted admissions. When a security inspection was ordered, facility liaisons and facility coordinator 1 did not require VVSD to fully implement the changes the inspector proposed. While VVSD updated several policies, the liaisons and inspector left physical security upgrades to VVSD's campus—including improved walls, gates, and camera coverage—as only recommendations, which VVSD did not implement. Moreover, documentation and testimony were insufficient for the OIG to determine whether improved security patrols and logs, viewed as an alternative to physical security upgrades, were effectively implemented following the inspection.

Second, the OIG found that staffing shortages were a persistent problem during the investigative review period, affected in part by the COVID-19 pandemic as well. VVSD committed to provide

[4] 38 C.F.R. § 61.80(b)(14).

[5] Two individuals served as the facility coordinator during the events covered by this report. The first facility coordinator served from approximately February 2021 to August 2022. One of the facility liaisons then became acting facility coordinator until she took on the role in a permanent capacity in January 2023 (facility coordinator 2). As of September 2024, this individual remained the facility coordinator.

[6] San Diego County entities referring patients to VVSD included the county's Veterans Treatment Court and its probation office. Drug Medi-Cal is a California state program that provides funding for substance use treatment programs.

[7] Two individuals served as the VA facility director that had responsibilities related to the initial investigative review period. The first VA facility director retired in June 2022 after approximately six years in that role. The facility's chief of staff then served as acting VA facility director until the appointment of a permanent facility director in January 2023.

certain staffing levels and resources in its GPD housing, including a 15:1 ratio of veterans to case managers. VVSD agreed to this ratio under its grant to provide needed services and fulfill the goals of improving veterans' mental health, maintaining their sobriety, and assisting them with obtaining employment and permanent housing. VA facility liaisons, facility coordinator 1 (who supervised them), and facility director 1 knew that throughout 2021 and most of 2022, VVSD was unable to fill key staff positions and was not maintaining the required veteran-to-case manager ratio. They also acknowledged that these issues posed a risk to veteran care and safety. Liaisons and facility coordinator 1 repeatedly accepted VVSD's proposed plans for addressing staffing concerns, but in practice the plans were ineffective at producing lasting improvement or were not fully implemented. Facility liaisons, meanwhile, continued to approve funding for veterans' stays at VVSD to allow for time to fix the problems. Only in fall 2022, nearly a year and a half after major staffing issues were identified at VVSD, did the VA facility institute an admissions hold in response to VVSD's staffing shortages.

VHA can ensure GPD grantee compliance through national, regional, and local coordination and support. Primary oversight is conducted at the local facility level.[8] Each VISN is also required to have a homeless coordinator to provide regional oversight and track corrective action plans for completion.[9] The GPD National Program Office is responsible for managing the grant award process and providing program guidance and broad oversight.[10]

VHA's oversight of VVSD during the FY 2021–2022 review period revealed opportunities for improvement at all levels. At the local level, responsible facility staff generally did not take timely or effective action to correct the issues at VVSD. This stemmed from several interrelated factors, including a reluctance to use available enforcement tools, such as admissions holds, and a failure to demand long-lasting corrective actions. In addition, the OIG found that staff exercised discretion not contemplated in GPD program policy when determining whether to *require* VVSD to correct certain compliance issues or merely make *suggestions* as to changes or improvements, such as considering the time or expense needed to address an issue. The OIG also noted that the facility lacked important information related to residents at VVSD who were funded by the state Drug Medi-Cal program and the potential risks this co-location presented for veterans at VVSD who were funded by the GPD program. In addition, the VISN homeless coordinator was not meaningfully engaged in supporting the facility's oversight during the period under review. Finally, the GPD National Program Office's policy, guidance, or training could better address key issues, such as when admissions holds or other enforcement tools should be deployed, how to classify inspection findings to ensure appropriate corrective action, and how to produce long-term improvement when faced with recurring compliance concerns.

[8] VHA Directive 1162.01, pp. 6–11.

[9] VHA Directive 1162.01, pp. 5–6.

[10] VHA Directive 1162.01, pp. 4–5.

Responsible personnel at the VA facility explained to the OIG team the challenges they faced in overseeing VVSD's GPD operations. In sum, those challenges included the difficulty facility staff and VVSD encountered in responding to the co-occurring needs of veterans who require transitional housing, substance use treatment, and other complex services (while acknowledging that relapse often occurs during drug abuse recovery). They also described the impact of the COVID-19 pandemic on trying to fill staffing vacancies. Further, staff shared that the facility did not want to halt admissions to VVSD for veterans in need because of VHA's "Housing First" approach to combating homelessness and had hoped that VVSD's proposed plans would remediate identified safety risks.[11] Finally, facility personnel mistakenly believed that they lacked authority to directly address the risks posed to GPD participants by co-located VVSD residents funded by Drug Medi-Cal. The OIG recognizes these many challenges. However, they do not exempt VHA from more effectively enforcing grant compliance when veterans' safety and services are at risk. The OIG's investigation provided lessons learned for VHA to improve its future oversight of GPD grantees like VVSD, particularly those with co-located residents funded by non-VA programs.

The OIG followed up the initial investigation with a limited review of VHA oversight of VVSD through September 2024. This was prompted in part by the overdose death of another Drug Medi-Cal participant at VVSD in March 2024, as well as the concern that reports of improvements may not have taken hold.[12] The OIG team conducted additional interviews and reviewed FY 2023 and FY 2024 inspection documents from the VA facility overseeing VVSD, as well as other communications between and among VA and VVSD staff. The team found that issues related to veteran care and safety recurred or persisted at VVSD following the close of the OIG's investigative review period in September 2022, including concerns related to drug use and dealing, security rounds, and staffing. Also present were ongoing concerns regarding the lack of information about incidents involving co-located Drug Medi-Cal residents, and how to address repeated noncompliance issues. The recurrence of similar concerns in the years following the OIG's review period underscores the current opportunity for VHA to improve its oversight of GPD grantees and to ensure frontline staff have the tools they need to remediate noncompliance.

As to VVSD, the OIG learned that in early September 2024, the California Health and Human Services Agency's Department of Health Care Services revoked VVSD's license to operate a residential substance use treatment center because of the deaths in recent years and licensing violations. Consequently, VVSD discharged its Drug Medi-Cal residents, and its GPD clinical treatment housing model was shut down. Facility coordinator 2 told the OIG during a follow-up

[11] VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016, p. B-5. As defined in VHA policy, "Housing First is a low-barrier, supportive housing model that emphasizes permanent supportive housing to end chronic homelessness" without first requiring abstinence or drug treatment. VHA Directive 1501, p. B-5.

[12] Greg Moran, "A death in March triggers more scrutiny of Veterans Village," *inewsource*, July 30, 2024, https://inewsource.org/2024/07/30/a-death-in-march-triggers-more-scrutiny-of-veterans-village/.

interview in September 2024 that her team met several times with the veterans from that housing model who moved to other transitional housing models at VVSD without clinical care to provide assistance and worked to connect those veterans with alternative drug treatment services.

To assist VHA with enhancing oversight of VVSD and other GPD grantees, the OIG has made four recommendations to the director of the GPD National Program Office related to improvements in governing policies, training, or other guidance, including when admissions holds or other enforcement tools are to be used for noncompliance. The recommendations also address better classifying and adequately addressing identified issues and recurring problems for corrective action, as well as requiring grantees to disclose adverse health and safety incidents involving co-located participants not funded by VA and related findings by non-VA oversight agencies. The OIG also made a fifth recommendation, to the VA facility director, to ensure local staff assist GPD participants at VVSD who no longer receive drug treatment there, due to its license revocation, in obtaining those services.

VA Comments and OIG Response

The under secretary for health, the VISN 22 interim director, and the current VA facility director reviewed the draft report and responded by concurring with the OIG's finding and recommendations. Their full responses are published as appendixes B, C, and D, respectively.[13] The OIG acknowledges that VHA and the VA facility have provided acceptable action plans and completion timelines in response to the recommendations and will monitor their progress until sufficient documentation has been received to close them as implemented.

In addition to concurring with the finding and recommendations, VA facility staff proposed six revisions to the report (see details in text). The proposed edits did not affect the OIG's substantive support for its finding but instead focused on recharacterizing statements in the report or addressing perceived inconsistencies between portions of the report. The OIG carefully reviewed these requested edits but determined they lacked evidentiary support and that the report fully, fairly, and accurately assesses the issues raised as written, without contradiction, and therefore made no corresponding revisions.

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[13] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—December 11, 2024, through January 17, 2025.

Contents

Abbreviations

FY	fiscal year
GPD	Grant and Per Diem
NPO	Grant and Per Diem National Program Office
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VVSD	Veterans Village of San Diego

Introduction

The Veterans Health Administration (VHA) Grant and Per Diem (GPD) program funds organizations that provide transitional housing and other services to veterans experiencing homelessness.[14] The Office of Inspector General (OIG) conducted an administrative investigation in response to reports of unsafe conditions during fiscal years (FYs) 2021 and 2022 at Veterans Village of San Diego (VVSD), a GPD program grantee.[15] The OIG also conducted a limited review of VHA's oversight of VVSD in FYs 2023 and 2024 to determine whether the oversight problems it identified during the initial investigative period had been resolved.

In June 2022, the OIG received an inquiry from Congressman Mike Levin regarding what oversight would be done at VVSD in the wake of news reports of issues such as drug use and dealing among its residents.[16] The news reports included accounts of a nonfatal drug overdose by a veteran and another resident's overdose death, as well as staffing shortages. The OIG had already received an April 2022 complaint alleging that general safety and the quality of treatment had deteriorated at VVSD; the complaint also cited drug sales and use among residents and ongoing staffing shortages. Further, the OIG learned that three other residents at VVSD, who were not funded by VA but were co-located with VA-funded residents, died of confirmed or suspected drug overdoses in 2022.

On June 9, 2022, the OIG referred these underlying complaints regarding health and safety issues to VHA to address. On June 23, 2022, the OIG team began work on this administrative investigation to assess the effectiveness of VHA's oversight of VVSD. The OIG examined whether VHA's oversight ensured VVSD delivered services in compliance with its grant agreement and federal regulations. The investigative team analyzed records from VVSD and the Department of Health Care Services of the California Health and Human Services Agency; reviewed applicable federal laws and regulations, as well as VA policies, procedures, and guidance, and VVSD's grant requirements; and interviewed numerous people responsible for and familiar with VVSD operations and VHA's oversight. The OIG's subsequent limited review examined inspection reports of VVSD and communications among and between VA and VVSD personnel from FYs 2023 and 2024, and included additional interviews, to determine whether issues related to veteran care and safety recurred or persisted following the end of the September 2022 initial investigative period. For more information on the scope and methodology

[14] 38 U.S.C. §§ 2011(a), 2012(a); 38 C.F.R. § 61.61; VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program*, November 17, 2020, p. 1.

[15] VVSD was founded in 1981 as Vietnam Veterans of San Diego and began doing business under the name Veterans Village of San Diego in 2005.

[16] At the time of his June 2022 inquiry, Congressman Levin was chairman of the Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs.

of this administrative investigation and for details on the complaints that prompted it, see appendix A.

The GPD Program

GPD is VHA's largest program supporting transitional housing for veterans experiencing homelessness. The program's goal is to help veterans achieve residential stability, increase life and employment skill levels and income, and obtain greater self-determination.[17] Grantees provide veterans with rehabilitative services, vocational counseling and training, and transitional housing assistance.[18]

GPD grantees are required to provide safe, supportive housing and services for veterans experiencing homelessness.[19] GPD programs are designed to help veterans who have no stable housing move to permanent housing as soon as possible.[20] Other services include

- food, nutritional advice, counseling, health care, mental health treatment, alcohol and other substance abuse services, and case management services;
- supervision and security arrangements for protecting residents;
- education, employment counseling and assistance, and job training; and
- legal assistance, advocacy, transportation, and other services essential for achieving and maintaining independent living.[21]

Case management is essential in meeting the needs of veterans in transitional housing. According to VVSD's grant application, its case managers meet one-on-one with each veteran on a weekly basis. Case managers and support staff create individualized plans and assist veterans in obtaining permanent housing, employment, and disability benefits, as well as acquiring life skills, attending therapy, and receiving substance abuse treatment and other medical care.

VVSD

VVSD has been a community partner of the VA San Diego Healthcare System (the VA facility) for decades. Veterans arrive at VVSD in a variety of ways, including self-presenting and referral from community healthcare facilities or programs for people who have no stable housing. Other

[17] VA Grant and Per Diem (GPD), "Grant & Per Diem (GPD) Program" (fact sheet), July 2022, p. 1; 38 C.F.R. § 61.2(a). Per diem grants provide funding to offset the operating costs of a supportive housing or services program. 38 U.S.C. §§ 2012(a), 2061(a).

[18] 38 U.S.C. § 2011(a); 38 C.F.R. § 61.2(a).

[19] VHA Directive 1162.01, p. 1.

[20] 38 C.F.R. § 61.1.

[21] 38 C.F.R. § 61.2(a).

residents, including veterans or nonveterans, may also be referred to VVSD by San Diego County court and probation programs.

In 2020, VHA approved VVSD to provide housing for up to 190 eligible veterans using a clinical treatment model along with several other transitional housing models, such as service-intensive and bridge housing models.[22] The finding in this report pertains only to operations and conditions at VVSD's main campus, where the clinical treatment model was separated from other models.[23] VVSD received approximately $3.5 million in GPD funding for FY 2022. According to an OIG analysis of VHA records, VVSD served approximately 390 veterans during calendar years 2021 and 2022.

VVSD also received funding from sources other than the GPD program during the investigative review period. One such source was Drug Medi-Cal, a California state program that provides funding for substance use treatment programs.[24] According to VA facility staff, about 50 percent of VVSD residents at any time during the OIG's investigative review period were funded by Drug Medi-Cal. VVSD maintained separate treatment staff for GPD and Drug Medi-Cal residents, but the two populations were co-located within VVSD's clinical treatment facilities, meaning that they shared common spaces and were assigned adjacent bedrooms.

VHA's Oversight Responsibilities

Federal law prohibits VA from making per diem payments to grantees for care that does not meet VA standards.[25] Although VA does not directly manage or control a grantee's operations, it may inspect or review those operations at any time to determine compliance with governing regulations or the grant agreement and to verify the care provided is necessary and appropriate.[26] As explained below, VHA coordinates oversight of GPD grantees at the national, regional, and local levels, including through regular inspections and reviews of grantee operations.

[22] A clinical treatment GPD housing model incorporates transitional housing with substance abuse or mental health treatment; other housing models provide housing and supportive services pending a move into permanent housing. VA GPD, *Grant Recipient Guide: Fiscal Year 2023 Transitional Housing Grants (Per Diem Only Models, Special Need, Transition in Place)*, October 18, 2022, pp. 28, 29, and 32. During FY 2021 and FY 2022, VVSD was the largest GPD grantee in San Diego, with other area grantees ranging from 20 to 64 beds. During the OIG's investigate review period, of the GPD grantees in San Diego, only VVSD had a clinical treatment model.

[23] VVSD operated GPD-funded housing at two locations in San Diego: one main campus containing multiple housing programs, and one smaller satellite location called the Welcome Home Family Program, which is geared toward veterans with families.

[24] The California Health and Human Services Agency's Department of Health Care Services conducted oversight for VVSD residents funded by Drug Medi-Cal. As discussed further below, VVSD discharged its Drug Medi-Cal residents in September 2024 after the California Health and Human Services Agency's Department of Health Care Services revoked its license to provide residential substance use treatment services.

[25] 38 U.S.C. § 2012(b).

[26] 38 C.F.R. §§ 61.33(b), 61.65.

VHA Conducts Oversight of Grantees Through National, Regional, and Local Coordination

The GPD National Program Office (NPO) is responsible for overseeing the grant award process and providing program guidance and oversight for all of VHA.[27] The NPO provides training to medical facility-level GPD staff and consults on grant compliance issues. In addition, each Veterans Integrated Service Network (VISN) is required to have a homeless coordinator (VISN coordinator) to provide regional oversight for all GPD programs within that VISN.[28] VVSD is located within VISN 22, the VA Desert Pacific Healthcare System.

The director of the local VA medical center is ultimately responsible for ensuring that grantees within the medical center's geographic area of responsibility provide "quality services consistent with [applicable federal regulations], applicable State and local laws," and the grantee's grant application.[29] Further, VA medical facilities assign liaisons to each grantee to oversee care and verify that grantees provide services in accordance with their grant agreements.[30] The VA San Diego Healthcare System is responsible for overseeing VVSD's GPD grant, and it had four full-time GPD liaisons assigned to VVSD during the investigative review period. The role of liaison supervisor is filled by the VA facility's Healthcare for Homeless Veterans coordinator (the facility coordinator).[31] The facility coordinator reports to the chief of social work, who reports to the associate director of patient care services, who in turn reports to the facility director. The chief of social work and the associate director of patient care services do not have roles defined in GPD policy but serve in the supervisory chain between the facility coordinator and the facility director.

Facility liaisons, including the four assigned to VVSD, assess veterans seeking program admission for eligibility, provide clinical oversight and care coordination, and meet regularly with veterans.[32] Liaisons also advise grantee staff on appropriate supportive service practices,

[27] VHA Directive 1162.01, pp. 4–5.

[28] VHA Directive 1162.01, pp. 5–6. VHA has divided the nation into 18 Veterans Integrated Service Networks, or VISNs, which are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Networks" (web page), Veterans Health Administration, accessed October 24, 2024, www.va.gov/HEALTH/visns.asp. The network homeless coordinator is appointed by the VISN director. VHA Directive 1162.01, p. 5.

[29] VHA Directive 1162.01, p. 6. According to the office's director, the NPO does not provide direct training to VA medical facility directors on their role in the GPD program.

[30] VHA Directive 1162.01, pp. 8–11; VA GPD Grant Recipient Guide, *Fiscal Year 2023 Transitional Housing Grants (Per Diem Only Models, Special Need, Transition in Place)*, p. 6.

[31] Other VA facilities may have an individual other than the Healthcare for Homeless Veterans coordinator serve as GPD liaison supervisor.

[32] VHA Directive 1162.01, pp. 8–9.

provide technical assistance on grant compliance issues, coordinate inspections, and enforce corrective actions.[33]

Figure 1 shows the organization of responsible officials within the GPD program; boxes with solid lines denote positions defined by GPD policy, and boxes with dotted lines indicate others in the supervisory chain for facility GPD oversight staff who do not have roles defined in GPD policy.

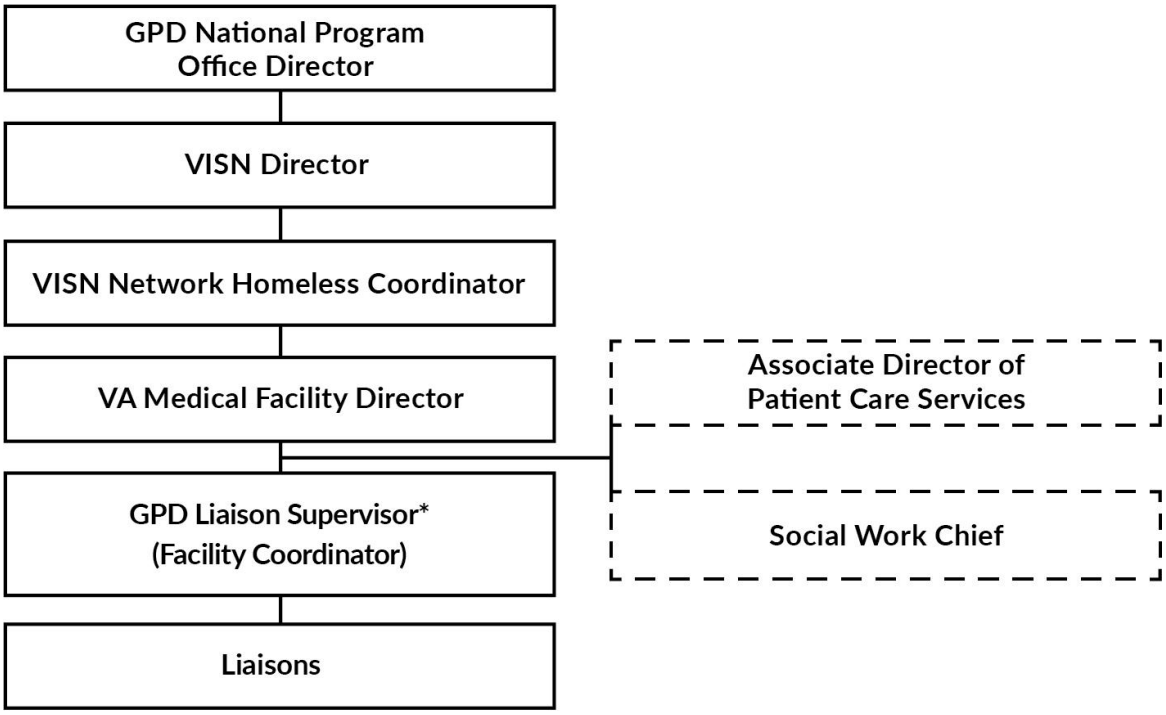

Figure 1. *Hierarchy of relevant VHA officials involved in the GPD program at the VA San Diego Healthcare System.*

Source: VHA Directive 1162.01, pp. 4–11; witness testimony

**The GPD Liaison Supervisor, referred to in the report as the facility coordinator, also serves as the facility's Healthcare for Homeless Veterans Coordinator.*

Two individuals served as the facility coordinator during the OIG's review periods, and two individuals served as the VA facility director. The first facility coordinator (facility coordinator 1) served from approximately February 2021 to August 2022. One of the facility liaisons then became the acting facility coordinator until assuming the role permanently in January 2023 (facility coordinator 2). As of September 2024, facility coordinator 2 remained in the same role. The first VA facility director discussed in this report (VA facility director 1) retired in June 2022 after approximately six years in that role. The facility's chief of staff then

[33] VHA Directive 1162.01, pp. 8–9; VA GPD Grant Recipient Guide, *Fiscal Year 2023 Transitional Housing Grants (Per Diem Only Models, Special Need, Transition in Place)*, p. 6.

served as acting VA facility director (VA facility director 2) until the appointment of a permanent director in January 2023. Their respective tenures are shown in Figure 2.

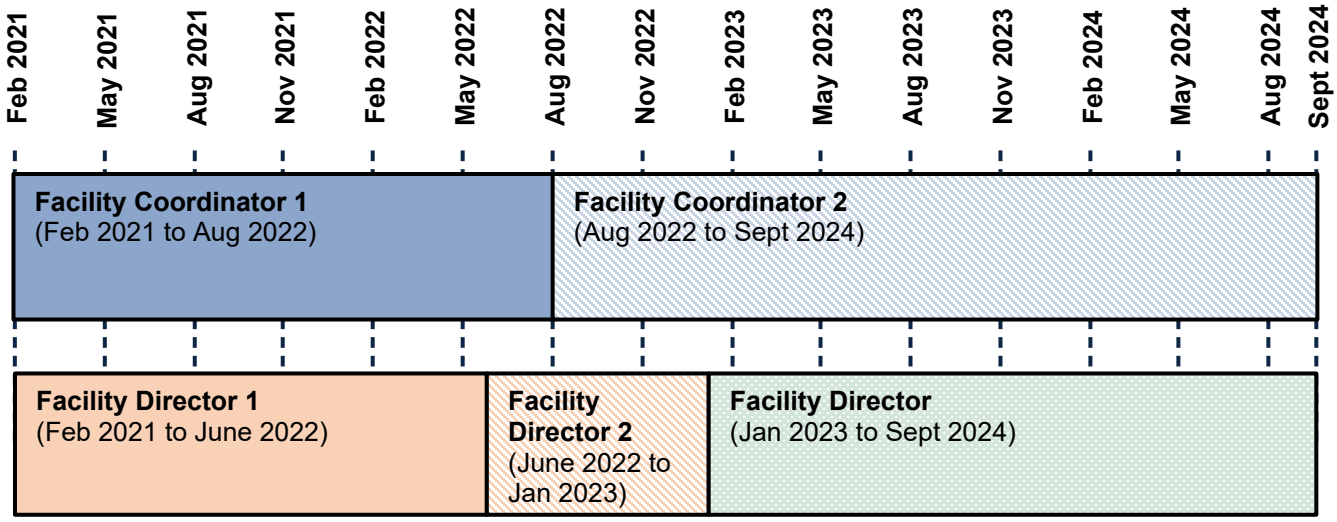

Figure 2. *Tenures of relevant incumbents of positions involved in the GPD program at the VA San Diego Healthcare System.*

Source: Incumbent testimony

VHA Regularly Inspects Grantee Operations and May Cite Deficiencies or Recommend Best Practices

GPD policy requires that facility liaisons and inspectors complete initial inspections before authorizing per diem payments to grantees and calls for annual reinspections, unannounced nutrition and food service reviews, scheduled or unscheduled site visits, and quarterly compliance reviews.[34] Inspectors are VA facility staff with the background, education, and experience needed to inspect GPD grantees.[35] Facility staff must notify grantees of items identified during any type of inspection that are "problematic or in non-compliance, in other words are identified as deficient."[36] Training materials for facility liaisons explain that deficiencies can stem from noncompliance with inspection checklist items, federal regulations, or the grant agreement.

If a grantee disagrees with an inspection finding or does not "expeditiously plan" to resolve the deficiency, the VA facility director must send a letter to the grantee requesting corrective

[34] VHA Directive 1162.01, pp. C-1–C-2.

[35] VHA Directive 1162.01, p. 7. GPD inspectors include facility staff from appropriate departments such as social work, mental health, nutrition, pharmacy, facilities management, and law enforcement. VHA Directive 1162.01, p. 7.

[36] VHA Directive 1162.01, pp. C-1–C-2, D-1.

action.[37] According to GPD policy, the VA facility director then reviews the grantee's response, including any corrective action plan the grantee proposes, for adequacy.[38] There is no guidance in the policy as to what constitutes an adequate corrective action plan or how to follow up on remediation, but the GPD grant recipient guide and NPO training materials advise that the corrective action request should be clear and specific regarding the deficiencies identified and the expected resolution and deadline.[39] NPO training materials also state that liaisons should rely on inspectors' expertise in determining when a deficiency is resolved. Once a resolution is reached, policy requires the VA facility director to write the grantee another letter noting acceptance of its corrective action plan or resolution of the deficiency.[40] In addition, the VISN coordinator is responsible for reviewing corrective action plans and "tracking follow-up activities associated with the deficiencies to ensure compliance with the procedures" related to addressing deficiencies.[41]

In addition to citing deficiencies, facility liaisons and inspectors can "provide suggestions to grantees that are 'best practices' as a means to improve service delivery. These items do not require correction but can be offered as consultation to the grantees."[42]

GPD policy allows a VA facility director to employ progressive enforcement actions to induce compliance, including temporarily withholding funding, suspending funding and, ultimately, recommending that the NPO terminate the grant.[43] Additionally, "for issues involving patient safety, it is acceptable to remove veterans from the GPD grantee's care immediately before a formal [corrective action] letter can be drafted."[44] The facility director can also halt new admissions in conjunction with any other enforcement measures "if needed to ensure the safe operation of the GPD grant."[45]

[37] VHA Directive 1162.01, p. D-1.

[38] VHA Directive 1162.01, pp. D-1–D-2.

[39] VHA Directive 1162.01, pp. D-1–D-2; VA GPD Grant Recipient Guide, *Fiscal Year 2023 Transitional Housing Grants (Per Diem Only Models, Special Need, Transition in Place)*, p. 22.

[40] VHA Directive 1162.01, p. D-2.

[41] VHA Directive 1162.01, p. 5.

[42] VHA Directive 1162.01, p. 7.

[43] VHA Directive 1162.01, pp. D-1–D-2.

[44] VHA Directive 1162.01, p. D-1.

[45] VHA Directive 1162.01, pp. D-1–D-2.

Finding and Analysis

Finding: VHA's Oversight Challenges Resulted in Veterans Remaining in Unsafe Conditions at VVSD

The OIG substantiated the allegations that veterans faced unsafe conditions at VVSD during FYs 2021 and 2022 due to understaffing and to drug use and dealing among residents. VA facility staff overseeing VVSD described the challenges in conducting effective oversight during this period caused by, among other factors, the COVID-19 pandemic and the enduring difficulties in serving vulnerable veterans experiencing homelessness with substance use and other disorders, especially under a "Housing First" approach.[46] While the OIG recognizes those challenges and the corrective actions taken, its investigation identified several areas in which VHA could have addressed the issues more fully at VVSD and can improve its future GPD oversight at the local, regional, and national levels—particularly for GPD grantees co-located with residents funded by non-VA programs.

VA's regulations require that VHA ensure GPD grantees provide veterans with "a clean and sober environment that is free from illicit drug use or from alcohol use that could threaten the health and/or safety of the residents or staff."[47] In addition, VVSD committed in its grant application to provide certain staffing levels and resources in its GPD models, including a 15:1 ratio of veterans to case managers.[48] In FY 2021 and through most of FY 2022, problems arose at VVSD that increased risk to veterans, including drug sales and use among residents, as well as insufficient staffing. Despite knowing of these issues and the risks they posed, VA facility staff charged with oversight of VVSD did not promptly or effectively use existing processes and resources to make certain that veterans received appropriate care and services in an environment free from substance use that could threaten their safety.

The OIG found these failures stemmed from several interrelated factors, including not using available enforcement tools to ensure regulatory and grant compliance, such as admissions holds, and focusing on continuing operations despite safety concerns. VA facility staff also did not elicit long-term corrective action for persistent staffing compliance issues. In addition, facility staff used discretion not afforded in policy when determining which inspection findings that were identified required corrective action. They lacked a way to obtain information on adverse health and safety events involving the many residents at VVSD who were not affiliated with the

[46] VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016, p. B-5. As discussed further below, VHA defines "Housing First" as a "low-barrier, supportive housing model that emphasizes permanent supportive housing" without first requiring abstinence or completing a drug treatment program. VHA Directive 1501, p. B-5.

[47] 38 C.F.R. § 61.80(b)(14). As explained above, VHA cannot provide funding to grantees that fail to meet prescribed standards, including the requirements of this regulation or the grant agreement. 38 U.S.C. § 2012(b); 38 C.F.R. § 61.65.

[48] VVSD's grant agreement required it to operate its GPD housing in accordance with its grant application.

GPD program, and on related findings by other oversight entities, as well. Facility staff also mistakenly believed they could not directly address risks created by the conduct of non-GPD VVSD residents. Furthermore, facility staff were hindered in oversight efforts because the responsible VISN coordinator was not meaningfully involved in oversight efforts during the investigative review period. Finally, the NPO's policy and guidance could better address key issues, such as when admissions holds or other enforcement tools should be deployed, how to properly classify potential issues of noncompliance so that there is appropriate corrective action, and how to produce lasting improvement when faced with recurrent compliance issues.

Figures 3 and 4 provide a timeline of key events related to the facility's oversight of staffing and drug issues occurring at VVSD during FY 2021 and FY 2022. This report discusses these issues in greater detail in the sections that follow, then describes the limited review determinations for FYs 2023 and 2024 that demonstrated many of the previously identified problems persisted or recurred, and concludes with opportunities for improvement in oversight at the local, regional, and national levels.

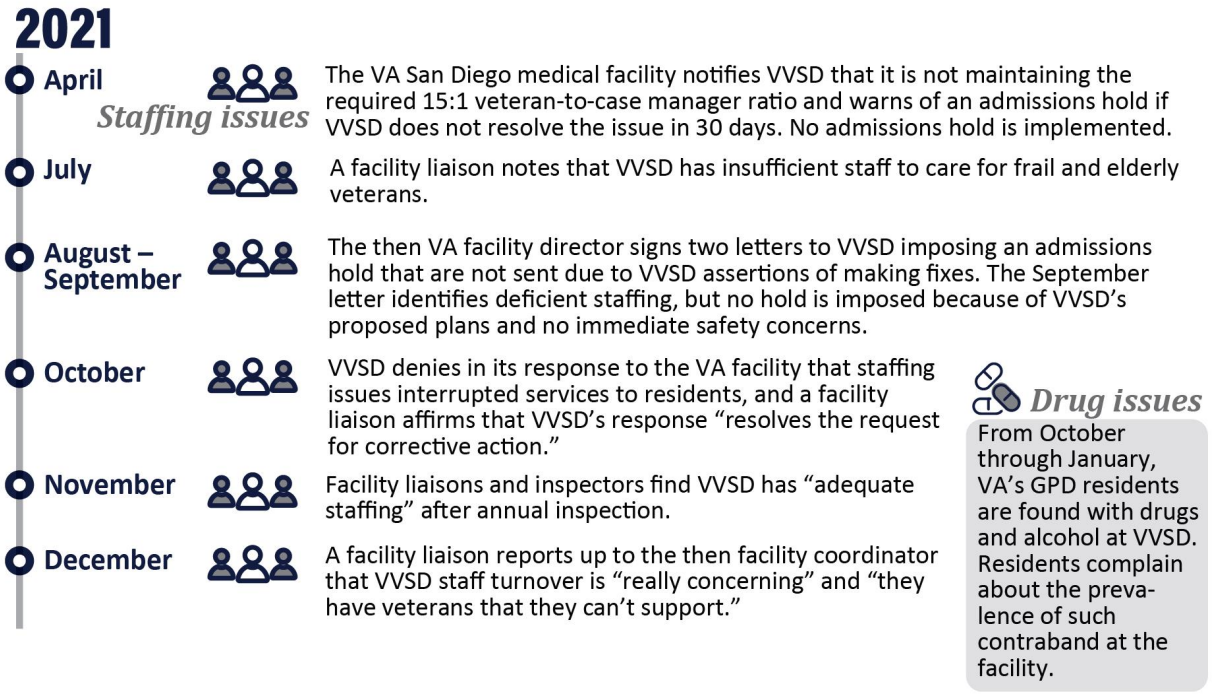

Figure 3. *Timeline of VA Facility Oversight of Staffing and Drug Issues at VVSD, 2021.*

Source: OIG analysis.

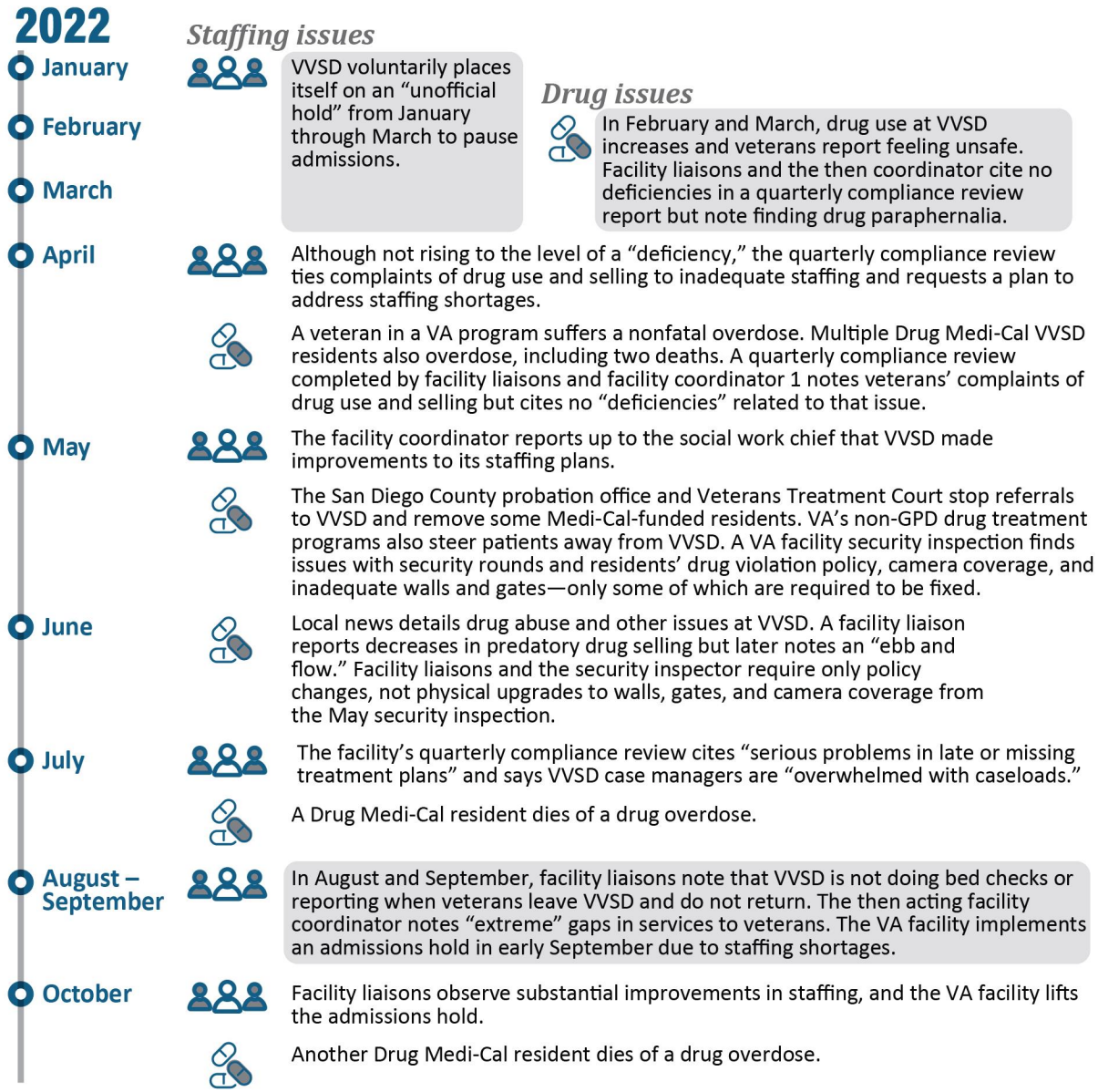

Figure 4. *Timeline of VA Facility Oversight of Staffing and Drug Issues at VVSD, 2022.*

Source: OIG analysis.

In support of this report's finding, the OIG made the following determinations:

- The facility staff overseeing VVSD did not respond promptly to a rise in drug use and dealing at VVSD during FY 2022 and did not require VVSD to implement all of the changes the facility's security inspector proposed to address identified risks.
- The facility personnel overseeing VVSD did not adequately enforce VVSD staffing requirements throughout most of FY 2021 and FY 2022, leading the VA facility to impose a hold on VVSD admissions in late FY 2022.

- Effective oversight of VVSD was hindered by numerous factors including
    - delaying the use of enforcement tools (such as halting admissions) to address grantee deficiencies while focusing on maintaining operations, even with unresolved safety concerns, to give VVSD opportunities to fix problems;
    - lacking robust information in GPD program policies and guidance on how to use enforcement measures;
    - failing to ensure corrective actions to noncompliance issues were implemented and sustained, including for areas in which national guidance on recurrent compliance concerns could be improved; and
    - improperly classifying which identified issues *required* corrective action and which could be simply *suggested* steps.
- These lapses were amplified by lack of timely information about non-GPD operations at VVSD, a mistaken belief that facility staff had no direct authority to require VVSD to take steps to address risks for veterans created by its non-GPD residents, and insufficient support from the VISN homeless coordinator.
- A limited review of FY 2023 and FY 2024 inspection findings and related communications showed that concerns at VVSD related to drug use and dealing, security, and staffing recurred or persisted following the close of the OIG's investigative review period in September 2022, underscoring the need for VHA action to improve oversight.

In making its findings and recommendations, the OIG recognizes the effect of the pandemic on staffing and the challenges in serving veterans with co-occurring housing, substance use, and other complex needs when there may be no other local alternative placements with the same clinical treatment capabilities.

VA Facility Staff Responded Slowly to Drug Problems at VVSD in FY 2022 and Did Not Enforce All Proposed Remedial Measures from Its Inspection

Starting in FY 2022, VA facility staff involved in GPD oversight knew that illegal drugs were increasingly available to GPD-funded veterans at VVSD. An October 2021 VVSD incident report to VA facility liaisons indicates that staff found alcohol bottles and drug paraphernalia

inside a GPD resident's room. Minutes of meetings between the liaisons and VVSD from October 2021 and January 2022 reflect discussions of veterans' complaints about drug use.[49]

Facility coordinator 1, a facility liaison, and a former VVSD staff member all told the OIG that, given the nature of substance abuse and recovery, concerns with the availability of drugs and alcohol in a substance abuse treatment program were always present.[50] However, the liaison stated that around February and March 2022, drug use at VVSD became more "rampant," "obvious," and "concerning." The liaison reported that residents who were at VVSD through funding from the state's Drug Medi-Cal program would target new GPD residents for drug sales, which she called "predatory behavior." Another facility liaison told the OIG that he heard from veterans around this time that there was drug use at VVSD, that they did not feel safe, and that they felt their sobriety was at risk. The VA facility's February 2022 quarterly compliance review showed that liaisons located drug paraphernalia and wine bottles in GPD resident rooms. The liaisons and facility coordinator 1 did not classify any of the findings in the compliance review as "deficiencies," which would have *required* remediation by VVSD.[51]

Concerns with drug use escalated in spring 2022. On April 16, 2022, a GPD resident at VVSD experienced a nonfatal fentanyl overdose. In a compliance review report in late April, facility liaisons noted "common trends" of veteran complaints included "substance use on campus" and "vulnerable Veterans being around those who are using or selling drugs." But, when listing matters in the report requiring corrective actions from VVSD, the liaisons and facility coordinator 1 made no reference to drugs.[52] Investigative reports from the California Health and

[49] Facility coordinator 1 told the OIG she first learned of drug concerns at VVSD in spring 2022. When shown these minutes, she did not recall whether she was informed of the drug issues reflected in them. She said that facility liaisons would not necessarily need to inform her of single instances of veteran drug use because it was not an uncommon occurrence and the liaisons responded appropriately by discussing it with VVSD.

[50] As noted above, facility coordinator 1 served in that role from approximately February 2021 to August 2022.

[51] VHA Directive 1162.01, pp. D-1–D-2. Facility coordinator 1 told investigators that these issues were not classified as deficiencies because the drug paraphernalia was immediately removed. She stated that when it comes to paraphernalia, "we're looking for patterns" more than individual incidents.

[52] Facility coordinator 1 indicated that follow-up action related to these drug concerns was to be addressed in an upcoming as-needed security inspection, discussed later in this report. However, emails show the facility liaisons reached out to the facility security inspector more than a week after the compliance review report was issued, so at the time of issuance, there was no forthcoming inspection requested. When asked about this by OIG investigators in October 2023, facility coordinator 1 maintained that the pending inspection could have been communicated to VVSD by the time the compliance review report was issued and that she suspected there were "follow-up actions in other avenues," although she could not remember specific details.

Human Services Agency's Department of Health Care Services corroborate that multiple drug overdoses occurred among Drug Medi-Cal VVSD residents in April 2022.[53]

On April 29, 2022, a VVSD Drug Medi-Cal resident died of a suspected fentanyl overdose on campus. On May 1, a San Diego County veterans treatment court judge wrote in an email to VA and county officials that she was "very concerned about the safety and welfare of those at VVSD" and would discuss moving state-funded VVSD residents to "safer environments." The judge's email was forwarded to facility coordinator 1 by a VHA employee, who added that "probation has stopped all referrals to VVSD as well. Per report, 4 OD's in 4 weeks." Later that month, the county's probation department removed several of its VVSD residents. On May 2, 2022, facility coordinator 1 informed the facility social work chief that the San Diego County probation office and Veterans Treatment Court, as well as VA facility drug treatment programs, had halted referrals to VVSD. According to VA facility director 1, a manager within the facility's substance use program later told him that the program did not make formal referrals but provided options, like VVSD, for patients to choose from.[54] However, VA facility director 1 told the OIG that the program was at that time "steering people away" from VVSD because "they were concerned about staffing and they were concerned about sobriety."

GPD and non-GPD populations lived in close proximity at VVSD during the investigative review period. Despite learning that entities funding these co-located residents, as well as other non-GPD facility programs, thought VVSD was not appropriate for referrals, VA facility director 1 did not place an admissions hold on the GPD program. Facility coordinator 1 told the OIG team that other entities halting referrals did not affect her view about whether GPD residents at VVSD were safe because the underlying concerns were already known to the liaisons and they were "already at this time heavily engaged in oversight at VVSD." She stated that she took the concerns "into account" but, with regard to a potential admissions hold, noted that the non-GPD programs were "much different" and that their actions "[did] not mean that we must follow suit." Facility liaisons and facility coordinator 1 discussed the drug issues at VVSD with the VISN homeless coordinator and NPO staff in summer 2022, but those communications do not reflect substantive input from the VISN or program office.

In her May 2, 2022, email to the social work chief, facility coordinator 1 wrote that the GPD program did not have an admissions hold in place because "they don't have specific grant deficiencies that are unresolved and they are (thus far) showing us their steps to address the

[53] According to one such report, a Drug Medi-Cal resident died on April 6, 2022, from a probable methamphetamine overdose after VVSD staff assessed that he was under the influence of drugs and told him to return when sober. Another report reflects that a Drug Medi-Cal resident was discharged for smoking methamphetamine in his room; this resident told a VVSD employee it was so easy to get high at VVSD that he might as well leave. A liaison told OIG investigators that Drug Medi-Cal overdoses were reported to her "informally," but facility liaisons received VVSD incident reports only about the April 16 GPD resident's overdose.

[54] As explained above, this individual retired in June 2022 after approximately six years as the VA facility director.

general safety issues raised." The social work chief forwarded facility coordinator 1's update to the associate director of patient care services and VA facility director 1. VA facility director 1 told the OIG team that although the holds by non-GPD entities on referrals raised concerns, he got the sense from the social work chief at this time that a GPD admissions hold was not needed because of ongoing oversight efforts.[55]

VA Facility Personnel Did Not Enforce All Proposed Corrective Actions from the Security Inspection

On May 5, 2022, facility liaisons asked their assigned GPD security inspector to conduct an as-needed inspection (not part of a quarterly or annual inspection) of VVSD's main campus.[56] The inspection was scheduled for May 17. In emails later that day, the inspector, facility coordinator 1, and liaisons discussed concerns with drugs coming in due to inadequate walls that could be jumped over or that had spaces that could be reached through, and "massive gaps" in camera coverage.[57] Meanwhile, reports of drug use at VVSD continued. In emails and messages from mid-May, liaisons reported discovering drug paraphernalia on campus and noted that "the two main dealers remain on campus." In one such email, a liaison wrote the facility security inspector,

> We are getting a lot of reports regarding problems around drugs, which impacts the safety of all those who reside on campus. I am sure that all substance use treatment programs struggle with things like this, but circumstances at VVSD right now seem worse than what we would expect.[58]

[55] While VA facility director 1 did not impose an admissions hold, a liaison told investigators that during this period, she advised GPD-funded residents "that [VVSD] was struggling, that veterans going into the program might see things that shouldn't be there, including drugs." She offered alternative arrangements for them and told the OIG team there were "absolutely" other places residents could go for assistance but noted that of the GPD grantees in San Diego, only VVSD had a clinical treatment program. She estimated that four to six residents opted to transfer out of VVSD during this period. Likewise, facility coordinator 1 told the OIG that the liaisons met with all GPD residents around the time that Drug Medi-Cal residents were removed to determine if they wanted to stay at VVSD; she believed one or two residents were moved as a result.

[56] GPD policy authorizes facility liaisons and inspectors to perform scheduled or unscheduled site visits at GPD grantee sites outside of the regularly scheduled quarterly compliance reviews and annual inspections. VHA Directive 1162.01, pp. C-1–C-2.

[57] According to the security inspector's photographs of VVSD's main campus taken during this as-needed inspection, some of the exterior walls of the campus consisted of solid walls and gates, or the walls of campus buildings, while in other places the campus was bounded by a chain-link fence. This report refers to these boundaries as "walls" and "gates" throughout for ease of reference.

[58] In this email, the liaison also asked the inspector to consider "whether we should be placing [VVSD] on an administrative hold while they work to address safety items that may be identified." The inspector told OIG investigators that while she believed it would be in the best interest to impose a hold until VHA figured out what was going on, the liaison and facility coordinator 1 cautioned her that a hold would mean other veterans may miss out on treatment. The VA facility did not implement an admissions hold related to the drug issue.

A facility liaison emailed the inspector's findings to VVSD on May 23, 2022. In doing so, the liaison, in consultation with the inspector, classified several of the inspector's requested remedial measures as "deficiencies." This was important because, under GPD policy, VVSD was obligated to address any issue classified as a "deficiency," while issues classified as "best practice recommendations" were considered optional.[59] Required fixes to "deficiencies" included updating policies on

- how to address drug violations,
- how to dispose of drugs and paraphernalia, and
- when and how to review security camera footage.

The liaison classified other requested corrections from the inspection report as "best practice recommendations." They included

- increasing the number of cameras in common areas,
- addressing walls and gates that were too low or easy to reach through,
- moving the smoking area to a part of campus with better supervision,
- improving security logs, and
- requesting alignment between GPD and Drug Medi-Cal resident policies.

Ultimately, VA facility staff required VVSD to implement only a few policy changes as a result of the May 2022 security inspection, while physical upgrades were not made.[60] The liaison who sent the findings to VVSD told the OIG that VVSD made the policy updates the inspector cited but also said, "the challenge we've had at VVSD is . . . they may hear our feedback, but if it's not a deficiency that's threatening action, they may not always follow through with what we're encouraging them to do."[61] The liaisons and facility coordinator 1 did not require VVSD to move the smoking area or increase camera coverage. The chief executive officer of VVSD told investigators that VVSD did not modify its gates or raise its walls. Facility coordinator 2 told the OIG that while she was concerned about the lack of camera coverage allowing drugs to come into campus, which was reported to her by veterans, she considered it a "gray area" whether it constituted a deficiency or a best practice since the grant did not specify that VVSD needed to

[59] VHA Directive 1162.01, pp. 7, D-1–D-2.

[60] Higher-level oversight staff at the VA facility could not recall being involved in the follow-up to this security inspection. When interviewed in October 2023, facility coordinator 1 indicated she was aware of the inspection findings but could not remember whether they were implemented because she left her role in mid-August 2022 and was on leave for a period of time before then. The social work chief, interviewed in June 2023, did not have a specific recollection of such a discussion but believed she would have discussed the corrective action plan and its outcome with facility coordinator 1. When the OIG team spoke with VA facility director 1 in July 2023, he could not recall learning of the results of any additional inspections at VVSD around that time.

[61] There is conflicting evidence on whether all VA-required policy updates were made, such as the inspector's request that VVSD update its policy on whether a resident found with illegal drugs would be discharged. Email follow-up on the inspection does not reflect that VVSD updated this policy. The security inspector stated that VVSD staff told her during the inspection that VVSD "tr[ies] to keep [residents] when possible."

have cameras. She told investigators that VHA could establish the required outcome—a safe environment—but could not dictate VVSD's method for accomplishing it.

The security inspector could not recall, when speaking with OIG staff in July 2023, whether the security rounding she believed was a substitute to physical upgrades was being performed adequately. According to the inspector, VVSD indicated adding cameras would be expensive and that the current camera coverage was adequate when paired with security patrols. The inspector noted to investigators that although she had concerns about the adequacy of security rounding logs, those rounds, if done properly, would satisfy her that veterans were safe. She stated that she did not know if VVSD staff "just weren't taking notes" on rounding "or they just weren't actually doing it as they were supposed to be." Yet, she could not remember whether VVSD fully implemented improved rounding and logging procedures following her inspection. When OIG investigators spoke to facility coordinator 2 in March 2023, she said the adequacy of security logs was still being monitored.

On June 8, 2022, a San Diego news outlet, *inewsource*, published several articles about alleged drug abuse on the VVSD campus, the GPD veteran overdose in April, and other concerns.[62] Facility coordinator 1 alerted the NPO, VISN homeless coordinator, and social work chief of the articles. The social work chief forwarded the articles to the associate director of patient care services and VA facility director 1, who discussed them but did not decide to impose an admissions hold. Facility coordinator 1 told the OIG that, given the prior oversight work and communications with VVSD, the articles did not provide new information and did not affect facility oversight at that time.

Facility liaisons and former VVSD staff said drug issues at VVSD improved in summer 2022. A liaison told investigators there was "ebb and flow" with regard to reported drug use in the months after June 2022. On June 8, 2022, this liaison wrote to facility coordinator 1 that reports from veterans were improving, with "no reports for 2-3 weeks of predatory drug selling." This individual told investigators that there was a "dramatic shift around the time that the [*inewsource*] articles started coming out where things were getting much better." Yet, on July 28, 2022, VA facility staff, including facility coordinator 1, the social work chief, and VA

[62] Jill Castellano, "Veterans say renowned rehab program is now a minefield of drug abuse," *inewsource*, June 8, 2022, https://inewsource.org/2022/06/08/veterans-village-san-diego-drug-abuse-rehab/; Jill Castellano, "Navy SEAL overdoses while seeking help with addiction at Veterans Village," *inewsource*, June 8, 2022, https://inewsource.org/2022/06/08/veterans-village-navy-seal-overdoses/; Jill Castellano, "Spoiled cheese, overflowing toilets: Food quality and sanitation pose 'health hazards' at rehab center," *inewsource*, June 8, 2022, https://inewsource.org/2022/06/08/veterans-village-health-hazards/; Jill Castellano, "'That's magic': Veterans fear life-changing rehab center drifting from mission," *inewsource*, June 8, 2022, https://inewsource.org/2022/06/08/veterans-village-rehab-mission/.

facility director 2, learned of another overdose death by a Drug Medi-Cal resident at VVSD.[63] Several witnesses the OIG interviewed stated that it was primarily the actions of San Diego County entities, not the VA facility, that resolved the drug crisis.[64]

VA Facility Personnel Did Not Adequately Enforce VVSD Staffing Requirements in FY 2021 and FY 2022

VVSD faced difficulties in early 2021 maintaining the 15:1 ratio of veterans to case managers required by its grant. In April 2021, VA facility director 1 notified VVSD by letter of its failure to maintain this ratio. VVSD responded by requesting permission to revise its staffing plan, including by increasing staff hours committed to GPD work, in order to reduce the veteran-to-case manager ratio. The response also asked to consolidate two program director positions into one, which in VVSD's view would better integrate its GPD housing models. Facility coordinator 1 apprised the VISN homeless coordinator and NPO staff of VVSD's staffing issues throughout April and May 2021. The NPO approved VVSD's request as a "change of scope" in June 2021.[65]

Although VVSD promised it would increase staff hours devoted to GPD work, a facility liaison noted in early July 2021 that VVSD had not done so, telling facility coordinator 1 that staffing "remains a serious concern." The liaison also explained that VVSD still had open positions for executive leaders and program managers, who supervised case managers. The liaison described the effect of VVSD's staff shortages on veteran care and safety:

> We are struggling to meet the needs and house the frail elderly veterans that we have had in [the service intensive housing model] for several months. These veterans have many doctor's appointments, frequent ER visits and some have been hospitalized at least twice during program tenure. These veterans need higher level of care that we cannot find anywhere. VVSD management does not seem to grasp that they are not prepared or staffed to handle this endeavor. This is a disservice to veterans and staff.

[63] According to a California Health and Human Services Agency Department of Health Care Services report on the incident, a VVSD resident admitted to using drugs with the decedent the day prior to the death, and fentanyl was located in the decedent's room. Additionally, as previously noted, VA facility director 2 was the facility's chief of staff, who served as acting VA facility director until a permanent replacement was appointed in January 2023.

[64] Another California Health and Human Services Agency Department of Health Care Services investigative report showed that in October 2022, a resident reported that a Drug Medi-Cal resident died of a suspected drug overdose.

[65] GPD policy requires the NPO to review requests like this one to change the scope of the grant. VHA Directive 1162.01, p. 5. According to GPD policy, a change of scope is "a request submitted by a GPD grantee to change specific programming listed in their original grant application," including "services provided, staffing, admission or discharge criteria." VHA Directive 1162.01, p. 1. NPO staff advised facility coordinator 1 that whether to impose an admissions hold to address the concern was a "local decision" but that the NPO team believed it made sense to await the completion of the change of scope process first.

According to facility coordinator 1, VA facility director 1 signed a letter to VVSD instituting an admissions hold due to staffing issues in mid-August 2021, but facility coordinator 1 did not send it because VVSD provided a case management coverage plan "at the 'last minute.'" Facility coordinator 1 informed the VISN homeless coordinator and NPO staff in July and August 2021 of VVSD's struggle to implement the change of scope, and updated them as she and the liaisons considered and then rejected imposing an admissions hold.

A similar pattern followed in August and September 2021. In August 2021, the social work chief reported to VA facility director 1 that VVSD was "continually losing" staff and "will likely be placed on an admissions hold in the near future due to staffing." Later that month, VA facility director 1 signed a second letter halting new admissions and citing VVSD's failure to fully implement its updated staffing plan, including vacancies in key positions and a failure to keep the required veteran-to-case manager ratio. However, facility coordinator 1 did not send the letter to VVSD. Later in September 2021, a facility liaison informed facility coordinator 1 that she wanted to discuss "chart reviews" because she had "many worries on the [clinical treatment] side about the services [VVSD] [is] providing given they are so short staffed and things are chaotic." In September 2021, VA facility director 1 sent a letter requesting that VVSD correct its staffing deficiencies, but the letter did not include a hold on new admissions. According to a contemporaneous email written by facility coordinator 1, a hold was unnecessary at that time because "case management coverage plans remain adequate and we have no immediate safety concerns."[66]

In its response to the September 2021 letter, VVSD stated that it was trying to hire staff and did not dispute that it had multiple open positions that the grant required it to fill, including positions responsible for clinical care. In mid-October 2021, a VVSD employee informed facility liaisons that VVSD case managers in one housing model were "well over the 15 caseload that they should have." Nonetheless, with the approval of facility coordinator 1, a liaison informed VVSD in late October that its response "resolve[d] the request for corrective action."

Staffing Issues Continued in 2022

VA annual inspection forms from November 2021 indicated that VVSD had "adequate staffing." But in late December 2021, a liaison told facility coordinator 1 that the level of turnover among case management staff was "really concerning" and that "they have veterans that they can't support." Between late January and the end of March 2022, VVSD gained and then lost several

[66] Facility coordinator 1 told the OIG that she did not remember a specific discussion with the social work chief related to not sending August 2021 letters with admissions holds or the inadequacy of VVSD's coverage plans but claimed that she would have done so pursuant to her ordinary practice. She stated that she did not communicate directly with VA facility director 1 and did not know whether the social work chief informed VA facility director 1 that his August 2021 letters implementing admissions holds were not sent.

case managers and voluntarily placed itself on an "unofficial hold" to pause admissions to its GPD housing.[67]

In March 2022, during VVSD's self-imposed admissions hold, a facility liaison informally drafted a staffing plan for VVSD. This liaison noted that the VA facility could later request a corrective action plan but was not doing so at the time "largely due to [VVSD's] open communication."[68] VVSD replied to the facility liaison's staffing plan with its own proposed plan. A liaison told facility coordinator 1 in March 2022 that VVSD's case managers lacked internal support from VVSD and were "spread very thin." The liaison observed, "It is sad because if it affects the staff, it trickles down to the veterans."

The facility liaisons quickly realized the new staffing plan and unofficial hold were not sufficient. VVSD said in its March 2022 proposed staffing plan that it would authorize overtime for case managers, but a VVSD case manager told a liaison that she was burned out and did not want overtime. Another liaison reported that each case manager she oversaw was "beyond cap" and her clients who "require lots of involvement . . . are not feeling safe." One of the liaisons called VVSD's staffing issues "extremely concerning." This liaison told the OIG team that even though claiming to informally limit its own admissions, VVSD would in actuality assign case management duties to program managers or, when reporting ratios, omit veterans soon to be discharged.

VVSD's quarterly compliance review in April 2022 confirmed that it operated above the veteran-to-case manager ratio required by the grant. The resulting report tied the staffing shortages to several cited deficiencies. The deficiencies identified in the report included inadequate clinical treatment planning and documentation, drug use and drug selling, and VVSD's poor performance metrics.[69] The report requested a plan to address staffing shortages. In early May 2022, facility coordinator 1 informed the social work chief "that VVSD did make improvements in the staffing/coverage plans."

However, VVSD's changes caused other problems. A liaison informed facility coordinator 1 in late June 2022 that, in order to meet the 15:1 case management ratio, two VVSD program managers were carrying "significant" case management caseloads in addition to their other

[67] The hold was "unofficial" because it was voluntary—not imposed by VHA.

[68] Facility coordinator 1 expressed a similar view when speaking with the OIG team, noting that if VVSD was communicating regarding case management coverage plans, the issue would likely not result in required corrective action. Corrective action could later be mandated depending on the circumstances, including whether particular services were not being provided or the amount of time that had elapsed since the issue first arose.

[69] Performance metrics for GPD grantees providing transitional housing included making sure veterans obtained employment and permanent housing and avoided "negative exits"—that is, discharges from the program for rules violations, failure to comply with program requirements, or leaving without consulting staff. VA GPD Grant Recipient Guide, *Fiscal Year 2023 Transitional Housing Grants (Per Diem Only Models, Special Need, Transition in Place)*, pp. 20–21.

duties, hampering their ability to oversee case managers.[70] Also, the improvements facility coordinator 1 had cited in May were short-lived. VVSD's former senior director for transitional housing told the OIG that after VVSD's chief operating officer resigned in early July 2022, VVSD's chief executive officer "would frequently push" to overload case managers with "more cases than they were equipped to manage and more than were allowed within the grant." According to a liaison, the July quarterly compliance review revealed "serious problems in late or missing treatment plans" along with clinical notes "missing pertinent information," and blamed case managers "being overwhelmed with caseloads . . . as well as case managers needing training."[71] The liaison asserted that the caseload issue was "in progress of being addressed" due to patient discharges and new hires. Facility coordinator 1 had made the same claim in June 2022.

Staffing Issues Led VHA to Impose an Admissions Hold in Fall 2022

In August 2022, facility coordinator 2 informed her predecessor that "staffing at VVSD is a mess," and said VVSD was potentially losing case managers.[72] She wrote, "we have gone above and beyond to support them and 19:1 ratios on east campus is not acceptable."[73] Once again, the facility liaisons requested, and VVSD provided, a new staffing plan intended to reduce the veteran-to-case manager ratio.

Concerns about the effects of the staffing shortage continued to mount. At the end of August, facility coordinator 2 informed NPO staff of "serious concerns" that veteran-to-case manager ratios were too high, resulting in veterans not seeing case managers until two to three weeks after admission at VVSD, liaisons experiencing "extreme difficulty" in reaching VVSD to work on clinical issues, and failure by VVSD to report critical incidents to VHA. Facility liaisons also noted that due to the staffing shortage, VVSD was not conducting bed checks or notifying liaisons when veterans left VVSD and did not return. In one instance, a veteran was missing from VVSD for three days before liaisons were notified, which a liaison called "an alarming safety concern." Facility coordinator 2 noted that "the gaps of services . . . were extreme."

The VA facility's approach to staffing compliance at VVSD appeared to change in fall 2022. The facility liaisons told VVSD on September 1, 2022, that they could not accept its new staffing plan. After consulting NPO staff, the liaisons gave VVSD one week to correct the staffing issues

[70] Facility coordinator 1 told investigators it was acceptable in the short term to assign case management duties to program managers and could not recall an instance in which this detracted from their other duties.

[71] The report for this compliance review detailed the issues with treatment plans and clinical notes but did not attribute them to case managers being overwhelmed or mention a need to hire more case managers.

[72] As noted previously, this individual served as a liaison, then the acting facility coordinator as of August 2022, then the permanent facility coordinator as of January 2023. As of September 2024, facility coordinator 2 remained the facility coordinator.

[73] The reference to "east campus" here meant the nonclinical treatment housing models at VVSD.

or face an admissions hold. The social work chief also informed VA facility director 2 of VVSD's staffing shortages and their consequences.

On September 12, facility coordinator 2 announced an immediate admissions hold, telling VVSD staff that a letter from VA facility director 2 was forthcoming. Over the next month, VVSD hired a new chief operating officer, transferred case managers to GPD from a non-VA program, submitted a new staffing plan, and instituted additional staff trainings. The liaisons noted substantial improvement in the completeness of VVSD's clinical chart documentation during this period. In October 2022, the VA facility lifted the admissions hold.

Numerous Factors Hampered Oversight of VVSD and Reveal Opportunities for Improvement

VHA had tools available to help ensure veterans at VVSD were safe and received quality services, yet, during the OIG's review period, responsible VA facility staff generally did not take timely or effective action to correct the issues at VVSD. The OIG found this stemmed from several interrelated factors, including failing to

- use available enforcement measures promptly, such as instituting admissions holds;
- ensure lasting, effective corrective actions;
- apply correct criteria when determining whether to require or merely suggest corrective actions for inspection findings; and
- obtain information about oversight of the Drug Medi-Cal residents at VVSD.

In addition, facility staff lacked meaningful regional oversight support from the VISN homeless coordinator, and NPO guidance could be improved in several key areas, such as how to classify compliance issues, when to deploy certain enforcement measures, and how to address recurrent compliance concerns.

VA facility staff involved in overseeing VVSD's GPD operations told the OIG that several issues influenced their approach to VVSD, such as a desire to keep VVSD available as a service provider under VHA's "Housing First" approach to combating homelessness, even during periods of risk to veteran care and services; the difficulties of serving a vulnerable population with many co-occurring needs; concerns about the lack of authority over VVSD residents funded by Drug Medi-Cal; and the effect of the COVID-19 pandemic on staffing. The OIG recognizes these challenges, but while these circumstances may require a strategic approach to oversight, they do not justify tolerating serious risks to veteran health or safety. In the sections that follow, the OIG details how oversight efforts might be improved to meet future GPD program challenges.

An Admissions Hold Was Not Promptly Used to Address Safety Risks While Focusing on Continuing Operations

Despite the documented risks to veterans' safety due to drug use and dealing at VVSD and to the quality of the care they received, the VA facility did not impose an admissions hold to address the FY 2022 drug problem at VVSD.[74] Federal regulation, however, required VHA to make certain that GPD grantee facilities are free from illicit drug use that could threaten resident health or safety.[75] In an interview with the OIG team, facility coordinator 1 pointed to measures that had been put into place to address individual incidents, such as removing paraphernalia found in a GPD participant's possession. When asked about the email from the San Diego County Veterans Treatment Court judge expressing concern about an overdose and for the "safety and welfare" of VVSD residents in April 2022, facility coordinator 1 indicated that the information was either not new or was being addressed through an upcoming as-needed security inspection. This approach failed to reflect a sense of urgency in addressing the evidence of serious drug problems at VVSD, which called for more proactive interventions to mitigate the risk of harm.

Similarly, with respect to staffing issues, facility coordinator 1, the liaisons, and VA facility director 1 were aware in 2021 and 2022 that requesting serial corrective action plans was not producing sustainable results. However, there was no admissions hold linked to staffing issues until September 2022, after news articles had been published and a member of Congress had questioned VVSD's capacity to provide safe, effective services. The September 2022 admissions hold was based in part on "concern that staffing shortages are impacting delivery of services for Veteran care and safety," and came a year and a half after facility staff began raising concerns.[76]

A facility liaison and the social work chief told the OIG that, in general, they sought to avoid imposing admissions holds so that veterans could continue to receive services. VA facility director 1 told investigators that VVSD was a "large service provider" in San Diego and that "it was in our interest to have them succeed, as opposed to simply cut [VVSD] off or cut veterans off from the ability to see them." He added, however, that "at some point I think you have to

[74] As previously discussed, GPD policy allows the VA facility director to halt new admissions "if needed to ensure the safe operation of the GPD grant." VHA Directive 1162.01, p. D-2. The OIG asked VA facility officials about discussions around the decision not to issue an admissions hold due to drug concerns. Facility coordinator 1, the social work chief, and the associate director of patient care services did not have specific recollections about such a discussion, although facility coordinator 1 indicated it would be part of her ordinary practice to discuss the issue with her superiors. VA facility director 1 said that he believed the issue of an admissions hold due to illegal drugs at VVSD came up with the social work chief, but he did not receive a recommendation to implement one.

[75] 38 C.F.R. § 61.80(b)(14).

[76] The September 2022 admissions hold was also incomplete; facility coordinator 2 told VVSD it could admit any veterans that liaisons had already vetted. VA facility director 2 told the OIG that admitting veterans to VVSD and implementing an admissions hold "seem to contradict each other . . . because if you say we're doing an immediate hold, then why would you say if a veteran chooses, he or she could go?"

decide to pull the plug on programs like that that are challenged in meeting programmatic requirements."

Facility coordinator 1 also said VHA's "Housing First" model for delivering services to veterans experiencing homelessness influenced oversight of VVSD.[77] VHA policy prefers the use of transitional housing "to minimize the time a Veteran spends on the streets or in shelter."[78] The NPO has explained that the goal of a Housing First approach is "to establish permanent housing while providing for the safety of staff and residents."[79]

VA facility director 1 told OIG investigators that a Housing First approach increased the risk that there would be individuals at VVSD who were not committed to sobriety or to program rules or goals. Similarly, facility coordinator 1 stated that a Housing First approach meant it was "not uncommon for there to be instances of substances in transitional housing programs . . . even in locked settings." She also told investigators that the "greater directive" for her as facility coordinator was to "get veterans off the street, keep them as safe as possible, and get them into permanent housing." Facility coordinator 1 observed that grantees "are tasked with significant work to do with veterans and other clients who are incredibly ill and they're facing a system that is not set up to make it easy to get housing, and treatment, and employment, and it's a big job." Similarly, the complainant told OIG investigators that their concerns emanated in part from the fact that veterans at VVSD "are people who are off the street and some of them [have] decades of alcohol and drug use, so they're very fragile and they're very vulnerable and they need support."

The OIG recognizes the challenges in overseeing care for a vulnerable population with many co-occurring housing, employment, and treatment needs. However, while VA facility staff emphasized that veteran care and safety came first, their actions throughout FYs 2021 and 2022 reflected a more lenient approach to upholding the requirements of federal law and regulation, VA policy, and VVSD's grant.

Guidance on Enforcement Measures Could Be Strengthened

The OIG also identified opportunities to improve national guidance for local staff tasked with determining when to halt admissions to a grantee or undertake other enforcement measures. As previously stated, GPD policy says that a facility director may impose an admissions hold "if needed to ensure the safe operation of the GPD grant" and that it is "acceptable" to remove a veteran from a GPD program immediately "for issues involving patient safety."[80] Yet, the policy

[77] VHA Directive 1501, p. B-5.

[78] VHA Directive 1501, p. B-5.

[79] VA GPD, "Grant & Per Diem (GPD) Program," p. 2.

[80] VHA Directive 1162.01, p. D-1–D-2. NPO training materials add that the safety issue must be an "acute safety concern."

does not specify when admissions holds or veteran removal are required or describe the circumstances under which they are appropriate.[81]

The NPO director told the OIG team that in overseeing grant compliance, "every scenario cannot be spelled out word for word" in regulations or policy and noted that VA facility staff must exercise professional judgment to address diverse circumstances. The social work chief and associate director of patient care services told the OIG that, in general, they deferred to frontline facility staff in assessing VVSD's grant compliance. VA facility director 1 said that the decision to implement an admissions hold was, in his experience, deferred to the facility coordinator and liaisons; he could not recall an instance in which he did not follow their recommendation as to an admissions hold or other steps. While discretion may be an appropriate feature of decision making on these issues, more robust guidance as to the proper deployment of admissions holds and other enforcement measures may help these frontline facility staff efficiently address risks to the health and safety of veterans receiving services from GPD grantees.

VA Facility Staff Did Not Enforce Long-Term Corrective Actions

Staffing problems at VVSD persisted throughout 2021 and 2022 in part because VA facility personnel failed to enforce plans for lasting corrective actions. On at least five occasions between April 2021 and August 2022, the VA facility asked VVSD to submit a new staffing plan. These requests were made in response to VVSD staffing levels being consistently below those required in the grant. In each instance, VVSD either petitioned the NPO to change the staffing requirements of the grant, submitted a staffing plan but failed to fully implement it, or denied that vacant positions were problematic. VA facility director 1 told the OIG that the facility gave VVSD "a little bit more grace than we might have other organizations," which meant "we tended to believe that they were going to do what they say they were going to do, even when it took them longer to do those things than it might be necessary."[82] Taken separately, individual decisions not to take stronger steps to enforce the staffing-related terms of VVSD's grant may have seemed reasonable at the time, particularly given the staffing difficulties during the pandemic. However, with the advantage of looking back over time, the OIG team determined GPD residents at VVSD were at risk for more than a year and a half largely due to lack of effective remediation.

Several VA facility personnel told the OIG team that the COVID-19 pandemic hindered VVSD hiring and retention efforts, but also said that GPD requirements still needed to be enforced. The facility's social work chief and facility coordinator 1 confirmed to the team that the pandemic created staffing shortages. VA facility director 1 also noted to the team that the pandemic

[81] VHA Directive 1162.01, pp. D-1–D-2.

[82] Likewise, when speaking with OIG investigators, facility coordinator 1 called the veteran-to-case manager ratio dictated by the grant a "goal" that could be changed in the short term by facility liaisons as VVSD addressed staffing shortages.

exacerbated understaffing in homeless and other healthcare programs. He maintained, however, that GPD programmatic or contractual expectations did not change. In an August 2021 letter to VVSD, he wrote that VHA understood the staffing challenges created by the pandemic, but "it remains important that the VA is able to confirm that adequate staffing and/or staff coverage is provided by VVSD to ensure the physical safety and clinical care of the Veterans served." Although the pandemic created staffing shortages for VVSD, responsible officials at the VA facility understood their duty was to see that veterans in VVSD's care received adequate services in a safe environment.

National guidance also could be improved on how to address persistent compliance concerns like the staffing issues at VVSD. The only reference to recurrent compliance issues in GPD guidance came from an NPO training presentation for facility liaisons, which advised that if a concern was one that could be addressed and then become deficient again in short order, liaisons should request a policy and plan as part of a corrective action request to hold the grantee accountable for long-term change. Despite this advice, during the investigative review period VA facility staff accepted successive promises of corrective action from VVSD for over 18 months. Greater guidance on how to make sure compliance issues are addressed in a sustainable way would help facility staff fulfill their obligation to protect veterans and uphold the quality of care.

VA Facility Staff Misapplied Terminology for Required versus Suggested Corrective Actions

The challenges to VVSD oversight were further complicated by facility staff's confusion regarding formally reporting and enforcing corrective actions. Specifically, there was a misunderstanding among VA facility oversight staff about the definitions of the terms "deficiency" and "best practice recommendation." GPD policy defines a deficiency as "any items that are identified as problematic or in non-compliance," which *must* be addressed.[83] By contrast, best practice recommendations are *suggestions* meant to "improve service delivery" but are not mandatory.[84]

VA facility staff interviewed by the OIG team, including liaisons, facility coordinators 1 and 2, and inspectors, said that in classifying concerns, they considered factors such as the urgency or seriousness of the problem, whether it was repeated or part of a pattern of issues, the problem's impact on grantee operations, how long the problem existed, and whether the solution was long-term or easy.[85] The NPO director explained that "there is a degree of reasonableness" that local staff can exercise in determining whether an issue constitutes a deficiency. GPD policy, however, does not reflect this level of discretion. Rather, issues that rise to the level of

[83] VHA Directive 1162.01, pp. C-1–C-2, D-1.

[84] VHA Directive 1162.01, p. 7.

[85] In a later interview with the OIG, facility coordinator 1 denied that the time or expense of remediation would influence the classification decision; instead, they would inform the expected time frame for remediation.

noncompliance with inspection checklist items, GPD regulations, or the grant must be fixed.[86] More robust guidance on classifying inspection findings would aid frontline staff tasked with making these determinations.

This inconsistency between practice and policy affected oversight of VVSD. For example, with respect to staffing, although VVSD was repeatedly failing to meet its obligations under the grant, the evidence shows that liaisons and facility coordinator 1 declined to cite this as a deficiency that would have triggered required and formal corrective action. Instead, they exercised discretion to credit VVSD's "open communication" as a reason not to cite the repeated deficiency, which had the effect of permitting the failure to persist.

Similarly, with respect to drug use and dealing, according to the security inspector, after the May 2022 as-needed security inspection, facility liaisons advised her that findings should be classified based, at least in part, on consideration of the time and expense required to address the issue and whether VVSD had shown progress in doing so. The inspector understood this focus to come from a desire to ensure residents were able to stay at VVSD "as long as they were doing good and they had the ability to fix" bigger items. While the inspector agreed with the classification decisions communicated to VVSD, basing them on this rubric meant that VVSD was not required to undertake physical changes to the campus perimeter or security camera coverage because these upgrades were classified as best practice recommendations.

As previously explained, the facility liaison who sent the inspector's findings to VVSD told investigators that VHA could prescribe the required outcome—a safe environment—but could not dictate VVSD's method for accomplishing it. The NPO director offered a similar view, telling OIG staff, "what the medical center is citing as the deficiency is not a fence deficiency, it's a safety deficiency. Safety is an inspection item." Even accepting that argument, the evidence is inconclusive as to whether VA facility staff ensured that VVSD successfully addressed safety concerns—as it is unclear whether VVSD actually implemented improved security rounding and logging procedures as a substitute for increased camera coverage at the time the follow-up on the May 2022 inspection had ended.

Facility Staff Incorrectly Believed They Could Not Address Non-GPD Residents' Drug Dealing and Lacked Access to Information

The evidence supports that drug issues at VVSD were in large part caused by residents funded through the state's Drug Medi-Cal program—not the GPD program. Veterans complained that Drug Medi-Cal residents targeted them for drug sales, and VA facility staff had concerns about the potential risk posed by Drug Medi-Cal residents. This circumstance highlighted two issues: concerns about oversight authority regarding non-GPD VVSD operations and lack of

[86] VHA Directive 1162.01, pp. C-1–C-2, D-1.

information-sharing about non-GPD operations at VVSD. The current and former NPO directors told the OIG that it was not uncommon for GPD- and non-GPD-funded residents to share space at other grantee facilities. Similarly, facility coordinator 2 indicated that "a lot of our community partners . . . have many, many different contracts with different organizations in addition to the VA because that's how they survive."

Facility coordinators 1 and 2 expressed the view that they had limited ability to intervene with respect to conduct by VVSD's Drug Medi-Cal residents. Facility coordinator 2 told the OIG team,

> The struggle on the [clinical treatment] side was not with the veterans, but there was a big concern that the Drug Medi-Cal contract had individuals who were not treatment focused and who were the primary source of bringing drugs onto campus, and we had no authority over them. So they were impacting the space of veterans, but we had no direct access.

But facility staff did have the capability to address non-GPD operations at VVSD when they compromised GPD resident care and safety. The associate director of patient care services and social work chief acknowledged in OIG interviews that non-GPD participants could create risks to GPD residents that VHA should address. Likewise, the NPO director told the OIG team that a drug overdose at a grantee site, even if not among the GPD-funded population, was a "significant issue" and that she would expect oversight staff to then engage with the grantee to ensure the veterans there are safe and could undertake additional as-needed inspections. VA facility staff could have used corrective action requests or other measures to get VVSD to develop a plan to address drug dealing and risks to GPD residents' safety caused by co-located non-GPD residents that affected compliance with federal regulation safety provisions.[87]

To bolster its ability to address the conduct of co-located non-GPD residents at VVSD, the VA facility would have benefited from VVSD providing information about adverse health or safety events involving co-located residents and the related activities of state and county entities overseeing non-GPD operations at VVSD (such as authorities monitoring Drug Medi-Cal funding for residential substance use treatment). There was nothing in GPD policy on developing such a mechanism, and VVSD's grant agreement did not require disclosure to VA of information on interventions related to non-GPD residents engaged in drug dealing or creating unsafe conditions. Yet, GPD regulation already prescribes a similar process: grantees must disclose sentinel events, including drug overdoses, deaths, and injuries, occurring within the GPD program at a grantee site, and both the NPO director and facility coordinator 2 told OIG staff that information about those types of events occurring among non-GPD residents at a grantee facility

[87] 38 C.F.R. §§ 61.33(b), 61.65, 61.80(b)(14); VHA Directive 1162.01, pp. D-1–D-2.

would be useful in assessing whether there are risks to veterans or additional safety measures are needed.[88]

Facility coordinator 1 confirmed that she did not have a formal, established method for information-sharing with non-GPD programs about their oversight at VVSD, nor did she employ informal methods to do so. Facility coordinator 2 told investigators that VVSD was not obligated to share information on sentinel events occurring among non-GPD residents, and she only heard informally about incidents involving non-GPD residents and about other oversight entities' responses to such incidents. There was no such information-sharing requirement under the terms of the grant or VA policy. Facility coordinator 2 told the OIG team that she developed contacts at state and county oversight agencies only as of September 2024.

In sum, the OIG found nothing in GPD policy that precluded VA facility staff from reaching out to other entities overseeing GPD grantee operations or asking VVSD to do so. However, facility coordinator 1 and the NPO director told the OIG that residents' privacy rights could affect what information could be shared. Facility coordinator 1 stated that when she heard other referral sources were taking action at VVSD, the liaisons would "go and see what [they could] get." Asked by investigators whether she ever saw inspections reports from entities overseeing Drug Medi-Cal residents at VVSD, facility coordinator 1 said no. Without timely, credible information about non-GPD operations at a grantee facility, the VA facility's ability to protect GPD residents was limited. To the extent privacy restrictions permit, information-sharing concerning non-GPD safety and security operations at VVSD would significantly assist facility oversight to promptly mitigate risks to GPD residents.

The VISN Homeless Coordinator Did Not Meaningfully Participate in Oversight

The OIG found that the VISN homeless coordinator misunderstood her role under GPD policy with respect to corrective action plans and did not provide meaningful support to facility staff. The VISN coordinator's responsibilities include "reviewing VA medical facilities' correction plans that have been developed as a result of inspection deficiencies identified with GPD grantees and tracking follow-up activities associated with the deficiencies to ensure compliance with the procedures" related to addressing such deficiencies.[89] However, the responsible VISN homeless coordinator told the OIG she never provided input on the content of a corrective action plan for any grantee. With respect to VVSD, she told investigators that she "was not involved" in the development of a proposed corrective action plan related to staffing in May 2021 and was only copied "for awareness." She made a similar claim about a September 2022 corrective action request also related to staffing, stating that she could not recall being involved in discussions or

[88] 38 C.F.R. § 61.80(n).

[89] VHA Directive 1162.01, p. 5.

providing guidance at that time and was included on emails for awareness. The belief that the VISN homeless coordinator was merely required to maintain awareness of corrective action plans, without having any substantive role, was inconsistent with policy requirements and represented a missed opportunity to sharpen corrective action plans for VVSD's recurring problems. One OIG recommendation in this report is for a mechanism to ensure that persistent or recurrent compliance concerns are effectively remediated. Considering the VISN homeless coordinator's responsibilities and access to facility-level information, this official could have a more active role in GPD policy to enhance corrective plan formulation and oversight.

An OIG Limited Review of VHA Oversight at VVSD through September 2024 Showed that Similar Compliance Issues Have Recurred

The OIG conducted a limited review of events that occurred through September 2024 to determine whether any of the compliance issues from FY 2021 and FY 2022 recurred or persisted. This limited review also was responsive to concerns raised by veterans to VA in a July 2024 open letter detailing conditions at VVSD, including drug use and lax security. In addition, on July 30, 2024, *inewsource* reported that a Drug Medi-Cal resident died on VVSD property from a fentanyl overdose in March 2024.[90]

The OIG review team determined that shortly after the March 2024 overdose death, facility coordinator 2 informed a liaison that a GPD-funded veteran was discharged from VVSD for possessing alcohol, and she noted a concern that this veteran was using drugs with or providing drugs to a Drug Medi-Cal resident who overdosed on fentanyl. In addition, facility coordinator 2 told OIG investigators in September 2024 that she had received a report from a veteran early that month about "predatory behavior," and she stated, "so that's really where my biggest concern is, people bringing substances on site, targeting other people, trying to sell."

The March 2024 overdose death underscored the limitations posed by the lack of information about co-located, non-GPD residents at VVSD. When reporting to NPO and VISN staff in July 2024 that San Diego County may have implemented an admissions hold at VVSD, facility coordinator 2 wrote, "It is challenging for our team because we do not get any formal information about the Drug Medi-Cal Program and can't require it as it is out of our purview, although sometimes we do see or pick up things while liaisons are on campus." In early August 2024, facility coordinator 2 wrote to the VVSD chief operating officer, forwarding the July 2024 *inewsource* article and adding, "From a VA perspective we always ask that any death that occurs on campus at VVSD, whether GPD or [Drug Medi-Cal], be reported to us, for awareness and coordination." He responded, "I was aware of the article and also aware of the

[90] Greg Moran, "A death in March triggers more scrutiny of Veterans Village," *inewsource*, July 30, 2024, https://inewsource.org/2024/07/30/a-death-in-march-triggers-more-scrutiny-of-veterans-village/.

notification process. There have not been any unreported incidents." Facility coordinator 2 told OIG investigators that this standing request for information from VVSD about deaths among non-GPD residents was not enforceable. Further, she told the OIG team that she did not recall receiving notification about the March 2024 death from VVSD around the time it occurred.

Another concern the OIG reviewed for FYs 2021 and 2022, and which remained in the ensuing years, was whether VVSD had adequate security measures in place to protect veterans, such as security patrols and cameras. The FY 2023 annual inspection report for the clinical treatment model at VVSD recommended, "continue to a [*sic*] log of rounds hourly during the day time and every 90 minutes throughout the night time," and the FY 2024 annual inspection report for the VVSD bridge and service-intensive models recommended "adding cameras to the new gym room and day rooms" and for "security guards to log patrols." Facility coordinator 2 wrote to VVSD staff in July 2024 that she needed to review security rounding logs since "a few years ago, there were some physical safety concerns so milieu checks were implemented rather than add additional cameras to campus to account for areas with less visibility." This effort reflects recurrent compliance concerns. Facility coordinator 2 told the OIG team that she asked to review the security logs in July 2024 because "it's just something that kind of has stuck with me as something to be aware of and to ask for, and to pay attention to." She stated, "I think the concern that exists with VVSD is how we make progress, how we hold them accountable to that progress, and then how it backslides."

Finally, VA facility staff continued to address compliance concerns related to staffing at VVSD among case managers and the adequacy of their care for veterans. For instance, in November 2023, one liaison observed of the service-intensive housing model, "most of the case managers are almost maxed out with their caseloads and inherited cases from the [case manager] who left, hence I understand that they are overwhelmed and lacking support." In addition, the VA facility instituted an admissions hold for the bridge and service-intensive GPD housing models at VVSD from early April to early May 2024 due to inadequate case management documentation, including missing assessments and lack of individualized plans and a lack of communication from VVSD on staffing coverage plans. In early August 2024, facility coordinator 2 wrote to VVSD staff to report concerns including, "Liaisons have been recently receiving communication from Veterans that they have difficulty reaching their case manager and case managers are overwhelmed."

In early September 2024, the California Health and Human Services Agency's Department of Health Care Services revoked VVSD's license to operate a residential substance use treatment center as a result of the deaths in recent years and licensing violations.[91] As a result, VVSD discharged its Drug Medi-Cal residents. Facility coordinator 2 said that the license revocation meant that the GPD clinical treatment housing model at VVSD was also shut down. Nonclinical

[91] VVSD's board of directors voted not to appeal the decision.

VVSD transitional housing remained operational. During her September 2024 follow-up interview, facility coordinator 2 told OIG investigators that the license revocation initially caused "massive panic" among the veterans, but in the weeks after the removal of Drug Medi-Cal residents, she heard reports that "things are much quieter, things are much safer" at VVSD and, as a result, her concerns around illegal drugs and staffing shortages had diminished. Facility coordinator 2 told the OIG team that a few veterans chose to leave VVSD following the clinical treatment model closure, but most veterans in that model remained at VVSD and were receiving other forms of transitional housing services. She said that she and her team met with these veterans "as a group multiple times, and then we met with everyone individually" to provide assistance. She told the OIG that her team worked to connect the remaining veterans with alternative substance use treatment services, stating, "any veteran that wanted mental health and substance use services now can access them through VA or any other resource."

The recurrence of similar compliance concerns at VVSD in the years following the OIG's FY 2021–2022 investigative period underscores the opportunity for VHA to improve its oversight of GPD grantees and ensure frontline staff have the tools they need to effectively remediate noncompliance. To learn whether the OIG's recommendations would improve oversight of other GPD grantees, the OIG team asked facility coordinator 2 how the recommendations would affect her oversight work. She indicated that it would be beneficial to receive information on adverse health and safety findings among co-located, non-GPD residents, even if individuals' identifying information were redacted to protect private health information. Further, facility coordinator 2 agreed that she would benefit from more robust guidance on addressing recurrent compliance issues, or greater authority to withhold or recoup funds for periods of repeated noncompliance, as well as additional guidance on how to evaluate and then classify inspection findings as either a deficiency or a best practice.

Conclusion

Grants awarded through VHA's GPD program fund crucial transitional housing and supportive services for veterans experiencing homelessness. VHA must ensure that grantees deliver the services they promise to provide in an environment free from substance use that could threaten veteran safety. VHA has the authority to enforce grantee compliance through appropriate grant terms, regular site inspections, corrective action requests, and admissions holds. In its administrative investigation, the OIG found that VHA's oversight of VVSD was inadequate—particularly in light of the grantee's prolonged and often ineffective responses to facility staff's serious safety and care concerns. In addition, the OIG found the VISN homeless coordinator did not provide adequate regional oversight or support, and national GPD guidance lacked sufficient clarity.

VA facility staff responsible for overseeing VVSD were slow to take enforcement actions when there was an increase in drug use and dealing at VVSD during FY 2022. Despite evidence of risks to veteran safety, the VA facility did not halt admissions during this period, which could

have prevented additional veterans from being exposed to drug-related risks at VVSD. Further, facility staff, in coordination with the inspector, did not require VVSD to implement all the changes that would address identified issues, which appeared to have resulted from staff misunderstanding GPD policy on classifying noncompliance with inspection checklist items. Additionally, throughout FY 2021 and most of FY 2022, facility staff knew that VVSD was struggling to provide the number of case managers its grant agreement required, and that this shortage placed veterans' care at risk. Until September 2022, the facility liaisons and coordinator continued to approve funding for veterans to stay at VVSD in reliance on its serial corrective action plans, which did not produce lasting change. The result was a permissive oversight approach that failed to adequately address persistently unsafe conditions at VVSD. The OIG's limited review for FYs 2023 and 2024 confirmed that similar noncompliance concerns remained or recurred.

The VISN homeless coordinator's lack of substantial involvement in corrective action follow-up at VVSD allowed the VA facility's permissive approach to continue. The NPO also could have provided more specific guidance to help facility staff determine how and when to act. GPD policy includes limited information regarding admissions holds; it explains when a hold is allowed but not when one is required. Likewise, with respect to veteran removal from a grantee, there is no clear guidance on when it is required or advisable. A more robust policy or other direction on when such compliance measures are appropriate or necessary would support facility-level staff efforts to assure grant compliance and veteran safety. Similarly, more detailed training or guidance would benefit future oversight efforts across the GPD program on how to classify grantee compliance issues, including whether and how local staff can exercise discretion. Further, the NPO has the opportunity to enhance policy or procedure for remediating recurrent issues of noncompliance, whether through creating a larger oversight role for the VISN network homeless coordinator in tracking recurrent concerns, a process of escalating enforcement measures for repeated noncompliance, or other methods. It would also be useful for the NPO to explore to what extent information on non-GPD operations affecting the safety and welfare of GPD grantees can be shared consistent with privacy mandates. The OIG has made four recommendations relating to these issues to improve future oversight efforts for VVSD and other GPD grantees. The OIG has also made a fifth recommendation asking the VA facility director to confirm that adequate steps are taken to ensure veterans previously receiving clinical drug treatment at VVSD have the support they need to obtain those services elsewhere.

The OIG recognizes that VHA and VVSD face complex challenges in meeting the needs of veterans who require transitional housing, substance use treatment, and other services. Any decision to halt admissions or otherwise take action against VVSD could have resulted in veterans being excluded from that program without alternatives, particularly for those in need of clinical drug treatment services. In addition, the COVID-19 pandemic hampered VVSD's efforts to meet its staffing obligations. This report demonstrates, however, that when noncompliance compromises veteran care and safety, it must be addressed with suitable corrective action.

Recommendations

The OIG recommends the director of the Grant and Per Diem National Program Office take the following actions:

1. Clarify policies, guidance, and/or training on when admissions holds, removal of veterans from grantee facilities, and the withholding or suspension of per diem payments are appropriate and required.
2. Clarify policies, guidance, and/or training on how facility staff determine whether corrective actions for an identified problem related to a grantee should be required or suggested, including what factors to consider, who makes the final determination, and whether and how the determination is reviewed by others.
3. Implement a mechanism designed to reasonably ensure that VA oversight staff take appropriate enforcement measures to address persistent or recurring deficiencies by a Grant and Per Diem grantee that pose risks to veteran care and safety.
4. Ensure grant agreements require the grantee to promptly disclose to VA any adverse health or safety conditions occurring at any facility where VA-funded participants are receiving service, including the occurrence of sentinel events affecting non-VA-funded participants on the grantee's premises and any adverse health or safety inspection results or similar findings made concerning the grantee's premises or operations by any non-VA oversight entity, such as a federal, state, county, or local regulator.

The OIG recommends that the director of the VA San Diego Healthcare System take the following action:

5. Ensure Grant and Per Diem participants residing at the Veterans Village of San Diego (VVSD) who are eligible for clinical drug treatment receive appropriate support to obtain those services despite the closure of VVSD's clinical treatment housing model.

VA Comments and OIG Response

The under secretary for health, the VISN 22 interim director, and the VA facility director reviewed the draft report and responded by concurring with the OIG's finding and recommendations. Their full responses are published as appendixes B, C, and D, respectively.[92] The OIG confirms that the NPO and VA facility director have provided acceptable action plans and completion timelines in response to the recommendations. The OIG will monitor the implementation of the recommendations until sufficient documentation has been received to close them as implemented.

VA facility staff also provided the OIG with six proposed edits to the report, which were presented as technical comments. Each was accompanied by a statement that the text of the report as written was either inaccurate, lacking context, or inconsistent with another passage in the report. The OIG carefully considered these requests but determined that no changes to the report were warranted. The OIG's report as written addresses the pertinent issues fully, fairly, consistently, and accurately, and the requested changes lack evidentiary support. In the paragraphs that follow, the OIG explains more fully why it declined to make each requested change.

The first requested change focuses on the informal interventions of responsible staff to address the drug issues at VVSD in FY 2022. The OIG did not base its finding on a distinction between informal or formal interventions. Instead, it found that the risks to veteran care and safety occasioned by the drug crisis demanded more immediate and forceful intervention, as detailed in the report. Further, while this requested change also notes that the VA facility security inspector approved VVSD's follow-up actions responsive to the May 2022 ad hoc inspection, the report details why an inaccurate interpretation of VA policy on characterizing inspection findings may have led to the inspector accepting mere policy changes as sufficient in place of physical upgrades. In addition, the evidence was insufficient for the OIG to determine that the security rounding the inspector deemed an acceptable alternative to physical upgrades was performed and documented adequately.

The second requested change claims that there were no improper classifications of inspection findings because applicable regulations and policy do not prohibit the exercise of discretion in this endeavor. As explained in the report, the language of the policy does not permit staff discretion; it instructs that noncompliance must be deemed a deficiency, which requires correction. Further, this claim of discretionary authority is inconsistent with the NPO's response to the report. In its action plan for this recommendation, the NPO acknowledged that it would provide enhanced guidance and training on this issue.

[92] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—December 11, 2024, through January 17, 2025.

The third requested change asserts that the drug crisis at VVSD in FY 2022 was primarily caused by Drug Medi-Cal residents, and therefore it was appropriate that the actions of San Diego County entities principally led to the abatement of the crisis. However, the report demonstrates that notwithstanding the cause of the surge in drug use and dealing, GPD-funded veterans suffered serious risks to their care and safety during this period, and responsibility for oversight of their care rested with responsible facility, VISN, and NPO staff.

The fourth requested change challenges the OIG's statement that VA facility staff could have used corrective action requests or other measures to address risks to GPD residents caused by co-located non-GPD residents. The OIG's report shows that the requests and other measures VA facility staff used to address the drug crisis were neither timely nor adequate. Moreover, the OIG's statement was made in response to the claims of facility coordinators 1 and 2, in their testimony to the OIG team, that they had limited ability to intervene with respect to conduct by VVSD's Drug Medi-Cal residents. The team explained why they were mistaken, since they have responsibility to ensure grantees protect veteran care and safety, whatever the source of the risk.

The fifth requested change claims that contrary to the OIG's assertion that concerns around drug use persisted as of September 2024, facility coordinator 2 took immediate action to investigate the report of drug use during that month and did not find evidence of drugs or predatory behavior. The purpose of the OIG's statement was to show that concerns around predatory behavior relating to drug use still existed at VVSD as of September 2024, whatever the outcome in that instance as to the investigation of those concerns. In sworn testimony to the OIG, facility coordinator 2 told investigators that her "biggest concern" was around "predatory behavior" and that she had received a report of such behavior from a veteran at VVSD.

The sixth and final requested change seeks to contextualize facility coordinator 2's email to VVSD in July 2024 about security rounding logs, claiming that it represents continued efforts to maintain compliance. However, the OIG did not impugn facility coordinator 2's efforts to ensure compliance surrounding the logs. The OIG's analysis is based on evidence that concerns about compliance with security rounding procedures have persisted. Indeed, in requesting this change, VA facility staff acknowledged that "VVSD staff turnover created hardships to ensuring compliance was maintained over time." Because such concerns persisted, the OIG found it appropriate to make recommendations for enhancements in policy, guidance, and training to bolster future compliance efforts.

Appendix A: Scope and Methodology

Scope

The OIG opened an administrative investigation in June 2022 to respond to allegations it received of drug dealing and other issues at the VVSD, including VHA's oversight of GPD programs at VVSD. On June 9, 2022, the OIG sent a referral to VA to review the underlying health and safety allegations and to provide awareness to VA officials responsible for taking action to address the concerns. On June 23, 2022, the OIG Office of Special Reviews initiated work on this administrative investigation. The investigation included a comprehensive review of evidence relating to events spanning from 2018 to 2023, primarily focused on FYs 2021 and 2022, and was expanded as described below.

Completion of the administrative investigation was delayed in part due to the unavailability of a key witness from March 2023 through October 2023. Immediately on returning from an extended leave of absence in August 2023, this individual resigned from VA, and thereafter declined to appear for a voluntary interview requested by the OIG. The OIG secured this individual's testimony in October 2023 through the issuance of a testimonial subpoena.

The OIG expanded its scope to include events occurring through September 2024 to determine whether the identified oversight problems had recurred or persisted and was responsive to concerns raised about the overdose death of another Drug Medi-Cal participant at VVSD in March 2024.[93]

Methodology

To evaluate the events in FYs 2021 and 2022, the investigative team collected and examined VA emails, personnel records, records of VVSD inspections and reviews, and documents from VVSD and the California Health and Human Services Agency's Department of Health Care Services. The team also analyzed the grant requirements, applicable federal laws and regulations, as well as relevant VA policies, procedures, and guidance. The team interviewed 24 individuals, including current and former VHA staff at the VA San Diego Healthcare System, VISN 22, and NPO, as well as current and former VVSD employees.

The OIG then performed a limited review of events occurring from September 2022 through September 2024 to determine whether issues related to veteran care and safety had recurred or persisted at VVSD. The OIG assessed inspection reports for FY 2023. The team also examined FY 2024 annual inspections of VVSD, quarterly compliance reviews for the second and third quarters of FY 2024, and email communications from the time periods surrounding the FY 2023

[93] Greg Moran, "A death in March triggers more scrutiny of Veterans Village," *inewsource*, July 30, 2024, https://inewsource.org/2024/07/30/a-death-in-march-triggers-more-scrutiny-of-veterans-village/.

and FY 2024 inspections. This limited review also included additional interviews with facility coordinator 2 and the NPO director.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Investigations*.

The Complaints

On April 24, 2022, the OIG received a complaint that, since fall 2020, the quality of treatment at VVSD had deteriorated "to the point that it is a dangerous environment for veterans and staff. Drugs and alcohol are rampant, drug sales are happening daily, and overdoses happen weekly." In addition, the complainant alleged that staffing shortages among case managers left VVSD out of compliance with its GPD grant. The complainant stated that the lack of case management staff led to "work overload" and meant that case management was only "cursory" due to "time constraints." According to the complainant, "[i]n spite of the risk of serious harm to the veterans, the dangerous living environments, and lack of compliance with the VA GPD contract by VVSD, VA Liaisons continue to place veterans in VVSD's programs."[94]

While the OIG was evaluating the initial complaint, on June 8, 2022, a San Diego news outlet, *inewsource*, published several articles about VVSD detailing allegations of drug use and dealing on campus, as well as concerns with poor food quality, poor sanitation, and a perception that VVSD prioritized filling beds over providing high quality care.[95] One article quoted residents as saying they were regularly offered drugs by others, with a former resident stating that some residents "almost prey on" others.[96] The article described drug overdoses that occurred among VVSD residents in April 2022, including several non-GPD-funded residents and one GPD resident.[97] Another article stated that "a severe staffing shortage has made it difficult to monitor clients' behaviors, which has allowed substance use on the campus to flourish."[98] On June 9, 2022, the OIG referred the underlying complaint regarding health and safety issues to VA officials for review and action. The OIG also received an inquiry on June 13, 2022, from

[94] The complainant reported leaving employment at VVSD in summer 2021 and that some allegations relayed information learned from employees after that departure.

[95] Castellano, "Veterans say renowned rehab program is now a minefield of drug abuse"; Castellano, "Navy SEAL overdoses while seeking help with addiction at Veterans Village"; Castellano, "Spoiled cheese, overflowing toilets: Food quality and sanitation pose 'health hazards' at rehab center"; Castellano, "'That's magic': Veterans fear life-changing rehab center drifting from mission."

[96] Castellano, "Veterans say renowned rehab program is now a minefield of drug abuse."

[97] Castellano, "Veterans say renowned rehab program is now a minefield of drug abuse."

[98] Castellano, "Navy SEAL overdoses while seeking help with addiction at Veterans Village."

Congressman Mike Levin on what oversight or investigative actions would be taken in light of the reporting on VVSD.[99]

[99] At the time of this inquiry, Congressman Levin was serving as the chairman of the Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs.

Appendix B: Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: January 13, 2025
From: Under Secretary for Health (10)
Subj: Office of Inspector General (OIG) Report, Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego (VIEWS 12567739)

To: Assistant Inspector General for Special Reviews (56)

1. Thank you for the opportunity to review the report on Ensuring Grantee Compliance with Veteran care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego. The Veterans Health Administration concurs with the recommendations and submits the attached action plan.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [redacted].

Original signed by:
Shereef Elnahal M.D., MBA

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report, Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego

(OIG Project Number 2022-03076-SR-0009)

Recommendation 1: Clarify policies, guidance, and/or training on when admissions holds, removal of veterans from grantee facilities, and the withholding or suspension of per diem payments are appropriate and required.

VHA Comments: Concur. The Veterans Health Administration (VHA) Grant and Per Diem national program office (GPD NPO) will propose revisions to VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program*, to reflect the responsibility to halt admissions, remove Veterans from grantee facilities, and withhold or suspend per diem payments. Policy revisions will be routed through the VA policy concurrence process and once approved by the Under Secretary for Health will be communicated to stakeholders (e.g., network directors, medical center directors, impacted supervisors, GPD liaisons, network homeless coordinators). The GPD NPO will provide updated training and guidance to stakeholders to accompany the updated policy.

Target Completion Date: June 2025

Recommendation 2: Clarify policies, guidance, and/or training on how facility staff determine whether corrective actions for an identified problem related to a grantee should be required or suggested, including what factors to consider, who makes the final determination, and whether and how the determination is reviewed by others.

VHA Comments: Concur. The VA GPD NPO will work with VHA stakeholders (e.g., impacted supervisors, GPD liaisons, network homeless coordinators) to develop and implement enhanced controls, such as guidance and training for medical facilities on how facility staff determine whether corrective actions for an identified problem should be required or suggested. Trainings will be documented when they are completed, and recordings will be accessible on demand through the GPD SharePoint site.

The VA GPD NPO will propose revisions to VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program*, to reflect who makes the final determination regarding required corrective actions and how the determination is reviewed by others.

Target Completion Date: June 2025

Recommendation 3: **Implement a mechanism designed to reasonably ensure that VA oversight staff take appropriate enforcement measures to address persistent or recurring deficiencies by a Grant and Per Diem grantee that pose risks to veteran care and safety.**

VHA Comments: Concur. The VA GPD NPO will propose revisions to VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program*, to reflect the responsibility to report and address persistent or reoccurring deficiencies by a GPD grantee that pose risks to Veteran care and safety. The VA GPD NPO will provide updated training and guidance to stakeholders (e.g., network directors, medical center directors, impacted supervisors, GPD liaisons, network homeless coordinators) to accompany the updated policy.

Target Completion Date: June 2025

Recommendation 4: **Ensure grant agreements require the grantee to promptly disclose to VA any adverse health or safety conditions occurring at any facility where VA-funded participants are receiving service, including the occurrence of sentinel events affecting non-VA-funded participants on the grantee's premises and any adverse health or safety inspection results or similar findings made concerning the grantee's premises or operations by any non-VA oversight entity, such as a federal, state, county, or local regulator.**

VHA Comments: Concur. The VA GPD NPO will revise future grant agreements to include a requirement for grantees to report to the VA GPD liaison any sentinel, serious, or other critical incidents impacting VA-funded participants or occurring at a facility where VA-funded participants are receiving services, including the occurrence of these types of events affecting non-VA-funded participants on the grantee's premises. Additionally, grantees must report any adverse health or safety inspection results or similar findings made concerning the grantee's premises or operations by any non-VA oversight entity, such as a federal, state, county, or local regulatory body. In the interim, to inform all grantees of this reporting requirement the VA GPD NPO will update grant recipient guides to reflect this expectation.

Target Completion Date: June 2025

Recommendation 5: **Ensure Grant and Per Diem participants residing at the Veterans Village of San Diego (VVSD) who are eligible for clinical drug treatment receive appropriate support to obtain those services despite the closure of VVSD's clinical treatment housing model.**

VHA Comments: [VA San Diego to provide response; see Appendix D]

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 30, 2024
From: Interim Director, Desert Pacific Healthcare Network (10N22)
Subj: Administrative Investigation—Ensuring Grantee Compliance with Veteran care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego

To: Assistant Inspector General for Special Reviews (56); Executive Director, Office of Integrity and Compliance (10OIC)

1. Veterans Integrated Services Network (VISN 22) appreciates the opportunity to work with the Office of Inspector General (OIG) Office of Special Review as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the findings and recommendation of OIG draft report, Administrative Inspection—Ensuring Grantee Compliance with Veteran care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego.

2. Should you need further information, please contact the VISN 22 Quality Management Officer.

Original signed by:
Stephanie Young, MHA, FACHE
VISN 22 Interim Network Director

Appendix D: VA San Diego Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: December 30, 2024
From: Director, Department of Veterans Affairs (VA) San Diego Healthcare System (664/00)
Subj: Administrative Investigation—Ensuring Grantee Compliance with Veteran care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego

To: Interim Director, Desert Pacific Healthcare Network (10N22)

1. We appreciate the opportunity to review and comment on the Office of Inspector General draft report, Administrative Investigation—Ensuring Grantee Compliance with Veteran care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego. VA San Diego Healthcare System concurs with the findings and will take appropriate actions as recommended.

2. Should you need further information, please contact the Chief of Quality and Patient Safety.

original signed by:
Frank P. Pearson, DPT, PA-C
Director, VA San Diego Healthcare System

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego
(2022-03076-SR-0009)

Recommendation 5 (VA San Diego HCS): Ensure Grant and Per Diem participants residing at the VVSD who are eligible for clinical drug treatment receive appropriate support to obtain those services despite the closure of VVSD's clinical treatment housing model.

VHA Comments: Concur. VA San Diego Healthcare System is committed to ensuring the Grant and Per Diem (GPD) participants residing at Veterans Village of San Diego (VVSD) who are eligible for clinical drug treatment receive appropriate support to obtain those services, despite the closure of the VVSD clinical treatment housing model. In September 2024, with the closure of VVSD's clinical treatment housing model, VA San Diego Healthcare System implemented several interventions, to include the following:

1. Individualized clinical plans for each Veteran was implemented to ensure continued access to all services, including referrals to VA and community-based substance use treatment. The individual clinical plans for each Veteran were completed on September 30, 2024.
2. VA San Diego Healthcare System staff are on site at VVSD and provide scheduled and ad hoc support services, including referrals to substance use treatment. VA San Diego Healthcare System staff will remain onsite at VVSD, in alignment with GPD Grant cycle.
3. All Veteran clinical plans will be re-reviewed by VA San Diego Healthcare System GPD Liaisons in January and February 2025 to confirm continued access to appropriate support and services.

Monitoring of all the interventions will be reported monthly at the Quality and Patient Safety Council until completion of all the interventions.

Status: In-Progress Target Completion Date: March 31, 2025

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