



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Suicide of a Veteran Enrolled in VA Supported Housing Bay Pines VA Healthcare System Bay Pines, Florida

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review in response to allegations by an anonymous complainant. Allegations included that a veteran living in Housing and Urban Development (HUD) VA Supported Housing (VASH) committed suicide, that he was considered high risk, and that he did not receive calls or contact from a VA case manager (CM) for months prior to his death. The complainant also alleged that the supervisor of the CMs in the HUD–VASH program at the Port Charlotte Community Based Outpatient Clinic only visited the clinic once since being assigned to the position and that she told the CM to “audit himself and get his charts straight” after learning of the suicide.

We substantiated that the veteran committed suicide. We did not substantiate that he had been identified as high risk for suicide. We found that the veteran went without seeing or speaking to a VA CM during 9 of 18 months in the program, including the almost 5 months prior to his death.

We substantiated that a supervisor visited the Port Charlotte clinic only once, but not that this was inappropriate. We could neither substantiate nor refute the allegation that a CM was told by his supervisor to “audit himself and get his charts straight” after learning of the suicide.

We found that oversight of the HUD–VASH program at the network and system level needed improvement. We determined that 23 out of a sample of 25 other veterans in the program did not receive full case management services such as monthly home visits with suicide assessments as required.

While the veteran may have been at high risk for a suicide event due to multiple risk factors including family history, age, possession of a weapon, and the recent death of a family member, much of this information was not known to the CM as reflected by documentation in the veteran’s medical record. Although they may not have prevented his suicide, home visits or phone contacts with suicide risk assessments during the months immediately prior to his death might have allowed the identification of changes in the veteran’s mental status and provided a possible opportunity to intervene.

We recommended that the System Director ensure that case management services are provided to veterans in the HUD–VASH program as required and that the Network and System Director implement measures to strengthen management controls and oversight of the HUD–VASH program.

The VISN and System Directors agreed with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.



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

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: Healthcare Inspection – Suicide of a Veteran Enrolled in VA Supported Housing, Bay Pines VA Healthcare System, Bay Pines, Florida

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to an anonymous complaint alleging inadequate social work case management. The complainant alleged that a 75-year-old veteran living in VA Supported Housing (VASH) in the Port Charlotte, Florida area committed suicide, that the veteran was known to be at high risk for suicide, and that the veteran had no contact with a social work case manager (CM) for months prior to his death. The complainant also alleged that the VASH program supervisor only visited the Port Charlotte Community Based Outpatient Clinic (the clinic) once since being assigned to the position, and told one CM to “audit himself and get his charts straight” after learning of the suicide. The purpose of this inspection is to evaluate whether the allegations have merit.

Background

The Bay Pines VA Healthcare System (the system) is a 153-bed tertiary care system that provides comprehensive healthcare through inpatient and outpatient services in medicine, surgery, mental health, and rehabilitation medicine. The system is part of Veterans Integrated Service Network (VISN) 8.

The clinic provides diagnosis and treatment of acute and chronic medical conditions, mental health care, and disease prevention and health promotion programs. Additional services include women’s healthcare and home-based primary care.

Program Elements. In 1992, VA partnered with the U. S. Department of Housing and Urban Development (HUD) to establish a program to reduce homelessness among veterans. Through the HUD–VASH program, HUD provides low-income homeless veterans with a Section 8 Voucher¹ and VA provides medical and other clinical services in order to help veterans remain medically and psychiatrically stable, so that housing can be maintained. In 2008, Congress allocated \$75 million to expand the program. As of December 2011, 33,597 formerly homeless veterans have been placed in housing with case management and supportive services.²

There are currently HUD–VASH programs based in over 130 VA facilities with funding appropriated to assist 49,000 veterans to move into permanent housing.³ Nationally, the Northeast Program Evaluation Center (NEPEC) monitors the HUD–VASH program data.⁴

A key component of the HUD–VASH program is mandatory case management services. Each veteran is assigned a CM who is tasked to maintain regular contact with the veteran during the search for housing and continued follow-up once the veteran is housed. The CM is responsible for arranging and coordinating care, as well as providing direct services such as assessment, mental health counseling, and crisis management. The CM also helps the veteran navigate through the Public Housing Authority, assists in locating affordable and safe housing, and negotiates with landlords. Veterans Health Administration (VHA) policy⁵ dictates that HUD–VASH caseloads should not exceed 35 veterans per CM so that “CMs can make frequent home visits” and “monitor physical and psychiatric health and stability.” Policy also requires that all services provided by a CM be documented via progress notes in the veteran’s medical record.

Elderly Suicide. According to the National Institute of Mental Health (NIMH), older adults are disproportionately more likely to commit suicide than the general population.⁶ Suicide rates go up after age 65, particularly among Caucasian males, whose rate of completed suicides increases 36 percent after age 65.⁷ There are many risk factors for suicide, including lack of social support, substance abuse, a history of

¹ A Section 8 Voucher is a HUD assistance benefit for subsidized rent.

² US Department of Housing and Urban Development Press Release: *VA–HUD Homelessness among veterans declines 12% in 2011*, December 13, 2011.

³ National Coalition for Homeless Veterans (NCHV) Newsletter, January 18, 2012.

⁴ NEPEC has broad responsibilities to evaluate VHA mental health programs.

⁵ VHA Handbook 1162.05, *Housing and Urban Development (HUD)–Department of Veterans Affairs Supported Housing (VASH) Program*, June 23, 2009.

⁶ NIMH Fact Sheet, *Older Adults: Depression and Suicide Facts*, National Institutes of Health Publication No.4593, April 2007.

⁷ Pearson, JL, *Progress in Identifying Risk and Protective Factors in Older Suicidal Adults*, *American Journal of Geriatric Psychiatry* 14:9, September 2006, pages 721-723.

depression, and a family history of suicide. Firearms are the most frequently used method for completed suicides in the United States.⁸

Scope and Methodology

We conducted interviews with the former VISN 8 Network Homeless Coordinator (NHC), the system's Chief of Social Work Service, the former supervisor of the HUD–VASH program CMs, CMs assigned to the veteran, the national Program Director of NEPEC, as well as the veteran's granddaughter. Prior to our onsite visit, we reviewed local and VHA policies, clinical practice guidelines, internal reviews and reports, and NEPEC data. In addition to reviewing the veteran's electronic medical record, we also reviewed the medical records of 25 other veterans enrolled in the HUD–VASH program in the same geographic service area.

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

Case Summary

The veteran was a 75-year-old widowed Caucasian male. He was followed for primary care at the clinic. The veteran had no documented history of substance abuse or prior mental health treatment. He was on fosinopril and metoprolol (for high blood pressure), aspirin (for heart protection), and simvastatin (to control elevated cholesterol), as well as zolpidem⁹ 10 mg daily as needed for sleep. Although 5 mg daily is the recommended dose for elderly patients, the veteran was taking 10 mg daily on a long-term basis.

On February 3, 2010, the veteran was screened for admission to the HUD–VASH program. The screening note indicates that program participants must agree to monthly home visits, monthly individual sessions, and monthly group sessions. On February 11, 2010, the veteran was notified of his acceptance into this program. The following day, his assigned CM accompanied him to the HUD office to complete paperwork to apply for a housing voucher. On February 23, 2010, the CM documented a psychosocial assessment of the veteran. The CM wrote that the veteran “has great emotional functioning, however has limited support after losing both of his daughters and his wife.” How and when these losses occurred is not documented. The note states that the veteran had “no traumatic events” in his history. In the same note, the CM documented that the veteran did not have a firearm or other weapon in his possession.

⁸ Centers for Disease Control, <http://www.cdc.gov/Features/PreventingSuicide/>, accessed September 6, 2011.

⁹ This is a sedative approved by the Food and Drug Administration for short-term treatment of insomnia that may in rare cases have side effects of depressed mood or suicidal thinking.

The CM assigned the veteran an Axis I¹⁰ diagnosis of “Phase of Life Problem” and noted current stressors to be financial difficulties and homelessness.

Also on this date, the CM documented a treatment plan for the veteran. The plan included bi-weekly contact between the veteran and CM, and once the veteran was housed, the plan included monthly home visits. The veteran’s stated goals were “to obtain housing, manage finances better, and be able to help my granddaughter and her family with their daily struggles.” The nature of the family’s struggles was not documented. The plan included a timeframe of 3 months to next review the plan.

The next documented contact between the veteran and his CM was a telephone call 5 months later on July 26, 2010, to arrange a home visit for the following day. Sometime between February and July, the veteran had obtained housing on his own; no details of this are documented. The CM made a call to the Housing Authority on this veteran’s behalf on August 10, 2010. The CM saw the veteran for home visits in August and September 2010. Suicidal ideation was assessed as absent during these home visits.

In October 2010, there was a note of a telephone call to arrange a home visit, but no documentation that the home visit actually occurred. Home visits occurred subsequently in November 2010, and in January and February 2011. Suicidal ideation was assessed as absent at each of these home visits. There was no documented contact with the veteran during December 2010.

On March 16, 2011, the CM wrote, “veteran enjoys having the support and advocacy that this writer has provided and does not feel ready to terminate case management services at this time” and “veteran is in need of case management services to support him with his transition from homelessness to independence in his daily life.” The CM progress note indicates the need for continued monthly home visits. The CM documented a two question screen for suicide risk, “Are you feeling hopeless about the present/future?” and “Are you now, or have you recently had thoughts about taking your own life?” The response to both questions was “No.” The mental status exam on that date documents no reported or observed suicidal ideation, intent, or plan.

March 23, 2011, is the last date that the veteran was seen by his CM prior to his death. His treatment plan was updated, and the CM was identified in the plan as his principal mental health provider. A two question suicide risk assessment completed this date by the CM documented that his suicide risk was “Nil,” based on absent thoughts of suicide and evaluation of risk and protective factors. His protective factors were identified as “skills in problem solving, conflict resolution, and nonviolent way of handling disputes, strong connections to family and community support, easy access to a variety of clinical

¹⁰The Diagnostic and Statistical Manual of Mental Disorders uses a multi-axial system to identify current diagnosis and other relevant clinical factors. Axis I is used to specify most clinical psychiatric disorders, or, as in this case, issues that are a focus of clinical attention that are not actually a psychiatric disorder (i.e. Phase of Life Problem).

interventions, and support for help seeking.” His risk factors were identified as “job or financial loss.” There was no assessment for weapons.

More than 3 months after this final visit, on July 5, 2011, the CM entered a note in the veteran’s medical record documenting that she had mailed him a letter notifying him that she would no longer be his CM and that another CM would assume this role. The letter provided the name and contact information for his new CM. Subsequently, on August 4, 2011, the veteran’s granddaughter called the originally assigned CM to notify her that the veteran had committed suicide, by firearm, the previous day.

An autopsy performed on August 4, 2011, categorized the manner of death as suicide, and the cause of death as a gunshot wound to the head. The autopsy report indicated the time of death as 9:37 p.m. The toxicology analysis showed an elevated level of zolpidem at about twice the upper limit of the reference range for a sample taken 1.6 hours after dose administration. In this context it is noteworthy that the veteran was refilling his zolpidem prescriptions at an accelerated rate. He obtained 30-day supplies of the 10 mg tablets on April 21, May 11, June 7, June 27, and July 27, 2011.

Inspection Results

Issue 1: Suicide and High Risk

We substantiated that the veteran committed suicide. Autopsy results confirm death by self-inflicted gunshot wound. We did not substantiate that the veteran had been identified as being at high risk for suicide. The veteran was screened for suicide risk at every home visit with his CM. The veteran consistently denied having suicidal thoughts, denied having a weapon, and had no history of mental health issues documented in his medical record.

Through our interview with the veteran’s granddaughter, we learned that the veteran’s daughter had committed suicide in the same manner, in 2005. We also learned that the veteran reportedly had a concealed weapons permit and owned a handgun. The granddaughter also told us that the veteran spoke openly with his family about committing suicide on the anniversary of his wife’s birthday and that his brother died from cancer just days before the suicide event. According to the NIMH, age, lack of social support, and a family history of suicide place elderly males at increased risk for suicide.¹¹

We found that the CM did not obtain (as documented by history and suicide screenings performed through March 2011) the information we learned from the veteran’s granddaughter. Therefore, it is uncertain how the veteran would have responded or if he

¹¹ NIMH Fact Sheet, *Older Adults: Depression and Suicide Facts*, National Institute of Health Publication No.4593, April 2007.

would have revealed this information if additional screenings had been performed or contact with a CM had occurred in the weeks or months prior to his death.

Issue 2: Inadequate Case Management

We substantiated that this veteran was not seen by a CM for almost 5 months prior to his death, and that this was a deviation from his treatment plan. There was no face-to-face or telephone contact by a CM for 133 days prior to his death and no documentation of CM contact for 9 of the 18 months the veteran was enrolled the HUD–VASH program. Local policy¹² indicates that veterans enrolled in the program will be contacted by their CM at least bi-weekly. Medical record documentation upon his admission to the HUD–VASH program in February 2010 indicated that this veteran agreed to monthly home visits, monthly individual sessions, and monthly group sessions. The veteran received his housing voucher in February 2010 and had no further contact with his CM for 5 months until he contacted her in July 2010. By that time, he had secured housing on his own. The CM told us that she had been unable to locate the veteran during that 5 month period; however, we found no documentation to support this.

The veteran was not seen again after March 2011. We learned that the CM initially assigned to this veteran changed jobs in April 2011. She told us that she understood she was only responsible for handling emergency phone calls. However, the former supervisor told us she expected continued coverage until another CM could be hired or assigned. We confirmed that the supervisor did not hold a staff meeting to discuss caseload redistribution until 2 months later, on June 22. We requested documentation from this meeting but were told that nothing was put in writing. The new CM assumed responsibility for the case effective July 1, 2011, but he stated that he did not visit the veteran because he had been told the veteran was stable and had no housing issues. His only medical record entry concerning this case consisted of closing the case after learning of the suicide. Transfer of this case from one CM to another was not managed appropriately. The veteran was only notified by letter that his assigned CM had changed.

Both of the CMs we interviewed told us that the size of their caseloads made it impossible to meet program visitation requirements. As of June 2011, Port Charlotte had two social workers working as HUD–VASH CMs. Port Charlotte had 70 housing vouchers available, which translated to an average caseload of 35 veterans per CM. This is in line with the VHA standard that CM caseloads not exceed 35 veterans.¹³

The veteran did not see or speak to a HUD–VASH CM during the almost 5-month period from March 23, 2011, until his death on August 3, 2011, although his CM documented in

¹² Social Work Service Memorandum 516/122–009, *Social Work Assessment and Documentation Policy*, March 2009.

¹³ VHA Handbook 1162.5.

March 2011, that the veteran enjoyed the relationship with the CM and still needed case management services.

Issue 3: Lack of Supervisory Controls

We substantiated that the supervisor visited the Port Charlotte facility only once since being assigned to the position, but not that this was inappropriate. The supervisor was responsible for 20 CMs in a nine county service area and told us that monthly staff meetings were conducted by phone and face-to-face at various locations. The Port Charlotte CMs we interviewed confirmed that in addition to meeting with the supervisor once in Port Charlotte, they had met with her in Sarasota and Bay Pines and participated in the supervisory conference calls she conducted.

We could neither substantiate nor refute the allegation that the supervisor told the new CM to “audit himself and get his charts straight” after learning of the suicide. There was no record of discussions held with the new CM and neither of these individuals could recall any specific details in this area.

We found there was a lack of supervisory control of the HUD–VASH program. The program supervisor did not have monitors in place, a process for chart reviews, or a performance improvement plan to ensure that veterans received services according to program requirements and individual treatment plans. The supervisor told us her focus was on servicing vouchers, housing veterans, and hiring new staff to handle the increasing workload; less attention was given to monthly visitation requirements.

To determine whether non-compliance with case management requirements was an isolated event or indicated a potentially systemic problem, we reviewed the medical records of 25 veterans enrolled in the HUD–VASH program in the same geographical area. We also spoke to management about how caseloads were managed when staff transferred to another area, necessitating a hand-off of care between one CM and another.

We reviewed documentation from the month the veteran entered the program through the end of September 2011. We found that only 2 of the 25 veterans received a home visit every month and only 4 of 25 had either a phone contact or home visit every month as required. We also found that 19 of the 25 veterans had experienced a change in their CM assignment (a hand-off). We found that 17 of 19 had at least some disruption in the continuity of CM contacts related to the hand-off. Twelve of 17 had no visits or phone contact for 3 to 6 months.

We compared the contact data from our medical record reviews with the reports sent to NEPEC and found them to be consistent. We confirmed that both the quarterly reports and monthly reports sent to NEPEC showed significant gaps in service. We found that 7 of 25 veterans had no NEPEC data entered for visits or CM contact of any type.

The supervisor had access to the NEPEC database information, but did not use the report functions to assess program productivity or monitor compliance with monthly visitation requirements. In addition, she did not arrange coverage or redistribute caseloads in a timely manner after staff turnover.

Issue 4: Lack of Program Oversight

While not one of the allegations, we found a lack of oversight at the VISN and system levels. VHA policy¹⁴ requires that NHCs monitor the HUD–VASH programs within their region. This includes review of NEPEC results, providing support to HUD–VASH CMs through regular communications, and site visits. The NHC is also responsible for working with quality management staff in initiating appropriate investigation and follow-up activities when necessary.

We spoke to the former VISN NHC who had retired only a few weeks prior to our interview. He told us that his involvement with HUD–VASH programs in the VISN consisted primarily of negotiations with VA Central Office about how many HUD vouchers were needed. He reported that he looked at NEPEC data “a few times” but left it to the facility supervisors to monitor for problems. He told us he did not routinely participate in calls with field offices.

The system’s Chief of Social Work told us that oversight of the HUD–VASH program was inconsistent. He stated there was a lack of leadership, inadequate standard operating procedures, and that CMs did not have sufficient guidance or support for the volume of work that they do.

Although the medical records and NEPEC data showed case management deficiencies, neither the NHC nor the supervisor was aware of these problems with CMs meeting the monthly visit requirements.

Conclusions

We substantiated that a veteran in the HUD–VASH program committed suicide but not that he had been identified as high risk for suicide. We found that the veteran went without seeing or speaking to a CM during 9 of 18 months in the program, including the almost 5 months prior to his death.

We substantiated that a supervisor visited Port Charlotte only once, but not that this was inappropriate. We could neither substantiate nor refute the allegation that a CM was told by his supervisor to “audit himself and get his charts straight” after learning of the suicide.

¹⁴ VHA Handbook 1162.5. With revision of this Handbook in September 2011, the responsibilities of the Network Homeless Coordinator have not changed in substance.

We found that oversight of the HUD–VASH program at the VISN and system level needed improvement. We determined that 23 other veterans in the program did not receive case management services such as monthly home visits with suicide assessments as required. We confirmed that NEPEC data showed similar deficiencies in case management services for veterans in the HUD–VASH program, yet these data were not monitored at the VISN or system level.

While the veteran may have been at high risk for a suicide event due to multiple risk factors including family history, age, possession of a weapon, and the recent death of a family member, much of this information was not known to the CM as reflected by documentation in the veteran’s medical record. Although they may not have prevented his suicide, home visits or phone contacts with suicide risk assessments during the months immediately prior to the veteran’s death might have allowed the identification of changes in his mental status and provided a possible opportunity to intervene.

Recommendations

Recommendation 1. We recommended that the System Director ensure that case management services are provided to veterans in the HUD–VASH program as required.

Recommendation 2. We recommended that the VISN and System Director implement measures to strengthen management controls and oversight of the HUD–VASH program.

Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 10–14 for the full text of their comments.) We will follow up on the planned actions until they are completed.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 22, 2012

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Healthcare Inspection — Suicide of a Veteran Enrolled in VA Supported Housing, Bay Pines VA Healthcare System, Bay Pines, FL**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

Thru: Director, Management Review Service (10A4A4)

1. We thank you for allowing us the opportunity to review and respond to the subject report.
2. We concur with the conclusions and recommendations presented by the Office of the Inspector General. We present you with the plans of action designed to correct those areas for which recommendations were provided.

Nevin M. Weaver

(original signed by:)

Nevin M. Weaver, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 21, 2012

From: Interim Director, Bay Pines VA Health Care System (516)

Subject: Healthcare Inspection — Suicide of a Veteran Enrolled in VA Supported Housing, Bay Pines VA Healthcare System, Bay Pines, FL

To: Director, VA Sunshine Healthcare Network (10N8)

1. The recommendations made during the VA Office of Inspector General Office of Healthcare Inspections review conducted in response to allegations by an anonymous complainant related to a Veteran enrolled in VA supported housing has been reviewed and I concur with the findings and recommendations. Our comments and implementation plans are noted below.
2. If you have questions or require additional information, please contact Joanna Eastman-Gaudreau, Risk Manager, at 727-398-9317.

(original signed by:)

KRISTINE M. BROWN

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure that case management services are provided to patients in the HUD-VASH program as required.

Concur

Target Completion Date: June 1, 2012

System's Response:

The management of the Homeless program was transferred from the Mental Health Service to the Social Work Service in August 2011 to enhance oversight of the program.

An orientation program was implemented for all Social Workers in the HUD-VASH program on January 3, 2012. Program specific training regarding National requirements is provided by the Homeless Program Coordinator monthly to current HUD-VASH employees. All HUD-VASH Social Workers have been given a copy of the VHA Department of Housing and Urban Development-Department of Veterans Affairs Supported Housing Program Handbook 1162.05. In addition, Suicide Prevention Training has been provided by the Suicide Prevention Coordinator at the February SWS staff meeting. Twenty-one of twenty-two case managers from the HUD-VASH program attended this staff meeting. The one case manager who did not attend the staff meeting is a senior social worker who is experienced with the suicide risk assessment requirements.

A Monthly Visit Monitor audit tool was put in place in March 2012 to track all visits and contacts. A retrospective review was completed for the months of December 2011, January 2012, and February 2012. The Monthly Visit Monitor is due to the HUD-VASH Coordinator the 21st working day of every month. The HUD-VASH coordinator is responsible for reviewing the report and contacting the Veteran's case manager for any Veteran reported with no visit to ensure a visit is

completed before the end of the month. A summary report is provided to the Chief Social Work Service by the 7th of every month to ensure program oversight.

The results show of the 500 Veterans admitted to the HUD-VASH program prior to December 2011, and still active in the HUD-VASH program, 64 percent had at least one face to face visit in December 2011, 70 percent had at least one face to face visit in January 2012, and 72 percent had at least one face to face visit in February 2012.

Of the 500 Veterans in the HUD-VASH program, there were six Veterans with no documented face to face visit from a HUD-VASH Case Manager from December 2011 through February 2012. Of those six, two had a face to face contact and one had a telephone contact initiated by a HUD-VASH Case Manager in March 2012.

Of the 26 new Veterans admitted to the HUD-VASH program in December 2011, 74 percent had at least one face to face visit in December 2011, January 2012, and February 2012. Of the 15 new Veterans admitted to the HUD-VASH program in January 2012, 97 percent had at least one face to face visit in January 2012 and February 2012. Of the 17 new Veterans admitted to the HUD-VASH program in February 2012, 100 percent had at least one face to face visit during February 2012.

Status: Open

Recommendation 2. We recommended that the VISN and System Director implement measures to strengthen management controls and oversight of the HUD-VASH program.

Concur **Target Completion Date:** September 30, 2012

System's Response:

The VISN has strengthened management controls and oversight through a variety of actions. Since the OIG review a new Network Homeless Coordinator (NHC) has been hired. The new NHC has begun monthly conference calls with the HUD-VASH managers and case workers to provide regular oversight of HUD-VASH functioning and to provide management advice and input on issues arising in HUD-VASH throughout the VISN (regular contact with staff in the field). In addition, the NHC has begun monthly conference calls with the HUD Regional Manager, VHA VASH Regional Manager, Local Public Housing Authorities, and HUD-

VASH supervisors to improve coordination and general oversight of the HUD–VASH program (regular contact with local management).

The NHC has requested input from VISN 8 facilities and from the National HUD–VASH office on current tools in use to monitor the quality of case management services provided in the HUD–VASH programming. This input will be used to create a quality review tool for local review of HUD–VASH case management contacts. The tool will contain (at a minimum) whether a monthly case management visit was provided and that the Veteran was assessed for changeable risk factors for suicide such as deaths of family members and firearm ownership. Local facility HUD–VASH management will conduct quality reviews using the tool no less than monthly and report review data summaries to the NHC on a monthly basis to ensure local and VISN oversight. Action plans to correct any quality deficits identified on the quality reviews will be required by the NHC. The NHC will do spot check reviews of the quality management auditing process when visiting facilities during periodic visits. This quality review process will be implemented by June 30, 2012.

In addition, locally, a Health Care System Memorandum will be drafted by May 1, 2012 to formalize the structure of the HUD–VASH program and clearly define responsibilities including supervisory controls, reporting responsibilities, psychosocial assessment, including suicide risk, and program improvements.

Social Work Service will review Visit Monitor Data, and other national data as available at the monthly Social Work Leadership Team meetings. Quarterly reports will also be presented to the Social Work Performance Improvement Committee. Performance Improvement Plans will be presented quarterly at the Administrative Management meeting beginning May 2012.

Status: Open

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Christa Sisterhen, MCD, Project Leader David Griffith, RN, Team Leader Wm. Eli Lawson, Program Support Assistant Alan Mallinger, MD

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