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VETERANS HEALTH ADMINISTRATION

Audit of Homeless Screening Clinical Reminder Process

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Executive Summary

The Veterans Health Administration's (VHA) Homeless Programs Office (program office) uses a required screening process to identify veterans who are experiencing housing instability—meaning they are experiencing or at risk of homelessness—and need assistance, and the electronic health record (EHR) has included a Homeless Screening Clinical Reminder (screening reminder) since fiscal year (FY) 2013.[1] Following a positive screening, meaning VHA staff have identified that a veteran is experiencing housing instability, veterans can request to be referred to social work or homelessness program staff to receive resources and services to address their housing concerns. Medical facilities must complete annual screenings for all veterans under their care, have a process in place for all positive screenings that includes immediate referral to local homelessness program staff for housing placement, refer positive screenings for veterans at risk of homelessness to social work services, and ensure that consults—requests for service made on behalf of veterans—are responded to within seven business days.[2]

In addition, the program office's standard operating procedure states that follow-up is expected to occur within 30 days of the screening but notes it is good clinical practice to reach out to veterans as soon as reasonably possible.[3] Follow-up should be either an encounter where the veteran receives information about VA homelessness programs or housing assistance or an assessment of the veteran's needs and a referral to homelessness programs.[4] Homelessness program supervisors are supposed to use the "Homeless Screening Clinical Reminder Follow-Up Report" (follow-up report) frequently to monitor follow-up activity and achieve the 30-day goal.[5]

From January through June 2024, VHA screened over 2.4 million veterans and identified 31,149 who reported experiencing housing instability. About 59 percent (18,250) of those veterans

[1] VHA Directive 1501*, VHA Homeless Programs*, October 21, 2016. Clinical reminders are notifications in the EHR that direct providers to perform certain tests or evaluations to enhance the quality of care for specific conditions in veterans. The primary goal is to provide relevant information to clinical staff at the point of care by providing data for clinical decision-making. The Homeless Screening Clinical Reminder is one of VHA's 71 national clinical reminders. "Clinical Reminder Resources" (web page), accessed February 11, 2024 (not publicly accessible).

[2] VHA Directive 1501. "Consult" is the term used for the Veterans Information Systems and Technology Architecture (VistA) and Computerized Patient Record System platforms. "Referral" is the term used in the Oracle Health platform. VHA Directive 1232, *Consult Management,* November 22, 2024. According to the program office, consults are not required, and medical facilities can determine whether consults or other referral methods are used to make referrals. VHA uses two electronic health record systems, VistA and Oracle Health. It is in the process of transferring all facilities to the Oracle Health platform.

[3] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)," September 30, 2019.

[4] "An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

[5] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

requested to be referred to social work or homelessness program staff for further assistance.[6] The VA Office of Inspector General (OIG) conducted this audit to evaluate the effectiveness of VHA's screening processes in making sure veterans who request referrals receive a follow-up encounter to discuss their housing instability and address their possible need for VA homelessness services. This audit included veterans who reported they were experiencing housing instability and requested to be referred for further assistance from June 6, 2024, through September 4, 2024.

The OIG conducted its work from October 2024 through July 2025 and reviewed VHA policies and procedures related to the screening reminder. In addition to examining veterans who reported they were experiencing housing instability, the audit team conducted site visits to four medical facilities to understand local referral, follow-up, and monitoring procedures, and sent an electronic questionnaire to homeless program coordinators from 20 additional facilities.

What the Audit Found

Some facilities appeared to be experiencing challenges in meeting the program office's expectation that they complete follow-up encounters within 30 days. The audit team evaluated screening reminder processes at four medical facilities—three that used the Veterans Health Information Systems and Technology Architecture (VistA) for their EHR and one that used the Oracle Health EHR.[7] From each facility, the team reviewed the records of 12 veterans and found weaknesses in the referral and follow-up processes that put veterans at risk of not receiving assistance after they indicated they were experiencing housing instability.

Review of Referral Management Process to Determine Whether Veterans Received Follow-up After Screenings

The audit team found that staff did not follow their facilities' local referral and follow-up procedures for 22 of the 36 veterans reviewed (about 61 percent) at the three sampled medical facilities that used VistA: VA San Diego Healthcare System, VA Oklahoma City Healthcare System, and VA Houston Healthcare System. Specifically, the audit team did not find evidence that the clinical staff from these three medical facilities who conducted screenings referred 11 veterans who indicated they wanted to further discuss their housing concerns. Furthermore, staff from the San Diego and Oklahoma City medical facilities did not follow local procedures

[6] Medical facility staff are not required to take further action if veterans decline to be referred for additional assistance. See appendix A for details on the screening reminder.

[7] In May 2018, VA awarded a contract to Cerner (Oracle Health) to implement an EHR system at VA medical facilities nationwide. VA's Electronic Health Record Modernization program manages the transition from VA's legacy medical records system, VistA, to the Oracle Health EHR system. From October 2020 to March 2025, the Oracle Health EHR system was deployed at six sites. "VA EHR Deployment Schedule" (web page), EHR Deployment Schedule, accessed April 18, 2025, https://digital.va.gov/ehr-modernization/ehr-deployment-schedule/. For more details about this report's scope and methodology, see appendix B.

regarding the number of outreach attempts and method of outreach to complete encounters for 11 veterans referred using consults. In some instances, staff did not make repeated attempts to reach veterans and only mailed or emailed information—efforts that did not meet the intent of completing encounters with referred veterans.

In total, 22 of 36 veterans were not referred for follow-up or did not receive outreach from staff in accordance with local procedures, and 20 of these veterans did not receive a follow-up encounter.[8] Two veterans received follow-up after they called the National Call Center for Homeless Veterans and their cases were referred to the medical facilities where they had originally been screened.

The audit team's assessment of screening procedures at the VA Central Ohio Health Care System in Columbus, a site that uses the Oracle Health EHR, revealed that the referral process there increased the risk that veterans would not receive follow-up. The audit team reviewed 12 veteran cases at the Columbus facility and found the screening data related to those veterans were unreliable. However, the team's interviews with staff who used the Oracle Health EHR and the team's observations of the referral process revealed risks. Staff reported using workarounds, such as instant messaging, to refer veterans to social workers because of the cumbersome Oracle Health EHR consult process. When referrals are made outside the EHR, veterans who have been screened at the Columbus facility and are awaiting follow-up could be at greater risk for being overlooked.

Review of Homelessness Screening Process Controls

Deficiencies in the screening reminder process occurred, in part, because medical facilities did not establish local written policies and procedures in accordance with federal internal control standards and VHA policy. As part of an effective internal control system, management should establish policies and practices that define roles and responsibilities and ensure policies are documented and communicated to ensure consistency in operations.[9] VHA policy requires medical facilities to have clear protocols for determining how veterans experiencing housing instability will be referred to services.[10]

Although the program office requested that the VHA Support Service Center develop the follow-up report for staff and recommended that supervisors monitor the report frequently, the

[8] During the audit, the OIG made facility homelessness program supervisors aware of veterans who did not receive a referral or follow-up encounter.

[9] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[10] VHA Directive 1501.

program office did not make sure the report was reliable.[11] Regardless of whether facilities are using the VistA or the Oracle Health EHR, it is critical for all facilities to have and use a reliable report so supervisors can determine whether staff met veterans' housing needs and monitor whether veterans received follow-up.

Additional controls over the screening reminder process could help VHA assist more veterans experiencing housing instability when they are identified during the screening process. Providing these veterans with the assistance they need helps ensure that VHA's significant efforts and resources to screen millions of veterans each year are not wasted and would further support VA's goal of ending and preventing veteran homelessness.

What the OIG Recommended

The OIG made four recommendations to the under secretary for health.[12] They included ensuring that medical facilities establish and implement clear written Homeless Screening Clinical Reminder policies that define the roles and responsibilities of staff, and ensuring that medical facility staff are aware of and were trained on written local policies and procedures for referrals, follow-up, and monitoring. The OIG also recommended developing and implementing a review process to determine whether medical facility staff followed local policies when veterans do not receive a follow-up encounter within 30 days of positive screenings and correcting any deficiencies. Finally, all medical facilities should have a report that accurately lists veterans who screened positive and accepted referrals with the status of follow-up actions.

VA Management Comments and OIG Response

The acting under secretary for health concurred with recommendations 1, 2, and 4; concurred in principle with recommendation 3; and provided an action plan for each recommendation. Network homeless coordinators will need to verify medical facilities update or establish homelessness screening policies and procedures and that staff are trained on their responsibilities. Furthermore, the program office will make sure the follow-up report is improved to accurately list veterans who screened positive and accepted referrals, as well as the status of follow-up actions.

The acting under secretary for health's planned corrective actions for recommendations 1, 2, and 3 are responsive to the intent of the recommendations. Regarding recommendation 3, the OIG

[11] The VHA Support Service Center creates and maintains secure data platforms, measurement systems, and analytic solutions that help providers work with veterans and their families to make well-informed decisions. VA Functional Organizational Manual, ver. 8.1, *Description of Organization Structure, Missions, Functions, Tasks, and Authorities Volume 1: Administrations*, 2023; VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

[12] 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.

acknowledges in the report that follow-up within 30 days of positive screenings is a goal stated in the program office's standard operating procedures, and the OIG does not refer to it as a requirement.[13] Regarding VHA's response to recommendation 4, VHA's planned corrective actions did not indicate how it will address inaccuracies the OIG found with the follow-up report for medical facilities operating the VistA EHR. VHA will need to ensure that all medical facilities, whether using the VistA or Oracle Health EHR, have a reliable report that accurately lists veterans who screened positive and accepted referrals, as well as the status of follow-up actions. The OIG will monitor VHA's progress on its planned actions and will close the recommendations when adequate documentation has been provided to demonstrate sufficient progress on implementation and fulfillment of each recommendation's intent. The full text of the acting under secretary's comments can be found in appendix C.

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[13] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

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Abbreviations

EHR	electronic health record
FY	fiscal year
OIG	Office of Inspector General
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

Introduction

The Veterans Health Administration (VHA), which oversees VA's nationwide healthcare system, has a requested fiscal year (FY) 2026 budget of about $3.5 billion for homelessness programs and is committed to preventing and ending veteran homelessness. From January through June 2024, VHA screened over 2.4 million veterans for homelessness and identified 31,149 veterans who reported they were experiencing housing instability—meaning they were at risk of or experiencing homelessness. The final question in the screening process asks the veteran whether they want to be referred to a social worker or homelessness program staff for further assistance, and 18,250 veterans (about 59 percent) requested such a referral.

The VA Office of Inspector General (OIG) conducted this audit to evaluate the effectiveness of VHA's screening processes in making sure veterans who request referral receive a follow-up encounter to discuss their housing instability and address their possible need for VA homelessness services.[14] The audit team examined veterans who reported they were experiencing housing instability and requested to be referred for further assistance from June 6, 2024, through September 4, 2024.

Screening for Homelessness

VHA's Homeless Programs Office (program office) proactively seeks and identifies veterans in need of assistance through its required screening process. The screening is administered in all VHA outpatient settings and is prompted by the Homeless Screening Clinical Reminder, which has been integrated into the electronic health record (EHR) since FY 2013. The reminder alerts healthcare providers to conduct this annual screening to identify veterans who are experiencing housing instability and can help veterans receive access to programs and services that address their housing concerns.[15]

VHA Directive 1501 establishes general requirements for homelessness screenings. The directive states that medical facilities are required, at a minimum, to

- complete annual homelessness screenings for all veterans served by VHA,
- have a process in place for all positive screens for homelessness that includes immediate referral to local homelessness program staff for placement into

[14] "An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)," September 30, 2019.

[15] Clinical reminders are notifications in the EHR that direct providers to perform certain tests or evaluations to enhance the quality of care for specific conditions in veterans. The primary goal is to provide relevant information to clinical staff at the point of care by providing data for clinical decision-making. The Homeless Screening Clinical Reminder is one of VHA's 71 national clinical reminders. "Clinical Reminder Resources" (web page), accessed February 11, 2024 (not publicly accessible).

emergency housing or residence through VA or community emergency housing, and

- refer positive screens for veterans who are at risk of homelessness to social work services and ensure those consults are responded to within seven business days.[16]

The clinical reminder in the EHR notifies staff when a veteran's screening is due.[17] During the screening at an outpatient visit, clinical staff, such as physicians and nurses, ask the veteran whether they have been living in stable housing in the past two months or are concerned about future housing stability. For veterans screened as at risk for homelessness, the clinical reminder prompts a referral to social work and for veterans screened as homeless, the clinical reminder prompts a referral to homelessness programs.[18] If the veteran wants to be referred, they are asked about the best way they can be reached.[19] The screening questions and the veteran's responses are added to a note in the EHR. The screening, referral, follow-up, and documentation process is illustrated in figure 1.

[16] VHA Directive 1501*, VHA Homeless Programs*, October 21, 2016. A consult is a request for service on behalf of a veteran. "Consult" is the term used for the Veterans Information Systems and Technology Architecture (VistA) and Computerized Patient Record System platforms. "Referral" is the term used in the Oracle Health platform. VHA Directive 1232, *Consult Management*, November 22, 2024. VHA uses two electronic health record systems, VistA and Oracle Health. It is in the process of transferring all facilities to the Oracle Health platform.

[17] The clinical reminder will not appear if a veteran has had a visit in the last six months with a homelessness program.

[18] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

[19] Medical facility staff are not required to take further action if a veteran declines to be referred for additional assistance. See appendix A for details on the screening reminder.

Figure 1. *The Homeless Screening Clinical Reminder process.*
Source: VA OIG.

Referral

VHA policy requires medical facilities to have clear protocols for determining how veterans experiencing housing instability will be referred to both homeless-specific and other programs and to develop screening and assessment procedures that assign these veterans to the appropriate assistance.[20] However, VHA policy and standard operating procedures do not have specific requirements for how referrals should be made by screeners, and program office officials told the audit team that medical facilities determine their own local processes. The audit team identified the following referral methods used by medical facilities:

- **Consults:** A consult is a request for services on behalf of the veteran through the EHR and allows the screener to document a veteran's needs and send the request to another service (for example, social work). Staff then document their actions, such as their outreach attempts and the outcomes of the outreach performed, within the consult.
- **Adding cosigners:** Screeners add other staff, such as social workers, as cosigners to the screening note in the EHR. When a veteran has been screened as positive, staff who have been added as cosigners are notified of the positive screen within the EHR and must acknowledge they reviewed the notification.
- **Instant messaging:** Screeners use instant messaging software to send messages to individual social workers or groups to coordinate care.

[20] VHA Directive 1501.

- **Warm handoffs:** Screeners or other staff accompany the veteran and transfer care to the appropriate receiving provider for immediate care.

Follow-up and Documentation

The program office's standard operating procedure states that follow-up action is expected to occur within 30 days of a positive screening and notes that it is good clinical practice to reach out to veterans as soon as possible.[21] At a minimum, this follow-up should consist of an encounter where the veteran receives information about VA homelessness programs or housing assistance, or an assessment of their needs and a referral to specific homelessness programs. VHA policy and standard operating procedures do not provide additional guidance to medical facilities on expected follow-up procedures, such as the number of attempts staff should make to follow up with veterans who accepted referrals or for how long staff should continue to attempt outreach.

Homelessness program supervisors at medical facilities are responsible for monitoring the "Homeless Screening Clinical Reminder Follow-Up Report" (follow-up report). The program office recommends regular reviews of this electronic report to achieve the 30-day follow-up goal.[22] The follow-up report is updated daily with data pulled from the clinical reminder and medical record and includes the veteran's identifying information, the type of screening (at risk of or experiencing homelessness), whether the veteran requested or declined referral, whether follow-up occurred, and the date that follow-up occurred. If follow-up has not occurred, the report will show the number of days follow-up has been pending since the screening. After 90 days, the veteran's name is dropped from the follow-up report whether follow-up has been completed or not.

A completed follow-up is noted in the follow-up report when a veteran has a documented encounter or a completed appointment with a prescribed homelessness program or social work clinic. VA uses "stop codes" to identify these clinical encounters and to capture clinical workload. The program office designated specific stop codes in the report to indicate whether veterans received follow-up encounters.[23]

[21] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

[22] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)." VHA's Support Services Center created the follow-up report for the program office.

[23] Clinical encounters that occur on the same day or after the screening in the following clinics are reported as follow-up: Social Work; Grant and Per-Diem; Department of Housing and Urban Development-VA Supportive Housing; Health Care for Homeless Veterans; Homeless Chronically Mentally Ill; Healthcare for Reentry Veterans; and Veterans Justice Outreach. Follow-ups can occur via telephone, face-to-face, or in a group setting. Additionally, encounters with the Homeless Patient Aligned Care Team also count as follow-up within the report. VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

Governance and Monitoring

Various VHA staff, including program office and medical facility staff, are involved in overseeing and monitoring the processes related to the screening reminder:

- The **Homeless Programs Office** develops policy and coordinates the provision of VHA's programs and services for homeless veterans at medical facilities. The office is responsible for establishing the recommended practice for follow-up after the screenings. This office also monitors and measures the integrity and effectiveness of VHA's homelessness programs through various tools and provides technical assistance to Veterans Integrated Service Networks, medical facilities, and community partners.[24]
- **Veterans Integrated Service Networks** are responsible for regional oversight. Network homeless coordinators provide guidance and monitor the delivery of services, program outcomes, and veteran satisfaction at medical facilities within their assigned Veterans Integrated Service Network but do not have monitoring responsibilities related to the homelessness screening process.[25]
- **Homelessness program supervisors** at medical facilities monitor the status of follow-up actions generated from the screening reminder, develop local follow-up strategies, and coordinate participation across homelessness services.[26] Supervisors also ensure that services for those experiencing housing instability are coordinated internally and with key external partners. Supervisors also make sure staffing and services are adequate to contact, assess, and engage veterans at risk of or experiencing homelessness.[27]
- **Homelessness program and social work staff** at medical facilities follow up, within 30 days, with veterans who have been referred after a positive screening.

VA's Two Electronic Health Record Systems

The Electronic Health Record Modernization program manages the transition from VA's current medical records system, the Veterans Health Information Systems and Technology Architecture (VistA), to a new EHR system. In May 2018, VA awarded a contract to Cerner (Oracle Health)

[24] VA Functional Organizational Manual, ver. 8.1, *Description of Organization Structure, Missions, Functions, Tasks, and Authorities Volume 1: Administrations*, 2023.

[25] VHA Directive 1501.

[26] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

[27] VHA Directive 1501.

to implement a new EHR system (Oracle Health EHR) at VA medical facilities nationwide.[28] The new system is intended to be interoperable with the Department of Defense system and community providers and give veterans and their healthcare providers a comprehensive record to improve the quality of care. As of March 2025, the new EHR system had been deployed at six sites.[29] Table 1 lists the facilities using the Oracle Health EHR and the date each began using the new EHR.

Table 1. Oracle Health Medical Facility Sites

Site	Location	Go-live date
Mann-Grandstaff VA Medical Center	Spokane, Washington	October 24, 2020
Jonathan M. Wainwright Memorial VA Medical Center	Walla Walla, Washington	March 26, 2022
VA Central Ohio Health Care System	Columbus, Ohio	April 30, 2022
Roseburg VA Health Care System	Roseburg, Oregon	June 11, 2022
VA Southern Oregon Rehabilitation Center and Clinics	White City, Oregon	June 11, 2022
Captain James A. Lovell Federal Health Care Center	Chicago, Illinois	March 9, 2024

Source: "EHR Deployment Schedule," (web page), VA EHR Modernization, accessed April 18, 2025, https://digital.va.gov/ehr-modernization/ehr-deployment-schedule/.

Although VA is using two EHR systems, the screening, referral, follow-up, and monitoring processes are similar.[30] However, there are differences in terminology between the two systems. For example, "clinical reminders" in VistA are called "recommendations" in the Oracle Health EHR, and "consults" in VistA are called "referrals" in the Oracle Health EHR. The OIG uses the terms "clinical reminders" and "consults" in this report.

[28] The Oracle Corporation acquired Cerner Corporation, including Cerner Government Services Inc., on June 8, 2022, assuming responsibility for the EHR contract with VA. Cerner became Oracle-Cerner at that time and now goes by Oracle Health Government Services Inc.

[29] On March 6, 2025, VA announced its plans to deploy the Oracle Health EHR at nine additional medical facilities, bringing the planned total to 13 medical facilities.

[30] The Oracle Health EHR prompts screeners to ask veterans if they are concerned about their housing situation in the next 30 days, whereas the VistA EHR prompts screeners to ask veterans if they are concerned about their housing in the next two months. See appendix A for the screening questions from the VistA and Oracle Health EHRs.

Results and Recommendations

Finding: Stronger Homelessness Screening Controls Are Needed to Ensure Veterans Receive Follow-up Action

In the OIG's review, at the three medical facilities that used the VistA EHR system, staff did not follow local referral and follow-up procedures for 22 of the 36 sampled cases (about 61 percent). The team found that at these three facilities, staff did not refer 11 of 22 veterans after the veterans indicated that they wanted to discuss their housing concerns with VA social workers or homelessness program staff. And, after receiving referrals for the 11 other veterans among the 22, social workers and homelessness program staff did not follow their facilities' local procedures regarding the expected level of effort and methods of outreach needed to complete encounters. The audit team determined that 20 of the 22 veterans received no follow-up from their facilities following a positive screening. The other two veterans, while waiting for follow-up, contacted the National Call Center for Homeless Veterans and then received follow-up when their cases were referred back to the local facility for action.

The audit team also reviewed 12 veteran cases at the Oracle Health EHR site in Columbus, Ohio, but found that the data did not accurately show how many veterans had screened positive or account for how many veterans requested referral for additional assistance. Based on interviews and observations, the audit team found that a cumbersome consult process resulted in staff using workarounds, such as sending instant messages to social workers, to make referrals outside the Oracle Health EHR. As a result, veterans could be at increased risk of not receiving follow-up at this facility.

Broadly, the audit team found that staff did not follow local referral and follow-up procedures because medical facilities did not establish written local policies about how staff should make referrals and the level of effort they should make to reach veterans to complete follow-up encounters. Despite recommending frequent monitoring of the follow-up report, the program office did not ensure that the report was reliable, and homelessness program supervisors at medical facilities did not review the report regularly. Improvements to these controls and ongoing monitoring will help make sure VHA's proactive efforts to screen all veterans are not wasted and would further support VA's goal of ending and preventing veteran homelessness.

This finding includes the following topics:

- Review of homelessness screening data
- Review of referral management process to determine whether veterans received follow-up after screenings
- Review of homelessness screening process controls

What the OIG Did

The audit team used data from the "Homeless Screening Clinical Reminder Follow-Up Report" dated September 4, 2024, to group medical facilities based on how well they appeared to have completed encounters with veterans within 30 days of a positive screening. Facilities were considered higher-performing if more than 80 percent of veterans received a follow-up encounter within 30 days and lower-performing if more than 25 percent of veterans did not receive a follow-up encounter within 30 days.[31] Based on the performance categories for the VistA sites, the team judgmentally selected two lower-performing facilities (VA San Diego and Houston Healthcare Systems) and one higher-performing facility (VA Oklahoma City Healthcare System) that had a high volume of veterans who requested referrals after positive screens.[32] The team also selected the VA Central Ohio Health Care System in Columbus because it was the Oracle Health site with the greatest number of veterans who reportedly screened positive.[33]

The team reviewed these four medical facilities' policies and conducted site visits to interview medical facility staff and observe the processes in the EHR. From each facility, the team selected a random sample of 12 veterans who had screened positive and requested a referral and either had follow-up within 30 days or had a follow-up pending for more than 30 days. The team also sent an electronic questionnaire to staff at 20 additional medical facilities (15 operating the VistA EHR and five operating the Oracle Health EHR). The purpose of this questionnaire was to obtain information about these facilities' screening policies and procedures. The team used facility responses to the questionnaire to assess the extent to which the practices and issues identified at the four site visit medical facilities occurred at other facilities. Because the questionnaire was sent to judgmentally selected facilities—rather than to all facilities or a representative sample—the information gathered is not representative of all VA medical facilities.[34]

Review of Homelessness Screening Data

Homelessness screening data in the September 2024 follow-up report indicated VHA had 9,052 veterans who screened positive for housing instability and accepted a referral in the 90-day period from June 6 through September 4, 2024.[35] Based on the report, 3,018 of those 9,052 veterans had not yet had a follow-up encounter (about 33 percent). Furthermore, 1,724 of

[31] A program office official told the audit team that there were no performance metrics related to the 30-day follow-up expectation. Therefore, the audit team established thresholds to categorize higher- and lower-performing facilities.

[32] A facility was considered "high volume" if the number of veterans who requested referrals was equal to or greater than the national average of 65.

[33] The follow-up report did not indicate whether veterans wanted to be referred for Oracle Health sites.

[34] See appendix B for details about this report's scope and methodology.

[35] The group of 9,052 veterans who screened positive includes 535 veterans from Oracle Health sites. However, the data from the VHA Support Service Center's report did not indicate whether those veterans wanted to be referred for additional assistance.

those 3,018 veterans pending follow-up (about 57 percent) had already passed the 30-day deadline, with an average of 60 days pending.[36]

The September 2024 follow-up report also indicated some facilities appeared to be experiencing challenges in meeting the program office's expectation that they complete follow-up encounters within 30 days of the screenings. At 42 of 140 facilities covered by the report, between 25 percent and about 71 percent of veterans (depending on the facility) who wanted to be referred for additional assistance during the screening did not receive a follow-up encounter within 30 days.[37]

Review of Referral Management Process to Determine Whether Veterans Received Follow-up After Screenings

The audit team assessed referral and follow-up procedures at the VA healthcare systems in Oklahoma City, San Diego, and Houston and determined that lapses in the implementation of local referral and follow-up processes at the San Diego and Oklahoma City medical facilities and the lack of a clear facility-wide process at the Houston facility hampered their ability to provide timely follow-up to veterans. In total, the team found that staff at these three facilities did not follow their local referral and follow-up procedures for 22 of the 36 veterans reviewed (about 61 percent). Specifically, facility staff did not make required referrals for 11 of 22 veterans after the veterans requested follow-up discussion of their housing concerns with a VA social worker or homelessness program staff. Facility staff also did not comply with local procedures to get in touch with the remaining 11 veterans who had requested follow-up. Table 2 shows the number of veterans who were not referred and the number of referred veterans for whom staff did not follow local procedures regarding outreach.

Table 2. Veterans Affected by Screening Reminder Process Deficiencies at VistA Sites

Medical facility location	Veterans reviewed	Veterans not referred	Veterans did not receive outreach actions in accordance with local procedures
Houston, Texas	12	8	0
San Diego, California	12	2	5
Oklahoma City, Oklahoma	12	1	6

[36] The veterans who had not yet received a follow-up after 30 days were pending follow-up an average of 60 days after their screenings.

[37] From these 42 medical facilities, the veterans who had not yet received a follow-up after 30 days had an average pending follow-up time of 60 days after their screenings. Veterans who had a completed follow-up after 30 days received their follow-up, on average, 49 days after their screenings.

Medical facility location	Veterans reviewed	Veterans not referred	Veterans did not receive outreach actions in accordance with local procedures
Total	**36**	**11**	**11**

Source: VA OIG analysis of sample results.

In total, 22 veterans were not referred or did not receive outreach from staff despite local procedures to do so, and 20 of these veterans did not receive a follow-up encounter.[38] The other two veterans, while waiting for follow-up, contacted the National Call Center for Homeless Veterans and then received follow-up when their cases were referred back to the local facility for action.

The audit team also selected 12 veterans from the follow-up report for the VA Central Ohio Healthcare System in Columbus, the site that operated the Oracle Health EHR. However, the report data for this facility did not accurately show how many veterans had screened positive or account for how many veterans requested referrals for additional assistance. Accordingly, the team relied on interviews and observations of the screening reminder process in the Oracle Health EHR to assess local homelessness screening referral and follow-up procedures. The team found that a cumbersome consult process resulted in staff using workarounds, such as sending instant messages to social workers, to make referrals outside the Oracle Health EHR. As a result, veterans could be at an increased risk of not receiving follow-up at this location.

Review of Medical Facility Clinical Staff Referral of Veterans Requesting Follow-up

According to the program office's standard operating procedures, the screening reminder ensures that veterans who are experiencing housing instability are referred for appropriate assistance.[39] However, the team found that screeners did not always refer veterans to social workers or homelessness program staff when veterans indicated they wanted to discuss their housing concerns. The processes used to make referrals varied within and between the reviewed medical facilities, and the team did not find evidence of referral for 11 of 36 veterans (about 31 percent).

The Houston medical facility did not have written referral procedures and did not follow a consistent referral process, but screeners as well as social work and homelessness program supervisors told the team the facility's local process to refer veterans after positive screenings did not involve the use of consults. Instead, screeners interviewed by the team reported using various referral methods. Some screeners said they would send instant messages to social workers while

[38] During the audit, the OIG made facility homelessness program supervisors aware of veterans who did not receive a referral or follow-up encounter.

[39] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

others said they alerted social workers by adding them as cosigners to the clinical note in the medical record. Staff also said that, if possible, screeners will do a "warm handoff" to the assigned Patient Aligned Care Team social worker—meaning that the screener physically walks the veteran to the social worker.[40] One nurse told the team that they would not typically refer veterans to a social worker but would instead verbally inform the provider about the positive screen or leave a written note on the veteran's intake sheet.

The audit team could not find any evidence indicating that eight of the 12 veterans reviewed at the Houston facility had been referred. Although one veteran received a follow-up encounter on the same day from the medical facility after the veteran called the National Call Center for Homeless Veterans, social workers did not complete encounters with the other seven veterans. Weaknesses in local referral processes resulted in missed opportunities to assist those seven veterans identified by the screening process. Example 1 shows how VA missed opportunities to assist veterans when they were not referred after positive screenings.

Example 1

A primary care physician assistant screened a veteran during the veteran's unscheduled visit at the Houston medical facility on August 2, 2024. The veteran reported experiencing housing instability and was living in a hotel. The veteran agreed to a referral and said phone was the best contact method. The physician assistant advised the veteran to see social workers at the facility after the veteran's mental health appointment but there was no documentation that a warm handoff was completed or that a referral was made. The veteran did not meet with a social worker on that day and did not receive any outreach from social work or homelessness program staff. Over two months later, on October 21, 2024, the veteran went to the Homeless Patient Aligned Care Team clinic for housing assistance and was referred to the Supportive Services for Veteran Families program and community resources.[41]

The team concluded that the absence of a consistent local process to initiate and track referrals through the EHR at the Houston facility increased the risk of veterans not receiving follow-up after they indicated they wanted to be referred for additional assistance.

[40] A Patient Aligned Care Team is a team of healthcare professionals that provides comprehensive care in partnership with the veteran and includes a primary care provider, pharmacist, nurse, and social worker.

[41] Homeless Patient Aligned Care Team clinics include medical staff, social workers, mental health and substance use counselors, nurses, and homelessness program staff to provide veterans with care and services that lead to permanent housing. "Homeless Patient Aligned Care Teams" (web page), VA Homeless Programs, accessed June 11, 2025, https://www.va.gov/homeless/HPACT.asp. The Supportive Services for Veteran Families program provides low-income veterans with case management and supportive services to prevent the imminent loss of housing or to identify new, more suitable housing situations. "Supportive Services for Veteran Families," (web page), US Department of Veterans Affairs, accessed June 11, 2025, https://www.va.gov/homeless/ssvf/index.html.

The San Diego and Oklahoma City medical facilities also did not have written referral procedures, but screeners as well as social work and homelessness program supervisors told the team that screeners were expected to submit consults through the EHR to make referrals. Based on the team's observation of the screening reminder process at these facilities, a consult appears in the EHR at the end of the screening when veterans indicate they want to be referred. The team found that, in general, staff referred veterans after positive screenings at these facilities and did not submit a consult to refer veterans to social workers in only three of 24 sampled cases (about 13 percent).[42] Two of these three veterans did not receive follow-up or any outreach attempts from social workers. The other veteran received follow-up, but only after the veteran called the National Call Center for Homeless Veterans and was referred back to the facility that conducted the original screening. Although screeners at the San Diego and Oklahoma City medical facilities generally followed their own process by submitting consults to refer veterans for further assistance, staff who responded to the consults at these two facilities did not always perform outreach following local procedures and with the intent of completing encounters—that is, interacting with veterans—as discussed in the following section.

Review of Social Work and Homelessness Program Staff Adherence to Local Procedures and National Guidance When Conducting Outreach

Social work and homelessness program staff are expected to have a follow-up encounter within 30 days of the screening with veterans who want to be referred for further housing assistance.[43] Staff conduct outreach to veterans to complete encounters, but the audit team found varying levels of compliance with local outreach procedures in its review of the three medical facilities operating the VistA EHR.

The Houston medical facility did not have written procedures for conducting outreach. However, social work and homelessness program staff and supervisors reported staff were expected to make a minimum of three phone call attempts. At the Houston facility, screeners referred four of the 12 veterans reviewed, and the audit team found that in these four instances the facility's outreach actions aligned with the described procedures. Specifically, the audit team found that screeners at the Houston facility completed a warm handoff to a social worker for one of these veterans, and the social worker provided the veteran with housing resources the same day. Social workers were alerted through the cosigning process for two veterans, and the social workers

[42] Although consults are generated automatically, the team observed that they were not automatically sent. Providers can enter additional details after the consult is created and must submit the consult. In one of these cases, the Patient Aligned Care Team social worker canceled the veteran's consult because the nurse did not put a "reason" for the consult, such as the veteran's needs or resources requested. Although the social worker added a note to resubmit the consult, the nurse did not submit a new consult and the veteran did not receive follow-up.

[43] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

called or met with these two veterans to provide housing information. The team could not determine the referral method in the EHR for the fourth veteran but confirmed with the screener that their process included instant messaging a specific social worker, and that social worker called the veteran on the same day and provided housing information.

The San Diego and Oklahoma City medical facilities also did not have written outreach procedures, and the audit team found that staff did not follow their stated local outreach procedures, despite more consistent referrals compared to the Houston medical facility. Social work and homelessness program staff in these two medical facilities did not make sufficient attempts to complete an encounter in accordance with local procedures when they performed outreach for 11 of the 24 veterans reviewed (about 46 percent).

At the San Diego medical facility, consults from the screening reminder are sent to the facility's social work service, and a social services assistant reviews the consults and delegates them to the veteran's assigned Patient Aligned Care Team social worker to perform outreach. Those social workers told the audit team they make a minimum of one phone call to the veteran. If they cannot reach the veteran, they send a letter to the veteran with information about housing resources and close the consult. However, in five of 12 cases, the team found that the social workers did not make these more substantial efforts to engage veterans and complete an encounter. Instead, they only sent veterans emails containing housing resource information and made no attempt to call the veterans before they closed the consults.

At the Oklahoma City facility, consults from the screening reminder are sent to the facility's Health Care for Homeless Veterans program.[44] Social workers in this program respond to the consults and stated they are expected to make three phone call attempts. If they cannot reach the veteran, they send them a letter before closing the consult. However, these social workers did not follow their local outreach procedures for six of 12 veterans referred through consults. In two cases, the social worker did not make any attempts to reach the veteran before closing the consult, while in three cases, the social worker only mailed housing resource information before closing the consult. In the last case, the social worker made one phone call and left a voicemail before closing the consult. Example 2 shows how VA can miss opportunities to provide veterans with needed information or services when staff do not conduct outreach to veterans who have been referred.

Example 2

A social worker at the Oklahoma City facility screened a veteran on August 13, 2024. The veteran reported experiencing housing instability and had

[44] The Health Care for Homeless Veterans program's goal is to reduce veteran homelessness by conducting outreach to those who are the most vulnerable and who are not receiving VA services. "Health Care for Homeless Veterans (HCHV) Program" (web page), VA Homeless Programs, accessed April 1, 2025, https://www.va.gov/homeless/hchv.asp.

> *been "couch surfing" and staying in hotels in the past two months. The veteran agreed to a referral and indicated preferring phone contact. Although the social worker from the Health Care for Homeless Veterans program who reviewed the consult noted the veteran was in a VA substance abuse treatment program and had temporary housing, the social worker did not make any attempts to contact the veteran before closing the consult. The social worker should have conducted outreach and attempted to complete a follow-up encounter because, as part of the screening, the veteran was asked if they wanted to be referred to talk more about their housing situation and for the best way to reach them. Almost four months later, on December 9, 2024, the veteran went to the Oklahoma City facility's homeless walk-in clinic to request information on affordable housing. Had the social worker called the veteran, the veteran's needs could have been addressed sooner.*

Homelessness program supervisors from the San Diego and Oklahoma City facilities agreed that staff did not adhere to their local follow-up procedures in these 11 cases because they did not make the minimum number of phone call attempts when responding to the consults. Veterans should have a reasonable expectation to be contacted after they communicate that they want to be referred to speak with someone about their housing situation.[45]

Review of Referrals Outside the Oracle Health EHR System for Veterans Requesting Follow-up

The audit team also selected 12 veterans from the follow-up report for the Columbus medical facility, an Oracle Health site, to assess the facility's referral and follow-up procedures. However, the team found the follow-up report was unreliable for Oracle Health sites because it did not accurately show veterans who screened positive and lacked information about whether veterans wanted to be referred.[46] Consequently, the team was unable to determine whether facility staff followed local referral and follow-up procedures for the 12 veterans selected from the Columbus medical facility. The team relied instead on interviews with clinical staff, social workers, and homelessness program supervisors, as well as observations of the process in the Oracle Health EHR to assess the facility's procedures. These interviews and observations revealed vulnerabilities in the referral processes that could lead to veterans not receiving a follow-up encounter.

When a veteran screens positive for housing instability and wants to be referred for further assistance, the Oracle Health EHR prompts the clinical staff to initiate a consult. Columbus facility staff reported that submitting consults in the Oracle Health EHR was a cumbersome

[45] See question four in appendix A.

[46] The unreliable data in the follow-up report from the Columbus medical facility is discussed later in this report.

process prone to user error and can lead to consults not being submitted. Specifically, providers must navigate to a separate screen, select the appropriate consult form, identify the correct referral clinic, and assign a provider. If any of these steps are missed, the consult would not be submitted. This differs significantly from the VistA consult processes, where the consult is automatically generated for the screener to submit when a veteran requests a referral after screening positive for homelessness or risk of homelessness. Due to challenges in the Oracle Health EHR, staff at the Columbus medical facility reported they used alternative referral methods such as instant messaging or warm handoffs to social workers instead of consults. However, veterans may be more likely to be overlooked when referrals are made outside the EHR, as the audit team found at the Houston facility.

Review of Homelessness Screening Process Controls

The team sent a questionnaire to 20 additional medical facilities to review their local screening reminder policies and procedures and generally identified gaps and vulnerabilities similar to those found at the four facilities where the team conducted site visits.[47] Except in the case of one facility, these facilities did not establish written local policies related to referral and follow-up procedures, and the program office did not ensure medical facilities had a reliable monitoring tool to track the completion of follow-up encounters.

Review of Medical Facilities' Establishment of Written Policies

VHA policy requires medical facilities to have clear protocols for determining how veterans at risk of or experiencing homelessness will be referred to homelessness services, but it does not require specific referral methods related to the homelessness screening to be used.[48] The program office's standard operating procedure states that veterans should receive a follow-up encounter within 30 days of positive screenings, but it does not provide guidance on how staff should conduct outreach or the number of attempts they should make to complete follow-up encounters.[49] Although program office officials told the audit team that facilities can implement their own local procedures, the audit team found that the Houston, San Diego, and Oklahoma City medical facilities did not have written policies on referral and follow-up processes. In addition, the audit team concluded that the Houston, San Diego, and Oklahoma City medical facilities need to define these processes in written policy because facility staff did not follow the self-reported local referral and follow-up procedures—as explained by these staff and their supervisors during interviews—for 22 of the 36 veterans reviewed (about 61 percent). The lack

[47] The team sent the questionnaire to 20 judgmentally selected medical facilities: 15 that used the VistA EHR and five that used the Oracle Health EHR. See appendix B for additional information about the questionnaire's methodology.

[48] VHA Directive 1501.

[49] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

of written policies—covering key processes such as how and to whom referrals should be made and expectations for outreach—can limit the effectiveness of the screenings and lead to missed opportunities to complete timely follow-up encounters with veterans. Further, according to questionnaire responses from staff at 15 medical facilities using the VistA EHR, only one of those facilities had a written policy that had specific guidance on how veterans should be referred after positive homelessness screenings.

Written policies are critical as part of an effective internal control system, and managers should establish policies and practices that define roles and responsibilities and ensure policies are documented and communicated so that operations are consistent.[50]

Review of Whether Homeless Programs Office Ensured Medical Facilities Had an Effective Mechanism to Monitor Follow-up Actions

The VHA Support Service Center developed the follow-up report so that medical facility staff could identify veterans awaiting follow-up.[51] The office also recommended that homelessness program supervisors monitor the report frequently and coordinate participation across homelessness services.[52] The team found data inaccuracies and other limitations in the report that reduced its usefulness for medical facility staff to monitor follow-up. If the report were more reliable, it could be used to not only monitor whether veterans received follow-up, but also to determine whether staff are following local policies and procedures for outreach.

At the three medical facilities operating the VistA EHR where the team reviewed 36 veteran cases, the team found that the report accurately captured the veterans' positive screenings and referral requests. However, the report did not always accurately reflect whether veterans received follow-up related to their housing concerns. For example, the report indicated that a veteran received follow-up if the veteran had an encounter or completed appointment with a social worker even if the encounter was unrelated to housing. This is because the report relies on "stop codes," which are used to capture data about an encounter and indicate whether veterans received follow-up. However, stop codes do not indicate whether an encounter was related to the veterans' housing concerns. The team found that, according to the report, 23 of the 36 veterans (about 64 percent) had received follow-up. But for eight of these veterans, there was no follow-

[50] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[51] The VHA Support Service Center creates and maintains secure data platforms, measurement systems, and analytic solutions that help providers work with veterans and their families to make well-informed decisions. VA Functional Organizational Manual.

[52] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

up related to housing documented in the medical record on the date indicated in the report.[53] As a result, supervisors cannot use the report to accurately determine whether staff have addressed veterans' housing concerns.

Medical Facility Monitoring

Medical facilities did not use the screening reminder follow-up report frequently as recommended by the program office. At the Oklahoma City facility, the homelessness program supervisor of the staff who respond to consults from the screenings stated they were not aware of the follow-up report. One homelessness program supervisor at the San Diego medical facility said they were aware of the report but also noted that they reviewed the report infrequently. Both facilities use consults to manage referrals from the screening reminder, and supervisors reported that consults are tracked closely. At the Houston facility, where consults are not used to make referrals, the homelessness program coordinator said the report was reviewed infrequently. However, they said homelessness program supervisors started reviewing the report weekly about two weeks before the audit team's site visit.

Additionally, staff from six of 15 medical facilities operating the VistA EHR who responded to the team's questionnaire reported that their facilities did not use the follow-up report for monitoring. Furthermore, four of these six facilities reported that they require the use of consults for referrals. Veterans could be at risk of being overlooked if staff do not submit consults, as the team found at the San Diego and Oklahoma City facilities. Additional review of the follow-up report would allow staff to identify veterans who screened positive and requested referral. Facilities that require the use of consults can then review the report to ensure follow-up occurs when staff do not submit consults. Facilities that do not use consults, like the one in Houston, can use the report to ensure veterans who screened positive do not get overlooked if they are referred outside the EHR.

All facilities, regardless of the referral processes used, would benefit from a more reliable follow-up report that is used regularly as recommended by the program office. In addition, using ongoing monitoring as an internal control can help facility leaders detect and mitigate risks, such as a lack of adherence to policies.[54]

Monitoring at Oracle Health Sites

As of March 2025, six medical facilities were using the Oracle Health EHR. The audit team identified significant data issues with the follow-up report after reviewing the 12 selected

[53] Thirteen of the 36 veterans were pending follow-up on September 4, 2024, the date the team downloaded the report.

[54] According to federal internal control standards, continuous monitoring enables real-time detection of control deficiencies and risks. Government Accountability Office, *Standards for Internal Control in the Federal Government*.

veterans on the report from the Columbus facility. Specifically, the team found that the report identified veterans who had homelessness program notes documented in their Oracle Health EHR as having positive homelessness screenings. The report also did not indicate whether veterans who screened positive wanted to be referred to discuss their housing concerns. As a result, the team concluded that users of the follow-up report at facilities operating the Oracle Health EHR cannot use the report to track the number of veterans who screen positive for homelessness or make sure that veterans who requested referral were referred and received a follow-up encounter. Specific limitations to the report from the Columbus facility are described below:

- For 10 veterans, there was no homelessness screening completed on the dates indicated on the follow-up report. Instead, the only information related to housing in their medical records on those dates were homelessness program notes, indicating that those veterans had already accessed services. Therefore, the report cannot be used as intended to monitor veterans who screened positive and ensure they receive a follow-up.
- For all 12 veterans, the report did not show whether they wanted to be referred for additional assistance.

After the team sent the questionnaire to the five other medical facilities operating the Oracle Health EHR, an official from Veterans Integrated Service Network 20 reported similar issues that the team had identified about the follow-up report to the program office.[55] In addition to the Columbus facility, the team identified another Oracle Health EHR facility that reported in its questionnaire responses that it did not require the use of consults to make referrals.[56]

If clinical staff routinely make referrals outside the medical record, veterans could be at risk of not receiving follow-up. The program office can mitigate this risk by ensuring the follow-up report, for all medical facilities, whether they are using the VistA or Oracle Health EHR, accurately captures the veterans who screened positive and requested a referral, the date they screened positive, and whether they received a follow-up encounter with a social worker or homelessness program staff that addressed their housing concerns.

[55] Veterans Integrated Service Network 20 has four medical facilities that use the Oracle Health EHR: Roseburg VA Health Care System in Roseburg, Oregon; VA Southern Oregon Rehabilitation Center and Clinics in White City, Oregon; Mann-Grandstaff VA Medical Center in Spokane, Washington; and Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington.

[56] The two Oracle Health sites that reported they did not require consults were VA Southern Oregon Rehabilitation Center and Clinics in White City, Oregon, and VA Central Ohio Health Care System in Columbus, Ohio.

Conclusion

VHA continues to screen millions of veterans for homelessness each year and has opportunities to assist more veterans facing housing instability when they are identified during the screening process. The screening's effectiveness in ending and preventing veteran homelessness depends on the work of various staff at medical facilities, including nurses who must ensure veterans are referred as requested during the screening, social workers who follow up with veterans, and homelessness program supervisors who monitor veterans needing follow-up. However, the team found that clinical staff did not consistently refer veterans as requested, and social work and homelessness program staff did not follow their facilities' local procedures regarding the expected level of effort and methods of outreach needed to complete encounters.

Additional controls, such as establishing written local policies that outline how and to whom referrals should be made and expectations for outreach, can ensure veterans do not get overlooked. Further, improving the follow-up report to accurately list veterans who screened positive and accepted referrals, as well as the status of follow-up, and making sure the report is reviewed on an ongoing basis can help homeless program supervisors identify veterans who may have been overlooked. Supervisors can also use this report to detect instances when staff do not follow local policies so those deficiencies can be corrected. Implementing these controls could help ensure that all veterans who request assistance receive the services and support they need in a timely manner and that VHA's significant efforts and resources to screen millions of veterans each year are not wasted.

Recommendations 1–4

The OIG made the following recommendations to the under secretary for health:[57]

1. Ensure medical facilities establish and implement clear written Homeless Screening Clinical Reminder policies that define the roles and responsibilities of staff involved in the referral, follow-up, and monitoring processes.
2. Ensure medical facility staff involved in the Homeless Screening Clinical Reminder process are aware of and trained on written local policies and procedures for making referrals, conducting follow-up, and monitoring.
3. Develop and implement a review process to determine whether medical facility staff followed local Homeless Screening Clinical Reminder policies whenever a veteran does not receive a follow-up encounter within 30 days of a positive screening and correct any identified deficiencies.

[57] 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.

4. Ensure all medical facilities have a reliable report that accurately lists veterans who screened positive and accepted referrals as well as the status of follow-up actions.

VA Management Comments

The acting under secretary for health concurred with recommendations 1, 2, and 4; concurred in principle with recommendation 3; and provided an action plan for each recommendation.

To address recommendation 1, the program office will collaborate with the chief operating officer to: (1) partner with social work leaders to review processes and identify opportunities to define roles and responsibilities of staff involved in the homelessness screening's referral, follow-up, and monitoring, and revise standard operating procedures where necessary; (2) implement changes across Veterans Integrated Service Networks and coordinate with network homeless coordinators to ensure facilities are aware of recommended practices to routinely use the follow-up report to identify and engage vulnerable veterans; (3) ensure that facility social work and homelessness program leaders share clearly defined roles and any new processes locally; and (4) task network homeless coordinators with verifying that each facility's homelessness program, including those at sites transitioning to the Oracle Health EHR, updates or establishes homelessness screening policies and procedures.

In response to recommendation 2, the program office will educate key stakeholders about expectations for medical facility staff involved in homelessness screening, work with social work leaders to provide training, facilitate quarterly meetings with network homeless coordinators to review guidance and expectations, and hold quarterly calls for facility supervisors and staff on homelessness screening procedures. The program office will also make sure network homeless coordinators verify that facilities establish homelessness screening policies and procedures and verify training, including on local policies.

For recommendation 3, the acting under secretary for health concurred in principle and said follow-up is encouraged in 30 days but not mandated in policy. To address the recommendation, the program office will identify ways medical facility staff can reduce the risk of missed opportunities for follow-up, such as identifying status updates based on time intervals, researching trends when follow-up does not occur, and implementing processes and resources for facility staff to improve routine tracking and monitoring of follow-up actions and adherence to local policies. The program office will consult with VHA social work leaders to develop training and facilitate quarterly meetings with network homeless coordinators to review follow-up report processes and resources for monitoring, and the program office will hold quarterly meetings so medical facility staff can ask questions and give feedback on review processes and tools.

Finally, for recommendation 4, the program office, through its membership and participation in the Behavioral Health Council, will coordinate with the Electronic Health Record Modernization team to develop a report for facilities operating the Oracle Health EHR that accurately lists

veterans who screened positive and accepted referrals and also gives the status of follow-up actions.

OIG Response

The acting under secretary for health's planned corrective actions for recommendations 1, 2 and 3 are responsive to the intent of those recommendations. Regarding recommendation 3, the OIG acknowledges in the report that follow-up within 30 days of positive screenings is a goal stated in the program office's standard operating procedures, and the OIG does not refer to it as a requirement.[58] Regarding VHA's response to recommendation 4, VHA's planned corrective actions did not indicate how it will address inaccuracies the OIG found with the Follow-Up Report for medical facilities operating the VistA EHR. VHA will need to ensure all medical facilities, whether using the VistA or Oracle Health EHR, have a reliable report that accurately lists veterans who screened positive and accepted referrals, as well as the status of follow-up actions. The OIG will monitor VHA's progress on its planned actions and will close the recommendations when adequate documentation is provided to demonstrate sufficient progress on implementation and fulfillment of each recommendation's intent. Appendix C includes the full text of the acting under secretary's comments.

[58] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

Appendix A: Homelessness Screening Questions

Figure A.1 shows the screening questions in the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record (EHR).

VA Homelessness Screening Clinical Reminder

Screen not performed:

- ❑ Already receiving homelessness services or assistance
- ❑ Long-term resident of Nursing Home/Long-Term Care Facility
- ❑ Declines screening at this time
- ❑ Veteran/Caregiver unable to answer

1. **In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household?**

- ❑ Yes, living in stable housing → *Proceed to question 2*
- ❑ No, not living in stable housing → *Proceed to question 3* **POSITIVE FOR HOMELESSNESS**

2. **Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household?**

- ❑ Yes, worried about housing in the near future → *Proceed to question 3* **POSITIVE FOR RISK**
- ❑ No, not worried about housing in the near future → *Reminder completed* **NEGATIVE**

3. **Where have you lived for MOST of the past 2 months?**

- ❑ Apartment/House/Room – no government subsidy
- ❑ Apartment/House/Room – with government subsidy
- ❑ With Friend/Family
- ❑ Motel/Hotel
- ❑ Hospital, Rehabilitation Center, Drug Treatment Center
- ❑ Homeless Shelter
- ❑ Anywhere outside (e.g., street, vehicle, abandoned building)
- ❑ Other *_____

4. **Would you like to be referred to talk more about your housing situation?**

- ❑ Patient agrees to referral
- ❑ Patient declines referral at this time – given information for future reference

What's the best way to reach you?

How to reach: _____

For more information, please contact [redacted]

Figure A.1. *Homeless Screening Clinical Reminder questions in the VistA EHR.*

Source: OIG re-creation of the National Center on Homelessness Among Veterans "VA Homelessness Screening Clinical Reminder" reference sheet.

Figure A.2 presents the screening questions from the Oracle Health EHR.

Homelessness Screening

1. In the past 30 days, have you been living in stable housing that you own, rent, or stay in as part of a household?

Select the most appropriate answer.

- ☐ Yes - Living in stable housing
- ☐ No - Not living in stable housing (select this option if Veteran is unstably housed or homeless)

2. Are you worried that in the next 30 days you may not have stable housing that you rent, own, or stay in as part of a household?

Select the most appropriate answer.

- ☐ Yes – Worried about housing in the next 30 days
- ☐ No – Not worried about housing in the next 30 days
- ☐ Veteran is currently without housing (select this option if Veteran is unstably housed or homeless)

If question #1 is option 1 and question #2 is option 2, screening is negative and ends – no other questions required to be answered.
If question #2 is option 1, question 3 is required to answer.
If question #2 is option 3, skip to questions #4 & #5.

3. If yes, what is the reason you may not have stable housing within the next 30 days?

Select the most appropriate answer.

- ☐ Court-ordered eviction notice to vacate rental unit
- ☐ Formal written notice from landlord to vacate rental unit (e.g., 30 day Notice to Quit)
- ☐ Written or verbal notice from family, friend or host to leave doubled-up housing
- ☐ Exiting an institution or system of care (e.g., hospital, jail, treatment facility, etc.)
- ☐ Insufficient resources to continue to pay for hotel or motel
- ☐ Other (describe): _____

4. Where have you lived for the most of the past 30 days?

Select the most appropriate answer.

- ☐ Housing owned by Veteran, no ongoing housing subsidy
- ☐ Housing owned by Veteran, with ongoing housing subsidy
- ☐ Housing rented by Veteran, no ongoing housing subsidy
- ☐ Housing rented by Veteran with HUD-VASH voucher
- ☐ Housing rented by Veteran with non-HUD-VASH housing subsidy
- ☐ Permanent housing for formerly homeless persons (such as: CoC project or S+C)
- ☐ Staying or living with family, permanent tenure
- ☐ Staying or living with family, temporary tenure
- ☐ Staying or living with friends, permanent tenure
- ☐ Staying or living with friends, temporary tenure
- ☐ GPD transitional housing
- ☐ Non-VA transitional housing for homeless persons
- ☐ VA MH RRTP
- ☐ Non-VA residential treatment program
- ☐ Non-VA substance abuse treatment facility or detox center
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Prison or jail
- ☐ VA contracted residential treatment programs (HCHV Contract Residential Services)
- ☐ Safe Haven (SH)
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Emergency shelter (ES), including hotel or motel paid for with emergency shelter voucher
- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway, station/airport or anywhere outside)

5. Where did you sleep last night (current housing situation)?
Select the most appropriate answer.

☐ Housing owned by Veteran, no ongoing housing subsidy
☐ Housing owned by Veteran, with ongoing housing subsidy
☐ Housing rented by Veteran, no ongoing housing subsidy
☐ Housing rented by Veteran with HUD-VASH voucher
☐ Housing rented by Veteran with non-HUD-VASH housing subsidy
☐ Permanent housing for formerly homeless persons (such as: CoC project or S+C)
☐ Staying or living with family, permanent tenure
☐ Staying or living with family, temporary tenure
☐ Staying or living with friends, permanent tenure
☐ Staying or living with friends, temporary tenure
☐ GPD transitional housing
☐ Non-VA transitional housing for homeless persons
☐ VA MH RRTP
☐ Non-VA residential treatment program
☐ Non-VA substance abuse treatment facility or detox center
☐ Hospital or other residential non-psychiatric medical facility
☐ Long-term care facility or nursing home
☐ Psychiatric hospital or other psychiatric facility
☐ Prison or jail
☐ VA contracted residential treatment programs (HCHV Contract Residential Services)
☐ Safe Haven (SH)
☐ Hotel or motel paid for without emergency shelter voucher
☐ Emergency shelter (ES), including hotel or motel paid for with emergency shelter voucher
☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway, station/airport or anywhere outside)

6. Housing details (including description of the situation if not stably housed):
_____

7. What is the best way to reach you? _____

8. Plan

☐ Veteran declines referral at this time

Auto-populate this selection if Question #2 is option 1 and Question #3 is answered AND if Question #5 is option 11, 12, 20, 21, 23, or 24

Homeless Services Plan

☐ Referral to homeless program - Veteran is literally homeless (this must be entered separately)

Auto-populate this selection if Question #5 is option 11, 12, 20, 21, 23, or 24

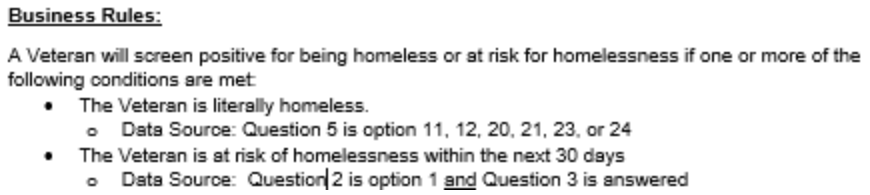
- ☐ VA homeless programs: _____(*details of VA homeless program)*
- ☐ Community homeless resource: _____ (*details of community homeless resource)*

Homelessness Prevention Plan

☐ Referral to Social Work – Veteran is currently at risk for homelessness (this must be entered separately)

Auto-populate this selection if Question #2 is option 1 and Question #3 is answered

- ☐ Further assessment needed to determine appropriate services:_____
(*details of follow-up provider information for further assessment*)
- ☐ Referral to Homelessness Prevention and/or Rapid Resolution Program/Intervention (e.g. SSVF):_____
(*details of follow-up provider information for homeless prevention assistance*)
- ☐ Housing needs will be addressed by current inpatient or residential program prior to discharge):_____(*details of follow-up provider information for homeless prevention assistance*)



Business Rules:

A Veteran will screen positive for being homeless or at risk for homelessness if one or more of the following conditions are met:

- The Veteran is literally homeless.
  - Data Source: Question 5 is option 11, 12, 20, 21, 23, or 24
- The Veteran is at risk of homelessness within the next 30 days
  - Data Source: Question 2 is option 1 and Question 3 is answered

Figure A.2. *Homeless Screening Clinical Reminder questions in the Oracle Health EHR.*
Source: OIG re-creation of the Homeless Programs Office "Homelessness Screening" reference sheet.

Appendix B: Scope and Methodology

Scope

The audit team conducted its work from October 2024 through July 2025. The team obtained the Homeless Screening Clinical Reminder follow-up report on September 4, 2024, which included data for June 6, 2024, through September 4, 2024. The scope included 9,052 unique veterans who screened positive for homelessness or for being at risk of homelessness and who had requested a referral during this period. The team judgmentally selected four medical facilities that had a high volume of veterans who requested referrals after positive screens. The four VA medical facilities selected for review follow in the order the audit team performed site visits:

1. VA San Diego Healthcare System, San Diego, California
2. VA Oklahoma City Healthcare System, Oklahoma City, Oklahoma
3. VA Central Ohio Health Care System, Columbus, Ohio
4. VA Houston Healthcare System, Houston, Texas

From each of these four medical facilities, the team reviewed a stratified random sample of 12 veterans who had screened positive and requested referrals for further housing assistance. The team also sent a questionnaire to 20 additional medical facilities (15 facilities operating the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record (EHR) and five facilities operating the Oracle Health EHR) to obtain information on the facilities' screening reminder policies and procedures.

Methodology

The audit team identified and reviewed regulations, VA policies, standard operating procedures, and guidelines related to the screening reminder processes and oversight. The team also interviewed leaders from the Homeless Programs Office to understand the guidance VA gave to medical facilities on processes and procedures related to the screening reminder referral, follow-up, and monitoring process.

The team analyzed data from the "Homeless Screening Clinical Reminder Follow-Up Report" to identify the four facilities for site visits. The team first determined the number of unique veterans who had screened positive and requested a referral for further assistance. The team then categorized the status of the veterans' referrals in four ways as of September 4, 2024, the date of the report: (1) pending follow-up—30 days or less since the screening, (2) pending follow-up—more than 30 days since the screening, (3) follow-up completed—30 days or less since the screening, and (4) follow-up completed—more than 30 days since the screening. Since the program office did not have performance metrics or targets related to the expectation that veterans receive a follow-up encounter within 30 days of the screening, the audit team

established thresholds to categorize facilities by performance. Facilities were considered higher-performing if more than 80 percent of the veterans received follow-up within 30 days of the screenings. Facilities were considered lower-performing if more than 25 percent of veterans were either pending follow-up after 30 days or received follow-up more than 30 days after the screenings. Neutral-performing facilities were those that did not meet the thresholds to be considered higher- or lower-performing. Table B.1 shows the number of medical facilities in each category.

Table B.1: VA Medical Facility Performance

Medical facility category*	Number of medical facilities	Percentage‡
Higher-performing	28	21
Lower-performing	32	24
Neutral	74	55
Total	**134**	**100**

Source: VHA Support Service Center's "Homeless Screening Clinical Reminder Follow-Up Report" dated September 4, 2024.
** Oracle Health sites are not included.*
‡ Percentages are rounded to whole number.

Based on the performance categories for the VistA sites, the team judgmentally selected two lower-performing facilities (in San Diego, California, and Houston, Texas) and two higher-performing facilities (in Oklahoma City, Oklahoma, and Bay Pines, Florida) that had a high volume of veterans who requested referrals after positive screens.[59] The team selected the VA medical center in Columbus, Ohio, an Oracle Health site, as the fifth site because it had the highest volume of screenings.[60] The team later determined that it was not necessary to review the Bay Pines medical facility because the team had obtained sufficient evidence from the work completed at the four other sites to address the audit objective. The team visited the San Diego VA medical facility in-person and conducted virtual site visits at the facilities in Oklahoma City, Houston, and Columbus to better understand how they managed referrals and follow-ups for veterans. During the site visits, the team interviewed medical facility staff such as nurses and providers who conducted screenings and social workers and homelessness program staff who conducted follow-ups, as well as social work and homelessness program supervisors. The team also observed the screening and referral process in the EHR and reviewed the medical facilities'

[59] A facility was considered "high volume" if the number of veterans who requested referrals was equal to or greater than the national average of 65.

[60] The team could not use the same site selection criteria for Oracle Health sites because the follow-up report did not have data that indicated whether veterans at Oracle Health sites requested to be referred after their positive screenings.

written policies and guidance related to screening reminder processes. The team also reviewed a stratified random sample of 12 veterans (six screened as experiencing homelessness—three who had follow-up within 30 days and three who were pending follow-up over 30 days; and six screened as at risk of homelessness—three who had follow-up within 30 days and three who were pending follow-up over 30 days) from each of the four medical facilities and reviewed their medical records using the Joint Legacy Viewer and the Oracle Health EHR to determine whether facility staff followed local referral and follow-up procedures. Veterans with referrals that were pending within 30 days were excluded from the sample selection because they were still within the program office's 30-day follow-up goal.[61] The team confirmed issues identified with the facilities' homelessness program supervisors but did not use the results of the random sample to make any inferences about the referral and completed follow-up rates for the selected facilities.

Finally, the team sent an electronic questionnaire to homeless program coordinators from 20 additional facilities (15 VistA sites and five Oracle Health sites) to obtain information about these facilities' homelessness screening policies and procedures.[62] The team used facility responses to the questionnaire to assess the extent to which the practices and procedures identified at the four medical facilities during site visits occurred at these other 20 facilities. To select the 15 additional VistA sites, the team chose the five facilities with the greatest number of veterans who requested referrals in each of the higher-performing, lower-performing, and neutral categories. The team also selected the remaining five Oracle Health sites to respond to the questionnaire.[63] Because the questionnaire was sent to judgmentally selected facilities—rather than to all facilities or a representative sample—the information gathered is not representative of all VA medical facilities.

Internal Controls

The audit team assessed internal controls of the homelessness screening referral, follow-up, and monitoring process that were significant in the context of the audit objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[64] The team also reviewed the

[61] VHA Homeless Programs Office, "Homeless Screening Clinical Reminder (HSCR) Follow-up Standard Operating Procedure (SOP)."

[62] The OIG included instructions that facility homeless program coordinators collaborate with other facility staff with expertise in the facility's screening and follow-up processes and procedures as necessary to complete the questionnaire.

[63] As of March 2025, six facilities were using the Oracle Health EHR.

[64] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

principles of internal controls associated with the objective. The team identified three components and three principles as significant to the objective.[65]

The team identified internal control weaknesses during this audit and proposed recommendations to address the following control deficiencies:

- Component: Control Activities
    - Principle 12: Implement Control Activities. Management should document responsibilities through policies and periodically review control activities.
- Component: Information and Communication
    - Principle 13: Use of Quality Information. Management should use quality information to achieve the program objective.
- Component: Monitoring
    - Principle 16: Performing Monitoring Activities. Management should establish and operate monitoring activities to monitor the internal control system and evaluate results.

Data Reliability

The audit team used computer-processed data from the Veterans Health Administration Support Service Center's "Homeless Screening Clinical Reminder Follow-Up Report" to judgmentally select the four medical facilities for site visits and to select a stratified random sample of veterans to review from each site. These data were also used to select 15 facilities operating the VistA EHR for the electronic questionnaire.[66] To test the reliability of these data, the audit team determined whether any data were missing from key fields, contained calculation errors, or were outside the time frame requested. The team also compared data in the follow-up report, such as screening dates, referral preferences, and follow-up encounter dates, with veterans' medical records. The team determined that the data used were appropriate and sufficient for the audit's purposes. However, the team identified data reliability issues with the report that could affect users' ability to monitor whether veterans received follow-up encounters timely. The Office of Inspector General (OIG) discusses these data reliability issues in the report and made related recommendations.

[65] Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

[66] The audit team sent the questionnaire to the five remaining facilities operating the Oracle Health EHR and did not use data from the report to select these facilities.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix C: VA Management Comments, Acting Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: September 15, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Improvements Needed to Ensure Medical Facilities Address Veterans' Needs After Positive Homelessness Screenings

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG's draft report on Improvements Needed to Ensure Medical Facilities Address Veterans' Needs After Positive Homelessness Screenings. 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. The action plan is included as an attachment.
2. VHA homeless services ensure that all Veterans who are homeless and at risk for homelessness, wherever they obtain care in VHA, have access to case management, housing, health care and other supportive services that promote housing stability and wellness. VHA is committed to increasing access to services for Veterans who screen positive for homelessness and will continue to ensure that homelessness is a top priority in the organization.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven Lieberman, M.D., MBA, FACHE

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report – Improvements Needed to Ensure Medical Facilities Address Veterans' Needs After Positive Homelessness Screenings

(Project No. 2025-00077-AE-0007)

Recommendation 1: Ensure medical facilities establish and implement clear written Homeless Screening Clinical Reminder policies that define the roles and responsibilities of staff involved in the referral, follow-up, and monitoring processes.

VHA Comments: Concur. The Veterans Health Administration (VHA) National Homeless Programs Office (HPO), in collaboration with the Chief Operating Officer, will implement the following actions to ensure that medical facilities establish and implement clear written Homeless Screening Clinical Reminder (HSCR) policies that define the roles and responsibilities of staff involved in the referral, follow-up, and monitoring processes.

HPO consulted with the VHA National Social Work Program within Care Management and Social Work Services and will partner to implement actions that ensure Veterans' needs are addressed after positive screenings of homelessness. HPO and VHA Social Work leadership will review the existing business workflows to identify opportunities to define the roles and responsibilities of staff involved in referral, follow-up and monitoring processes related to the HSCR. HPO will review the existing HSCR standard operating procedures and make revisions, where necessary, to ensure roles and responsibilities are clearly defined and establish consistency in referral procedures, where possible, across VA Medical Centers (VAMC) in alignment with standards of clinical practice.

HPO will review and encourage the use of HSCR Follow-Up Report as a tracking tool available to staff to identify Veterans who screened positive or at-risk by the HSCR, and track follow-up contacts with those requesting referrals in alignment with local policies and processes for quality assurance. HPO will implement a change management strategy across Veterans Integrated Service Networks (VISN), and coordinate with Network Homeless Coordinators (NHC) to ensure VAMCs are aware of recommended practices to utilize the HSCR Follow-Up Report to routinely identify and engage with vulnerable Veterans in need of homeless or prevention services.

HPO and VA Social Work leadership will foster relationship building among Social Work Chiefs/Executives and Homeless Leads at VAMC facilities to socialize clearly defined roles and any new processes that mitigate the risk of missed follow-up opportunities with vulnerable Veterans.

HPO leadership will implement a change management strategy across the VISNs and coordinate with NHCs to ensure awareness of new and revised procedures related to referrals and follow-up of Veterans with positive screening. This will include a wide-scale action tasking NHCs to verify that each VAMC Homeless Program update or establish policies and procedures related to HSCR and follow-up with Veterans who screen positive. Consideration will be given to sites implementing the Oracle electronic health record to ensure continuity and standardization of care.

Status: In-Progress Target Completion Date: July 2026

Recommendation 2: Ensure medical facility staff involved in the Homeless Screening Clinical Reminder process are aware of and trained on written local policies and procedures for making referrals, conducting follow-up, and monitoring.

VHA Comments: Concur. The VA HPO will implement the following actions to ensure that medical facility staff involved in the HSCR process are aware of and trained on written local policies and procedures for making referrals, conducting follow-up, and monitoring. HPO will conduct an education and awareness campaign with key stakeholders about expectations for medical facility staff involved in the HSCR process. HPO and Social Work leadership will complete joint training and education for staff. HPO will facilitate quarterly meetings with the NHCs to highlight themes of the report and review process overview guidance and expectations. HHPO will conduct quarterly "office hours" calls for homeless program staff, supervisors, and other VAMC staff to ask open-ended questions about the HSCR and what constitutes a referral following a positive screening.

HPO will partner with VISN and Facility Clinical Leadership to task NHCs to verify that each VAMC with staff involved in the HSCR establishes policies and procedures for routine review of the referral, follow-up and monitoring of Veterans who screen positive on the HSCR. HPO will provide HSCR resources and training materials on the Homeless Operational Hub for staff. HPO will partner with VISN and Facility Clinical Leadership to task NHCs to verify training and enhanced communication of local policies. HPO will solicit feedback from local facilities who participated in national training so HPO can make improvements as needed.

Status: In-Progress Target Completion Date: August 2026

Recommendation 3: Develop and implement a review process to determine whether medical facility staff followed local Homeless Screening Clinical Reminder policies whenever a Veteran does not receive a follow-up encounter within 30 days of a positive screening and correct any identified deficiencies.

VHA Comments: Concur in Principle. The VA HPO concurs in principle, as 30 days is encouraged for follow-up but is not mandated in policy. HPO will implement the following actions to develop and implement a review process to determine whether medical facility staff followed local HSCR policies whenever a Veteran does not receive a follow-up encounter within 30 days of a positive screening and correct any identified deficiencies.

HPO will review the existing HSCR follow-up review processes and resources that are available to VAMC staff to support follow-up tracking and monitoring of Veterans who screen positive. HPO will identify opportunities to improve the review process that will provide staff with additional information about the timeframe between the positive screening result and the follow-up encounter. HPO will implement review processes that help mitigate risks of missed opportunities for follow-up with Veterans, such as identifying status updates based on time passed (i.e., 30, 60, and 90 days). This review will also be guided by research conducted to identify any Veteran characteristics associated with lack of follow-up. HPO will implement the improved HSCR follow-up review processes and related resources to improve routine tracking for VAMC staff involved in the HSCR to monitor follow-up actions and adherence to local policies.

In consultation with VHA Social Work Leadership, HPO will develop training materials and educational sessions to reinforce the importance of timely follow-up for positive homeless screenings. HPO will facilitate quarterly meetings with NHCs to review HSCR follow-up report processes and resources for tracking and monitoring. Additionally, HPO will hold quarterly "office hours" for homeless program staff, supervisors, and other VAMC staff to ask questions and provide feedback on the HSCR follow-up review processes and tools.

Status: In-Progress Target Completion Date: July 2026

Recommendation 4: Ensure all medical facilities have a reliable report that accurately lists Veterans who screened positive and accepted referrals as well as the status of follow-up actions.

VHA Comments: Concur. HPO will coordinate with the Behavioral Health Council and the Electronic Health Record Modernization (EHRM) team to develop a reliable report that accurately lists Veterans who screened positive and accepted referrals, including information on the status of follow-up actions. HPO will leverage its membership and participation in VHA's EHRM Behavioral Health Council to advocate for system design features that support reporting needs, including those related to monitoring HSCR follow-up actions.

As EHRM efforts continue over the next few years, and Oracle Cerner rollout expands to additional sites, HPO will focus on strategies and opportunities to develop operational reports and data visualizations that provide VAMC staff with a reliable report that accurately lists Veterans who screen positive and accept referrals as well as the status of follow-up actions.

Status: In-Progress Target Completion Date: August 2026

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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