US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in VA Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes

National Review | **23-02507-210** | **September 11, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a national review to evaluate the alignment of information related to mental health, substance use disorder (SUD), and suicide risk treatment needs within the Veterans Health Administration's (VHA's) Homeless Operations Management and Evaluation System (HOMES) data collection system and electronic health record (EHR).[1] The OIG also assessed homeless program staff's adherence to suicide risk screening procedures and applicable care coordination for patients entering homeless programs.[2]

Approximately 1 in 10 veterans will experience homelessness and seek services from VA homeless programs at some point in the veteran's life.[3] Additionally, veterans with a mental health condition, SUD, or who experienced homelessness are at increased risk for suicide.[4] From 2001 to 2022, the suicide rate among VHA patients with indications of homelessness was greater than those without indications of homelessness.[5] Preventing veteran homelessness and suicide is one objective outlined in the VA strategic plan.[6]

HOMES is designed to track veterans receiving VA homeless program services, is independent of the EHR, and is accessible only by authorized VA homeless program staff. Homeless program staff complete the HOMES Homeless Services Assessment Form Worksheet (HOMES Assessment) after a veteran has been identified as needing homeless program services and the veteran's urgent clinical needs have been met.[7] The HOMES Assessment is completed to determine VA homeless program entry and includes the veteran's demographic information and prompts homeless program staff to document clinical impressions of the veteran's risk of danger

[1] VA documents refer to VA Homeless Programs and VHA Homeless Programs interchangeably. For purposes of this report, the OIG will refer to VA Homeless Programs. "Integrated Operations Platform," VHA Homeless Programs Hub, https://iop.med.va.gov/hub2/hp/index.html. (This site is not publicly accessible.) "VA Homeless Programs," VA, accessed March 7, 2024, https://www.va.gov/homeless/.

[2] Not all veterans who receive VA homeless program services are eligible for VHA patient care. The OIG, thus, uses the term *veteran* to generally refer to veterans who may or may not be receiving VHA services and uses the term *patient* to refer to veterans receiving VHA patient care.

[3] Jack Tsai, Dorota Szymkowiak, and Hind A. Beydoun, "Drug Overdose Deaths Among Homeless Veterans in the United States Department of Veterans Affairs Healthcare System," *Addiction* 120, no. 2 (October 17, 2024): 306–315, https://doi.org/10.1111/add.16689.

[4] VA Office of Mental Health and Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report Part 2 of 2: Report Findings*, December 2024.

[5] VA Office of Mental Health and Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report Part 2 of 2: Report Findings*. VHA defined indications of homeless as a diagnosis related to problems with housing and economic circumstances or social environment.

[6] VA, *Department of Veterans Affairs Fiscal Years 2022-28 Strategic Plan*.

[7] VA Manual, "Homeless Operations Management and Evaluation System (HOMES) User Manual – Phase I," April 19, 2011.

to self, and mental health and SUD treatment needs.[8] Homeless program staff must enter HOMES information into the patient's EHR for VHA staff outside of VA homeless programs to have access to the information.

The OIG conducted EHR reviews of a sample of 200 patients from 86 facilities and all 18 Veterans Integrated Service Networks (VISNs) who had a HOMES Assessment completed between October 1, 2023, and March 31, 2024.[9] The OIG interviewed Homeless Programs Office (HPO) leaders, the 18 VISN homeless coordinators (NHCs), and 36 randomly selected facility homeless program leads.

The OIG determined that homeless program staff did not document the HOMES Assessment in 42 percent (84 of 200) of patient EHRs, which limited access to important clinical information among clinicians outside of VA homeless programs.[10]

VHA requires outpatient mental health staff, including homeless program staff, to complete a suicide risk screening using the Columbia-Suicide Severity Rating Scale (suicide risk screening) at program intake unless a patient has had a documented suicide risk screening within 30 days prior.[11] HPO leaders told the OIG that homeless program staff should complete a suicide risk screening at the time the HOMES Assessment is completed.

The OIG found that 85 percent (170 of 200) of patient EHRs included a suicide risk screening at the time of the HOMES Assessment or in the 30 days prior. Given that individuals are at the highest risk for suicide in the 60 days prior to becoming homeless, the OIG would expect suicide risk screening for all patients in this vulnerable population.

Over 90 percent (17 of 18) of NHCs and facility homeless program leads (34 of 36) told the OIG that if a patient was assessed as a danger to self in the HOMES Assessment, homeless program staff are expected to complete a suicide risk screening. The OIG found that 12 patients' HOMES Assessments indicated the patient was a danger to self. Of those 12 patients, VHA staff failed to complete a suicide risk screening for 1 and completed a suicide risk screening more than a week

[8] VHA Homeless Programs Office HOMES Access Policy 17-01-03, *Homeless Operations, Management, and Evaluation System (HOMES) Access Policy*, October 1, 2023; VA Manual, "Homeless Operations Management and Evaluation System (HOMES) User Manual – Phase I."

[9] VHA is organized into 18 networks defined by specified geographic regions. "Veterans Integrated Service Networks (VISNs)," VA, accessed January 8, 2025, https://www.va.gov/HEALTH/visns.asp.

[10] VHA Homeless Programs Office HOMES Reporting Policy 17-01-07, *Homeless Operations, Management, and Evaluation System (HOMES) Reporting Policy*, October 1, 2023.

[11] VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Minimum Requirements by Setting*, updated May 10, 2023; VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Frequently Asked Questions (FAQ 5.0)*, updated August 14, 2024; The Columbia-Suicide Severity Rating Scale uses "simple, plain-language questions" to determine the presence and severity of suicide risk and the level of support needed. "About the Protocol," The Columbia Lighthouse Project, accessed April 17, 2025, https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/.

after the HOMES Assessment for an additional 6.[12] The OIG determined that HOMES Assessment instructions do not prompt homeless program staff to complete the required suicide risk screening, which may result in a lack of clarity regarding a patient's level of risk and failure to complete more comprehensive suicide risk screening when warranted.

The OIG found that homeless program staff did not document care coordination as outlined in VA homeless program policy.[13] Of the 200 patient EHRs reviewed, homeless program staff documented that all 200 patients needed mental health or SUD treatment, and 172 patients were interested and willing to participate in treatment. However, the OIG found EHR evidence of care coordination for only 31 of 88 patients who were not already engaged in mental health or SUD treatment prior to the HOMES Assessment.

HPO leaders and most NHCs and facility homeless program leads told the OIG that homeless program staff were expected to discuss and document treatment options with veterans and coordinate care based on the HOMES Assessment clinical impressions of mental health or SUD treatment needs.[14] However, an HPO leader told the OIG that VHA does not monitor mental health and SUD care coordination for patients receiving VA homeless program services. The OIG determined that VHA does not clearly delineate care coordination responsibilities, which may contribute to inadequate care coordination and oversight to meet the needs of patients receiving VA homeless program services.

The OIG made four recommendations to the Under Secretary for Health related to HOMES documentation in patients' EHRs, suicide risk screening during homeless program intake and in response to danger of self-harm identified in HOMES Assessments, and mental health and SUD care coordination.[15]

[12] The six patients were screened 8, 13, 14, 36, 42, and 48 days after the HOMES Assessment. The OIG determined that although VHA staff failed to complete suicide risk screening with one patient, the patient engaged in substance use treatment one day after the HOMES Assessment and mental health treatment approximately one month after the HOMES Assessment.

[13] The OIG defined care coordination as EHR documentation of the following: a referral to a mental health or SUD provider within the homeless program, a consult for specialty services, a scheduled appointment, collaboration with or a warm handoff to a mental health provider, or instructions for self-referral.

[14] In interviews, 16 of 18 NHCs and all facility homeless program leads expected discussion of mental health and SUD treatment options. Additionally, 17 of 18 NHCs and 34 of 36 facility homeless program leads expected documentation of that discussion.

[15] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

VA Comments and OIG Response

The Acting Under Secretary for Health concurred with recommendations 1, 2, and 4, and concurred in principle with recommendation 3. Acceptable action plans were provided (see appendix B). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

JULIE KROVIAK, MD
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In the role of Acting Assistant Inspector General,
for Healthcare Inspections

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Abbreviations

EHR	electronic health record
HOMES	Homeless Operations Management and Evaluation System
HPO	Homeless Programs Office
OIG	Office of Inspector General
NHC	network homeless coordinator
SUD	substance use disorder
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a national review to evaluate the alignment of information related to mental health, substance use disorder (SUD), and suicide risk treatment needs within the Veterans Health Administration's (VHA's) Homeless Operations Management and Evaluation System (HOMES) data collection system and electronic health record (EHR).[1] The OIG also assessed homeless program staff's adherence to suicide risk screening procedures and applicable care coordination for patients entering VA homeless programs.[2]

Background

Approximately 1 in 10 veterans will experience homelessness and seek services from VA homeless programs at some point in the veteran's life.[3] In 2010, when the VA first launched a plan to end veteran homelessness, veterans comprised less than 8 percent of the United States population, and 16 percent of the homeless adult population.[4] In 2023, veterans represented 6 percent of the United States population and 7 percent of the homeless adult population.[5] VA homeless programs aim to reduce veteran homelessness by providing access to housing and clinical services, including mental health care.[6]

[1] VA documents refer to VA Homeless Programs and VHA Homeless Programs interchangeably. For purposes of this report, the OIG will refer to VA Homeless Programs. "Integrated Operations Platform," VHA Homeless Programs Hub, https://iop.med.va.gov/hub2/hp/index.html. (This site is not publicly accessible.) "VA Homeless Programs," VA, accessed March 7, 2024, https://www.va.gov/homeless/.

[2] Not all veterans who receive VA homeless program services are eligible for VHA patient care. The OIG, thus, uses the term *veteran* to generally refer to veterans who may or may not be receiving VHA services and uses the term *patient* to refer to veterans receiving VHA patient care.

[3] Jack Tsai, Dorota Szymkowiak, and Hind A. Beydoun, "Drug overdose deaths among homeless veterans in the United States Department of Veterans Affairs healthcare system," *Addiction*, no. 120(2) (October 17, 2024): 306-315, https://doi.org/10.1111/add.16689.

[4] US Department of Housing and Urban Development and VA, *Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report to Congress*. Veteran homelessness is based on a point-in-time estimate of sheltered and unsheltered homeless veterans on a single night in January of each year.

[5] US Department of Housing and Urban Development Office of Community Planning and Development, *The 2023 Annual Homelessness Assessment Report (AHAR) to Congress*, December 2023; "Veterans Day 2024: November 11," United States Census Bureau, accessed April 10, 2025, https://www.census.gov/newsroom/facts-for-features/2024/veterans-day.html.

[6] VHA Directive 1501, *VHA Homeless Programs,* October 21, 2016.

Homelessness and Suicide Risk

Veterans with a mental health condition, SUD, or who experience homelessness are at increased risk for suicide (see figure 1).[7] "Veterans are at the highest risk for suicide 30 to 60 days prior to" becoming homeless.[8] From 2001 to 2022, the suicide rate among VHA patients with indications of homelessness was greater than those without indications of homelessness.[9] Individuals experiencing housing instability, which includes difficulty paying rent, eviction, and moving frequently, are also at increased risk for suicide.[10] Veterans with housing instability in the previous 12 months are six times as likely to report suicidal ideation as those who did not experience housing instability.[11] Preventing veteran homelessness and suicide is one objective outlined in the VA strategic plan.[12]

[7] VA Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023; VA Office of Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report Part 2 of 2: Report Findings*, December 2024.

[8] *Hearing on Invisible Wounds of War: Improving Mental Health and Suicide Prevention Measures for our Nation's Veterans*, Before the Senate Committee on Veterans' Affairs, 118th Cong. (September 20, 2023) (statement of Dr. Matthew Miller, VHA Executive Director, Suicide Prevention).

[9] VA Office of Mental Health and Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report Part 2 of 2: Report Findings*. VHA defined indications of homeless as a diagnosis related to problems with housing and economic circumstances or social environment.

[10] "Housing Instability," US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, accessed February 12, 2025, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability; VA Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*.

[11] VA Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*.

[12] VA, *Department of Veterans Affairs Fiscal Years 2022-28 Strategic Plan*.

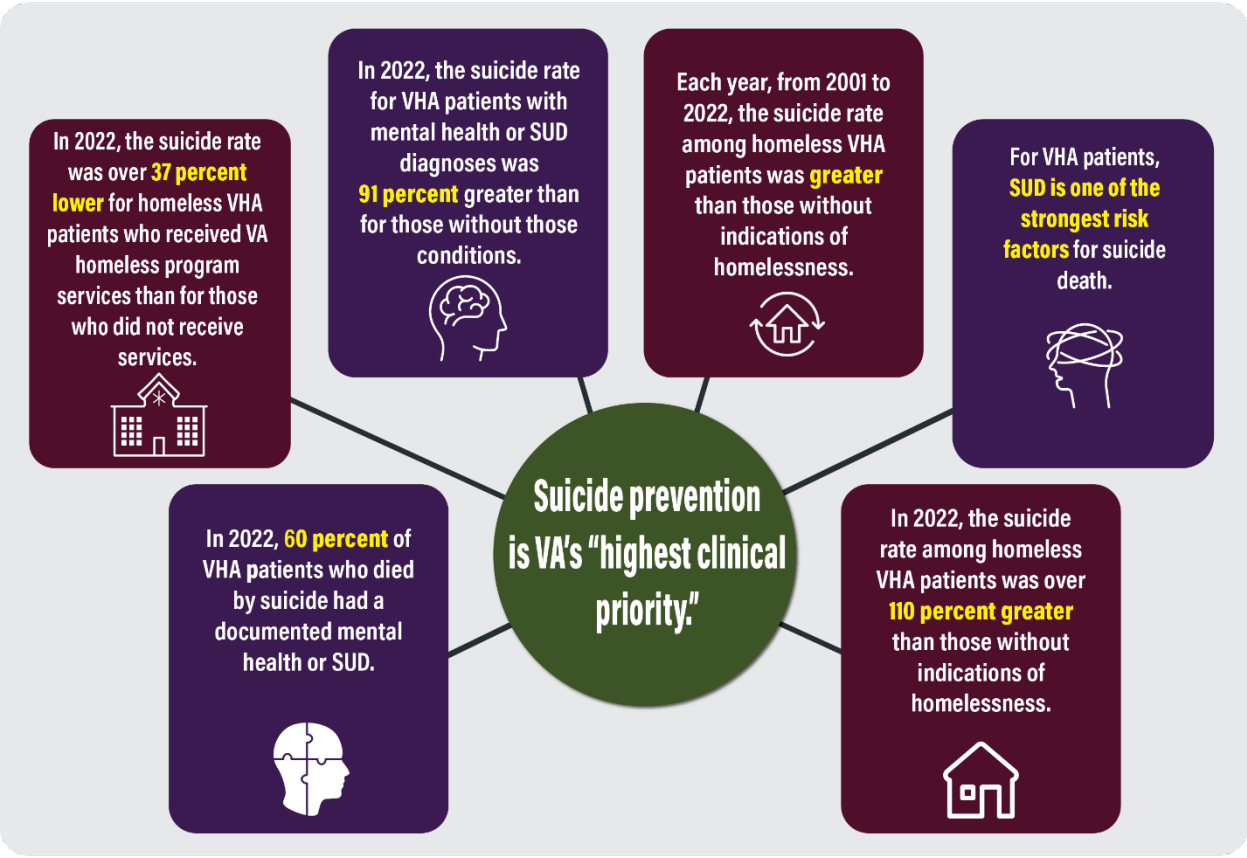

Figure 1. *VHA patient data for suicide risk and homelessness.*
Source: OIG analysis of VA memorandum and publications.

Homeless Operations Management and Evaluation System

HOMES is designed to track veterans receiving VA homeless program services through the collection of intake, progress, and outcome data. HOMES allows homeless program staff access to veteran information across VHA programs and facilities.[13]

HOMES is independent of the VHA EHR, and to maintain data security, HOMES access is limited to authorized VA homeless program staff.[14] VHA staff outside of the homeless programs only have access to HOMES information when homeless program staff enter the information into the patient's EHR.

[13] VHA Homeless Programs Office HOMES Access Policy 17-01-03, *Homeless Operations, Management, and Evaluation System (HOMES) Access Policy*, October 1, 2023.

[14] VHA Homeless Programs Office HOMES Access Policy 17-01-03, *Homeless Operations, Management, and Evaluation System (HOMES) Access Policy*; VHA Homeless Programs Office, "HOMES Reporting Overview: Grant & Per Diem (GPD)," August 2024.

The HOMES Homeless Services Assessment Form Worksheet (HOMES Assessment) includes a veteran's military service and demographic characteristics.[15] The HOMES Assessment also prompts homeless program staff to document clinical impressions of a veteran's risk of danger to self or others, and mental health and SUD treatment needs.[16]

Prior OIG Reports

In March 2024, the OIG found that staff at a VA facility did not complete VHA-required documentation following a patient's suicidal statements and failed to document an inability to complete a Columbia-Suicide Severity Rating Scale (suicide risk screening) in the EHR or efforts to develop a safety plan. The OIG made four recommendations related to suicide screening, safety plans, and referrals to suicide prevention staff.[17] As of May 2025, one recommendation related to safety plans remained open.

In July 2024, the OIG found that a homeless program staff member did not document a patient's suicide risk assessment and failed to review or update the patient's safety plan. The OIG made one recommendation to the Under Secretary for Health related to homeless program staff's suicide risk assessment responsibilities and safety plan reviews and updates for high risk for suicide patients.[18] The OIG closed this recommendation in December 2024.

Scope and Methodology

The OIG initiated the national review on July 24, 2024, to evaluate VA homeless program staff's documentation of HOMES Assessment clinical impressions in patients' EHRs, adherence to suicide risk screening procedures, and coordination of care.

The OIG established the population of patients with a completed HOMES Assessment in the HOMES data collection system between October 1, 2023, and March 31, 2024. The OIG randomly selected a sample of 200 patients receiving VHA care and enrolled in select homeless programs, which excluded residential treatment and veterans justice programs (see appendix A).[19] The OIG completed EHR reviews of the sample, which included patients from 86 facilities

[15] VA Manual, "Homeless Operations Management and Evaluation System (HOMES) User Manual – Phase I," April 19, 2011.

[16] VA Manual, "Homeless Operations Management and Evaluation System (HOMES) User Manual – Phase I."

[17] VA OIG, *Deficiencies in Quality of Care at VA Maine Healthcare System in Augusta*, Report No. 23-00528-92, March 12, 2024.

[18] VA OIG, *Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas*, Report No. 23-00776-207, July 31, 2024.

[19] The underlined terms are hyperlinks to another section of this report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

and all 18 Veterans Integrated Service Networks (VISNs).[20] See figure 2 for additional characteristics of the patient EHR sample.

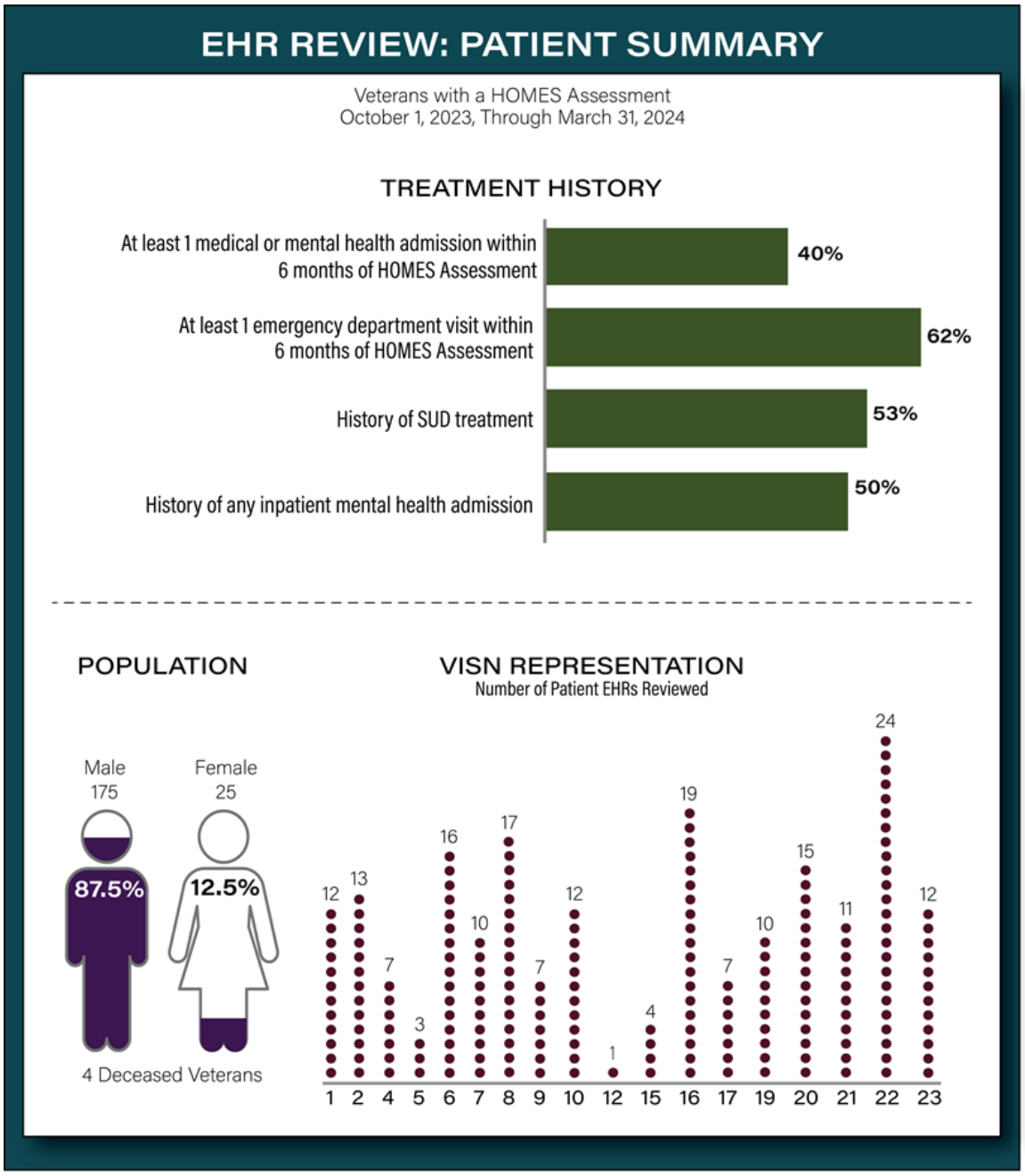

Figure 2. *Characteristics of EHR review sample.*
Source: OIG analysis of the EHR review sample HOMES data.
Note: The OIG determined that one patient died due to an accidental overdose, one patient died due to medical reasons, and was unable to determine the cause of death for the remaining two patients.

[20] VHA is organized into 18 networks defined by specified geographic regions. "Veterans Integrated Service Networks (VISNs)," VA, accessed January 8, 2025, https://www.va.gov/HEALTH/visns.asp.

The OIG reviewed VHA documents, policies and procedures, guidelines, and memoranda related to VA homeless programs, suicide risk screening, and care coordination. The OIG interviewed Homeless Programs Office (HPO) leaders, the 18 VISN homeless coordinators (NHCs), and 36 randomly selected facility homeless program leads.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Results

1. Inadequate Alignment of HOMES and EHR Documentation

Homeless program staff complete the HOMES Assessment after a veteran has been identified as needing homeless program services and the veteran's urgent clinical needs have been met. The HOMES Assessment includes military history, housing stability, employment status, and financial information as well as medical and mental health history. The HOMES Assessment prompts homeless program staff to document clinical impressions, including mental health and SUD treatment needs, willingness to engage in treatment, and whether the veteran is a danger to self or others (see figure 3).[21]

[21] VA Manual, "Homeless Operations Management and Evaluation System (HOMES) User Manual – Phase I." Although the HOMES Assessment question asks about psychiatric treatment needs, HOMES instructions use the terms psychiatric and mental health interchangeably; VHA Homeless Programs, "HOMES Data Definitions Guide," October 2023. For the purposes of this report, the OIG will use the term mental health to refer to treatment which may or may not include psychiatric treatment.

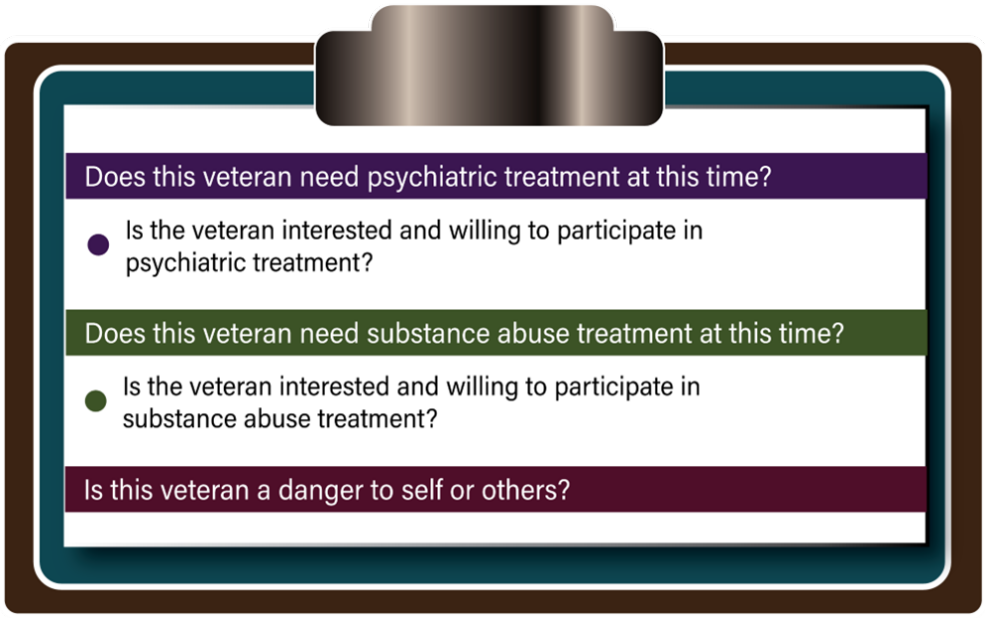

Figure 3. *HOMES Assessment clinical impressions related to mental health, SUD, and suicide risk.*
Source: HOMES Data Definitions Guide.

VHA requires all documentation to be entered in HOMES within three business days and to "align" with information in the patient's EHR.[22] HPO instructs homeless program staff to use the "Copy to Clipboard" function to add HOMES documentation to clinical notes in the EHR to ensure consistency and access to the HOMES Assessment clinical impressions by VHA clinicians. Among the sample of 200 patient EHRs reviewed, homeless program staff did not complete any EHR documentation for one veteran. Additionally, although homeless program staff completed progress notes in the EHR for the remaining 199 patients, the OIG found that 84 patient EHRs (42 percent) did not include the HOMES Assessment (see figure 4).

[22] VHA Homeless Programs Office HOMES Reporting Policy 17-01-07, *Homeless Operations, Management, and Evaluation System (HOMES) Reporting Policy*, October 1, 2023.

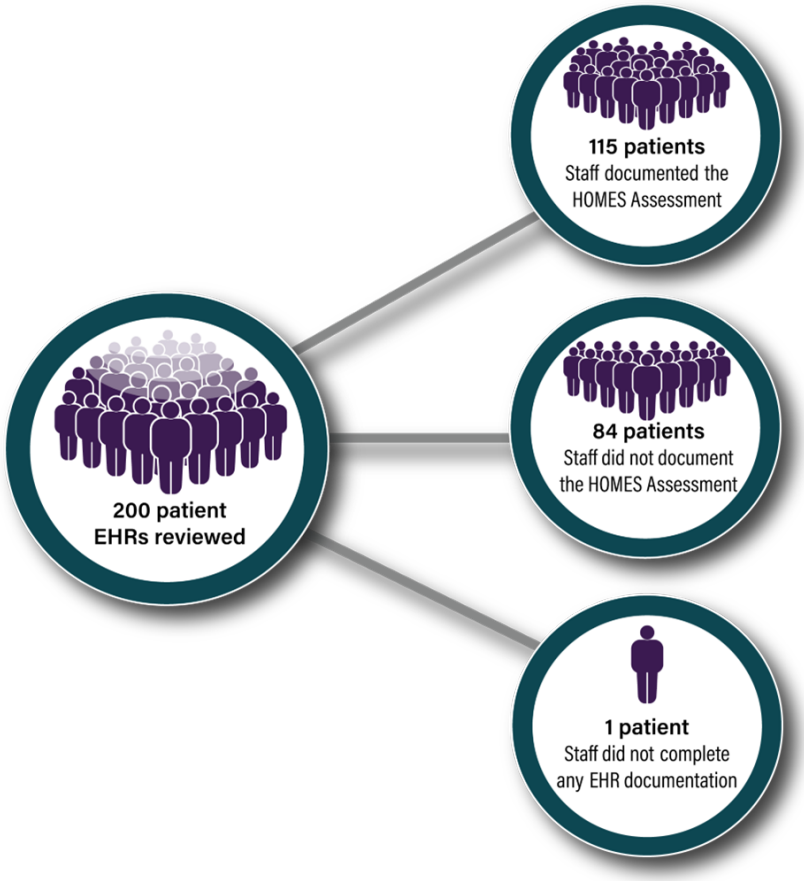

Figure 4. *EHR documentation analysis of HOMES Assessment.*
Source: OIG analysis of EHR review data.

The OIG determined that homeless program staff did not routinely document the HOMES Assessment in the EHR. Failure to complete EHR documentation of the HOMES Assessment results in incomplete documentation and limits access to important clinical information among clinicians who are not VA homeless program staff.

2. Suicide Risk Identification Processes

VHA requires outpatient mental health staff, including homeless program staff, to complete a suicide risk screening using the Columbia-Suicide Severity Rating Scale (suicide risk screening) at program intake.[23] If a patient has had a suicide risk screening documented within 30 days prior to homeless program intake, staff do not have to complete another suicide risk screening unless

[23] VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Minimum Requirements by Setting*,updated May 10, 2023; VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Frequently Asked Questions (FAQ 5.0)*, updated August 14, 2024. The Columbia-Suicide Severity Rating Scale uses "simple, plain-language questions" to determine the presence and severity of suicide risk and the level of support needed. "About the Protocol," The Columbia Lighthouse Project, accessed April 17, 2025, https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/.

clinically indicated.[24] The OIG learned, during the course of another review, that VHA had not established a benchmark or mechanism to monitor adherence to these suicide risk screening requirements in homeless programs. As of May 2025, the OIG has an open recommendation issued to VHA related to setting-specific suicide risk screening adherence.[25]

HPO leaders told the OIG that homeless program staff should complete a suicide risk screening at the time the HOMES Assessment is completed. The OIG found, in interviews, that 12 of 18 NHCs (67 percent) and 34 of 36 (94 percent) facility homeless program leads expected homeless program staff to always complete a suicide risk screening at the time of the HOMES Assessment completion or when a suicide risk screening had not been completed in the 30 days prior. Additionally, 35 of 36 (97 percent) facility homeless program leads who expected suicide risk screening completion told the OIG that the suicide risk screening should be documented the same day as the HOMES Assessment completion.

The OIG found that, despite VHA not having an established benchmark or monitoring adherence to suicide risk screening, 170 of 200 (85 percent) patient EHRs included a suicide risk screening at the time of the HOMES Assessment or in the 30 days prior. The OIG acknowledges VHA staff's suicide risk screening efforts; however, the OIG would expect suicide risk screening for all patients in this vulnerable population. Given that individuals are at the highest risk for suicide in the 60 days prior to becoming homeless, a failure to complete suicide risk screening at the time of the HOMES Assessment, or within 30 days prior, may result in the failure to identify and mitigate patients' risk for suicide during this critical time.

The HOMES Assessment also includes an item that prompts homeless program staff to determine whether the veteran is a danger to self or others. In interviews, over 90 percent of NHCs (17 of 18) and facility homeless program leads (34 of 36) reported an expectation that if the patient was assessed as a danger to self or others in the HOMES Assessment, a suicide risk screening should be completed. The OIG found that 12 patients' HOMES Assessments indicated that the patient was a danger to self or others. Among those 12 patients, VHA staff completed the suicide risk screening within one day with 5 patients. However, the OIG found that a suicide risk screening was not completed for 1 patient, and the suicide risk screening was completed more than a week after the HOMES Assessment for the remaining 6 patients.[26]

The OIG determined that HOMES Assessment instructions do not prompt homeless program staff to complete the required suicide risk screening if the clinical impressions include the

[24] "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Frequently Asked Questions (FAQ 5.0)."

[25] VA OIG, *Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies*, Report No. 23-02939-13, December 18, 2024.

[26] The six patients were screened 8, 13, 14, 36, 42, and 48 days after the HOMES Assessment. The OIG determined that although VHA staff failed to complete suicide risk screening with one patient, the patient engaged in substance use treatment one day after the HOMES Assessment and mental health treatment approximately one month after the HOMES Assessment.

determination that a patient is assessed as a danger to self. This may result in lack of clarity regarding a patient's level of risk and failure to complete more comprehensive suicide risk screening when warranted.

3. HOMES-Identified Treatment Needs and Care Coordination

Consistent with VHA policy, the HPO strategic plan identifies goals of coordinating services to address veterans' mental health and SUD treatment needs.[27] To comprehensively meet the treatment needs of veterans experiencing homelessness, VA homeless program services should include connecting veterans to mental health care.[28] VHA further instructs that accessing care should be achieved through the use of the HOMES Assessment, "a single, common screening and assessment tool that can be used to direct Veterans to the appropriate intervention at their first point of entry."[29]

Facility directors and chiefs of staff must ensure mental health and homeless program leaders work together to meet the mental health and SUD treatment needs of veterans experiencing homelessness.[30] Facility homeless program leads are responsible for ensuring that homeless program staff actively collaborate with mental health program staff to meet veterans' mental health and SUD treatment needs.[31]

The OIG found that homeless program staff did not consistently provide care coordination related to mental health and SUD treatment needs identified in the HOMES Assessment.[32] Of the 200 patient EHRs reviewed, homeless program staff documented, in the HOMES Assessment clinical impressions, all 200 patients as in need of mental health or SUD treatment and 172 patients as interested and willing to participate in treatment. Among those interested and willing to participate in treatment, 84 (50 percent) were already engaged in treatment or had a consult pending at the time of HOMES Assessment completion.

The OIG found that of the 88 patients who were not engaged in treatment at the time of the HOMES Assessment, 31 (35 percent) had documentation of care coordination. The remaining 57 (65 percent) did not have documentation of care coordination.

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[27] "VHA Directive 1501, *VHA Homeless Programs*; "Strategic Plan 2021-2025, Spring 2024 Update," VHA Homeless Programs Office (HPO), accessed August 20, 2024, https://dvagov.sharepoint.com/sites/. (This site is not publicly accessible.)

[28] VHA Directive 1501, *VHA Homeless Programs*; Deputy Under Secretary for Health for Operations and Management, "VAMC Homeless Program Integration with Suicide Prevention Efforts," memorandum to Veterans Integrated Service Network Directors, June 8, 2018.

[29] VHA Directive 1501, *VHA Homeless Programs*.

[30] VHA Directive 1160.01, *Uniformed Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

[31] VHA Directive 1160.01, *Uniformed Mental Health Services in VHA Medical Points of Service*.

[32] The OIG defined care coordination as documentation of referral to a mental health or SUD provider within the homeless program, consult for specialty services, a scheduled appointment, EHR documentation of collaboration with or warm handoff to a mental health provider, or instructions for self-referral.

Of the 31 patients with documented care coordination, 19 (61 percent) went on to engage in treatment after the HOMES Assessment. Twenty-nine (51 percent) of the 57 patients without documented care coordination later engaged in treatment (see figure 5).

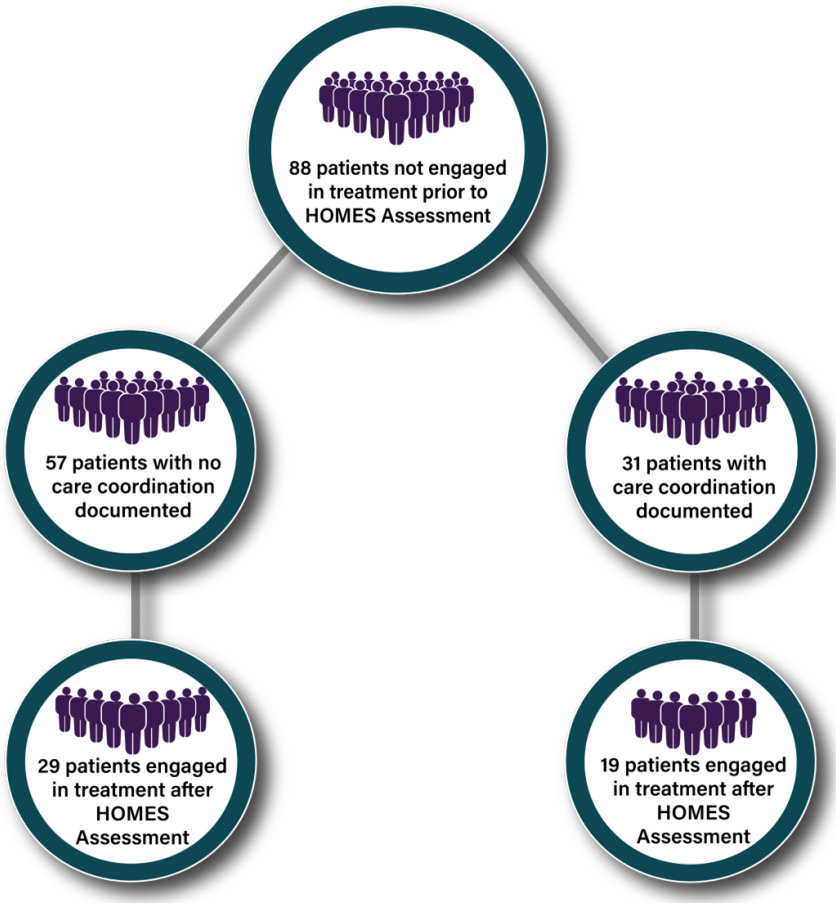

Figure 5. *Mental health and SUD care coordination.*
Source: OIG review of HOMES Assessment data and patient EHRs.

HPO leaders and most NHCs and facility homeless program leads told the OIG that homeless program staff were expected to discuss treatment options with veterans and coordinate care based on the HOMES Assessment clinical impressions of mental health or SUD treatment needs.[33] Despite these expectations, an HPO leader told the OIG that VHA does not monitor mental health and SUD care coordination for patients receiving VA homeless program services. The OIG also found that NHCs inconsistently reported monitoring to ensure care coordination to meet patients' mental health and SUD treatment needs. Although 6 of 18 NHCs (33 percent) reported conducting EHR audits to monitor care coordination in response to identified mental

[33] In interviews, 16 of 18 NHCs and all facility homeless program leads expected discussion of mental health and SUD treatment options. Additionally, 17 of 18 NHCs and of 34 of 36 facility homeless program leads expected documentation of that discussion.

health and SUD treatment needs, the remaining 12 NHCs (67 percent) reported not conducting any monitoring to ensure care coordination.

An HPO leader and several NHCs explained to the OIG an understanding that facility staff are responsible for monitoring and ensuring care coordination.[34] However, nearly 20 percent of facility homeless program leads reported not monitoring mental health and SUD care coordination.[35] Facility homeless program leads who reported monitoring care coordination most frequently used EHR reviews to monitor. Both NHCs and facility homeless program leads most frequently reported a lack of tools or data to support monitoring as a barrier to ensuring care coordination.

The OIG found that homeless program staff did not document the provision of care coordination as outlined in VA homeless program policy.[36] Further, the OIG determined that VHA has not clearly delineated responsibility for ensuring care coordination, which may contribute to a lack of oversight to ensure care coordination to meet the needs of patients receiving VA homeless program services.

Conclusion

The OIG determined that homeless program staff did not routinely document the HOMES Assessment in the EHR, as expected. Failure to complete EHR documentation of the HOMES Assessment results in incomplete documentation and limits access to important clinical information among clinicians who are not VA homeless program staff.

Despite VHA not having an established benchmark or monitoring adherence to suicide risk screening, the OIG found that 85 percent (170 of 200) of patient EHRs included a suicide risk screening at the time of the HOMES Assessment or in the 30 days prior. The OIG acknowledges VHA staff's suicide risk screening efforts; however, the OIG would expect suicide risk screening for all patients in this vulnerable population.

The OIG determined that HOMES Assessment instructions do not prompt homeless program staff to complete the required suicide risk screening if the clinical impressions include the determination that a patient is assessed as a danger to self. This may result in lack of clarity regarding a patient's level of risk and failure to complete more comprehensive suicide risk screening when warranted.

Homeless program staff did not consistently document the provision of care coordination related to mental health and SUD treatment needs identified in the HOMES Assessment. Further, the OIG concluded that VHA has not clearly delineated responsibility for ensuring care

[34] In interviews, 9 of 18 NHCs reported that facility staff are responsible to ensure care coordination.

[35] Two facility homeless program leads reported that other supervisors provide oversight and the remaining five reported no oversight.

[36] VHA Directive 1501, *VHA Homeless Programs,* October 21, 2016.

coordination, which may contribute to a lack of oversight to ensure care coordination to meet the needs of patients receiving VA homeless program services.

The OIG made four recommendations to the Under Secretary for Health.[37]

Recommendations 1–4

1. The Under Secretary for Health ensures that VA homeless program staff consistently document, in patients' electronic health records, the clinical information from the Homeless Operations Management and Evaluation System.
2. The Under Secretary for Health makes certain that a suicide risk screening is completed with patients during intake into VA homeless programs, consistent with Veterans Health Administration policy.
3. The Under Secretary for Health ensures that staff complete suicide risk screening in response to danger of self-harm identified in the Homeless Operations Management and Evaluation System.
4. The Under Secretary for Health makes certain that homeless program staff provide and document care coordination to address patients' mental health and substance use disorder treatment needs as identified in the Homeless Operations Management and Evaluation System.

[37] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: VA Homeless Programs

VA Homeless Programs, independently and in partnership with federal and community agencies, provide housing, employment, health care, justice, and reentry services to hundreds of thousands of veterans each year.[38] VA Homeless Programs that require HOMES Assessment include:

- **US Department of Housing and Urban Development – VA Supportive Housing** provides veterans experiencing homelessness with rental assistance vouchers for permanent housing and case management to help access health care and other supports to maintain housing.[39]
- **Homeless Providers Grant and Per Diem** funds community agencies through grants and per diem payments to provide services to veterans experiencing homelessness, including transitional housing and social services.[40]
- **Compensated Work Therapy – Transitional Residences** provides time-limited residential treatment and supported employment services with the intent for veterans' reentry into the workforce and to maintain employment.[41]
- **Domiciliary Care for Homeless Veterans** provides residential treatment to veterans experiencing homelessness and co-occurring mental health, SUD, medical, and psychosocial treatment needs.[42]
- **Health Care for Homeless Veterans** conducts outreach aimed at connecting veterans living on the street or chronically homeless to emergency shelter and short-term case management for engagement into health care and other social services.[43]
- **Veterans Justice Outreach** aims to prevent homelessness through partnerships with the criminal justice system to identify justice-involved veterans with mental health and substance use issues and facilitate access to VA services.[44]

[38] "VA Homeless Programs," VA, accessed February 25, 2025.

[39] "U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program," VA, accessed February 25, 2025, https://www.va.gov/homeless/hud-vash.asp.

[40] "VA Homeless Programs," VA.

[41] VHA Directive 1501, *VHA Homeless Programs*; VA Manual, *Homeless Operations Management and Evaluation System (HOMES) User Manual*.

[42] VHA Directive 1501, *VHA Homeless Programs*.

[43] VHA Directive 1162.03, *Health Care for Homeless Veterans Community Resource and Referral Centers*, July 19, 2022; "VA Homeless Programs," VA.

[44] "Veterans Justice Outreach Program," VA, accessed February 18, 2025, https://www.va.gov/homeless/vjo.asp; "VA Homeless Programs," VA.

- **Health Care for Reentry Veterans** provides outreach and case management to veterans prior to release from jail or prison to facilitate referrals to medical, mental health, and social services to prevent homelessness and re-incarceration.[45]

[45] "Health Care for Re-entry Veterans Services and Resources," VA, accessed February 18, 2025, https://www.va.gov/homeless/reentry.asp.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: August 4, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Deficiencies in Veterans Affairs (VA) Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the OIG draft report. The Veterans Health Administration (VHA) concurs with recommendations 1, 2 and 4 and concurs in principle with recommendation 3, made to the Under Secretary for Health. An action plan is included in the attachment.

2. VHA continues to implement several improvements to enhance the documentation and care coordination within VA homeless programs. The National Homeless Program Office (HPO) will conduct educational campaigns to ensure clinical information from the Homeless Operations Management and Evaluation System (HOMES) is consistently documented in electronic health records (EHR). Additionally, the HPO will work with the Office of Suicide Prevention to streamline procedures and ensure training aligns with VHA's suicide risk management strategies.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vha10oicgoalaction@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on August 4, 2025.]

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

Office of the Inspector General (OIG) Draft Report – Deficiencies in Veterans Affairs (VA) Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes
(2023-02507-HI-1376)

Recommendation 1: The Under Secretary for Health ensures that VA homeless program staff consistently document, in patients' electronic health records, the clinical information from the Homeless Operations Management and Evaluation System.

VHA Comments: Concur. The VA National Homeless Programs Office (HPO) will implement the following actions to ensure that VA homeless program staff consistently document in patients' electronic health records (EHR) the clinical information from the Homeless Operations Management and Evaluation System (HOMES).

1. Leverage the findings of this report to direct homeless program staff to the existing HOMES documentation overview guidance and training:

    a. HPO will highlight themes of the report;

    b. HPO will identify recommended practices for ensuring HOMES information is consistently available in the electronic health records notes; and

    c. The HPO Business Intelligence (BI) team responsible for HOMES will ensure HOMES documentation guides and technical assistance materials clearly describe these expectations and will make refinements where necessary.

2. Conduct an education and awareness campaign with key stakeholders about expectations for homeless program staff to consistently document HOMES information in the EHR and to decrease limitations of information sharing with clinicians. Implement the following stakeholder engagements:

    a. Quarterly meetings with Network Homeless Coordinators to review HOMES documentation overview guidance and expectations; and

    b. Quarterly "office hours" call for homeless program staff, supervisors, and other VA medical center staff to ask open-ended questions about information sharing between HOMES and the EHR.

3. Leverage HPO's membership and participation in VHA's EHR Modernization Behavioral Health Council to provide education and awareness of homeless program information captured in the EHR to increase information sharing with clinicians.

    a. Continue providing HPO subject matter expertise related to information capture and sharing across the continuum of care during standing engagements.

    b. Ensure HOMES documentation overview guidance and expectations of homeless program staff are shared with EHR Councils to support effective systems implementation and information sharing with clinicians.

Status: In-Progress **Target Completion Date: July 2026**

Recommendation 2: The Under Secretary for Health makes certain that a suicide risk screening is completed with patients during intake into VA homeless programs, consistent with Veterans Health Administration policy.

VHA Comments: Concur. The VA National HPO will implement the following actions to make certain that homeless program staff continue to complete suicide risk screening requirements consistent with current VHA policy for suicide risk screening and evaluation for outpatient mental health programs.

1. HPO will clarify guidance for homeless program staff on the definition of "intake" as it pertains to homeless programs and the requirement to complete suicide risk screening at the time of intake.

2. HPO will conduct an internal reassessment of HOMES documentation and technical assistance materials to ensure alignment with revised clarifications to the definition of "intake" as it pertains to HOMES episodes of assessment, referral, entry, and exit.

3. In alignment with the Office of Suicide Prevention's (OSP) Suicide Risk Identification and Management Strategy, HPO will provide training and awareness to homeless program staff to ensure understanding of when suicide risk screening must be completed in VA homeless programs, in compliance with existing VHA policy for suicide risk screening and evaluation for outpatient mental health programs.

    a. HPO will continue to partner with the OSP to ensure suicide prevention training for homeless program staff aligns with VHA policy and supports Veterans Integrated Service Network Executive Leadership's responsibility of monitoring Risk ID processes across clinical services and the administration of the Columbia-Suicide Severity Rating Scale screener and Comprehensive Suicide Risk Evaluation.

b. HPO will continue to consult with the OSP to ensure awareness and alignment with any OSP enhancements to monitoring of adherence to suicide risk identification screening and evaluation of setting-specific requirements as reflected in the December 18, 2024, VA OIG Report 23-02939-13 recommendation 3 that may impact HPO's action plan for this report.

Status: In-Progress **Target Completion Date: March 2026**

Recommendation 3: The Under Secretary for Health ensures that staff complete suicide risk screening in response to danger of self-harm identified in the Homeless Operations Management and Evaluation System.

VHA Comments: Concur in Principle

The VA National HPO concurs in principle with the proposed recommendation, although adjustments may be required related to information stored within the Homeless Operations Management and Evaluation System. The VA National HPO will implement the following actions to ensure that VA homeless program staff are aware of suicide risk screening requirements and complete suicide risk screenings in alignment with VHA policy and enhance the protection and care for this vulnerable Veteran population.

1. In consultation with the OSP and to align homeless programs procedures with current VHA policy for suicide risk screening and evaluation, HPO will remove items from HOMES forms that contain questions about suicide risk.

    a. Suicide risk screening frequency by homeless program staff will not be reduced by this change; rather, the removal of an ancillary process that is inconsistent with OSP's validated suicide screening tools will increase homeless program staff awareness and consistency in completing all risk screening requirements as specified by the VHA Suicide Risk Identification Strategy.

    b. HPO consulted with the OSP regarding this action plan, and OSP is in support of the removal of risk screening questions from HOMES to support alignment with current VHA policy for suicide risk screening and evaluation.

2. To ensure that homeless program staff are aware of suicide risk screening requirements, HPO will provide updated guidance stating that all suicide risk screening and evaluation should be completed according to the procedures outlined in VHA Memorandum 2025-01-03 "*Suicide Risk Screening and Evaluation Requirements and Implementation Update",* using validated screening and evaluation tools which are administered through the electronic health record.

a. HPO will continue to consult with OSP to leverage the protective measures in place to provide training and guidance to homeless program staff as the recommendations in this report are implemented, in alignment with OSP's implementation of recommendations in VA OIG Report 23-02939-13.

Status: In-Progress **Target Completion Date: July 2026**

Recommendation 4: The Under Secretary for Health makes certain that homeless program staff provide and document care coordination to address patients' mental health and substance use disorder treatment needs as identified in the Homeless Operations Management and Evaluation System.

VHA Comments: Concur. The VA National HPO will implement the following actions to make certain that homeless program staff provide and document care coordination to address patients' mental health and substance use disorder (SUD) treatment needs, as identified in the HOMES.

1. HPO will review barriers that impact homeless program staff ability to consistently document the provision of care coordination related to mental health and SUD treatment needs identified in the HOMES Assessment, as identified in the report.

    a. HPO will identify and implement strategies that address barriers of documenting care coordination in alignment with VHA policy.

    b. HPO will review and reiterate care coordination documentation requirements in HOMES with homeless program staff.

2. HPO will consult with mental health clinical specialty leaders to identify strategies to enhance communication and clearly delineate responsibilities for ensuring care coordination to meet the needs of patients receiving VA homeless program services.

    a. HPO will review opportunities to provide homeless program staff with business intelligence products that increase efficiencies in viewing HOMES data related to mental health and SUD care coordination referrals for treatment of Veterans from VA homeless program services with the VA electronic health record data of enrollment in mental health and SUD treatment.

Status: In-Progress **Target Completion Date: July 2026**

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