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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE HEARING ON  
*ENDING HOMELESSNESS AMONG VETERANS -  
VA's PROGRESS ON ITS 5 YEAR PLAN*  
MARCH 14, 2012**

Madam Chairman and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) work related to VA's homeless veterans programs, specifically the results of our report, *Audit of the Homeless Providers Grant and Per Diem Program*. I am accompanied by Mr. Gary Abe, Director of our Seattle Audit Operations Division, who directed the audit.

**BACKGROUND**

In November 2009, VA Secretary Shinseki announced a goal to end homelessness among veterans by 2015. In 2011, VA and the Department of Housing and Urban Development jointly released a supplement to *Housing and Urban Development's Annual Homeless Assessment Report*, which estimated 67,500 veterans were homeless on a single night in January 2011. VA requested \$224.2 million to address this problem and establish the capacity to serve approximately 20,000 veterans in 2012. According to VA, the Grant and Per Diem (GPD) Program, administered by the Veterans Health Administration, provided services and transitional housing for over 100,000 veterans since 1994. It is the largest of several VA homeless programs currently providing annual funding and services to homeless veterans. The GPD program offers support services in all 50 states, the District of Columbia, Puerto Rico, and Guam, through 515 operational projects providing approximately 12,000 transitional housing beds. Community agency providers receive VA funding in addition to revenues from other Federal, state, or local sources. These programs operate based on unique designs as stated in their grant application. Responsibility for the management and operation of projects rests with community providers while local VA medical facilities provide oversight of the support services provided.

GPD program liaisons are VA employees appointed by local VA medical facility directors and are typically social workers. As part of their oversight responsibilities, GPD program liaisons have regular contact with veterans and community agency providers. Additionally, GPD program liaisons coordinate annual inspections of the providers' facilities and submit annual performance reviews to the GPD's national program office. GPD program liaisons screen homeless veterans, verify their eligibility for the GPD program, and determine which homeless programs are most suitable to meet the needs of individual veterans. GPD program liaisons also work with the staff of

the community providers in developing treatment goals and plans for each veteran and assessing the veteran's progress in reaching those goals.

## **AUDIT OF THE HOMELESS PROVIDERS GRANT AND PER DIEM PROGRAM RESULTS**

In our report, we reviewed community agencies receiving funds from the GPD program to determine if they were providing services to homeless veterans as outlined in their grant applications. We also reviewed GPD program funding to determine if it was effectively aligned with program priorities. Grants were selected to reflect a variety of locations and sizes. We statistically selected 26 GPD program grant providers under 8 VA medical facilities (Chicago, Illinois; Los Angeles, California; Long Beach, California; Portland, Oregon; New Orleans, Louisiana; Lyons, New Jersey; Atlanta, Georgia; and Sheridan, Wyoming).

We found a lack of program safety, security, health and welfare standards; an incomplete grant application evaluation process; and an inconsistent monitoring program that impacted the program's effectiveness. Also, VHA lacked a mechanism to assess and measure bed capacity, procedures to monitor the reliability of reported information, and sufficient training on program eligibility.

### **Program Operations**

#### **Safety and Security Issues**

VHA policy requires supervision and security arrangements for the protection of homeless veterans using GPD program housing. However, VHA does not provide guidance on the level of supervision and security measures expected for various homeless veteran populations, such as female veterans living in GPD program transitional housing.

Thirty-one percent of the 26 providers reviewed did not adequately address the safety, security, and privacy risks of veterans, especially female veterans. GPD program medical facility staff allowed providers to house female veterans in male-only approved facilities and multi-gender facilities for which security and privacy risks had not been assessed and mitigated. For example, we identified the following risks:

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

In addition, some providers housed female veterans in female-only facilities that had inadequate security measures, such as inadequate monitoring and not restricting access to non-residents.

We discovered serious female veteran safety, security, and privacy issues at one site that required immediate VHA management attention. Two homeless female veterans were housed in a male-only approved provider facility. The two female residents shared

a bathroom with male residents without an adequate lock and had sleeping rooms on the same floor as male residents without adequate barriers restricting access to the female rooms. We found that since fiscal year (FY) 2002, VA's GPD program staff had placed 22 homeless females in this male-only approved facility without adequately addressing the safety, security, and privacy needs of the female veterans. The GPD program medical facility staff said they were unaware that the facility was approved as a male-only facility. After we discussed this situation with the VA Medical Center Director, VA staff took immediate action and moved the two current female veterans residing in the provider facility to alternative housing (*Veterans Health Administration – Safety, Security, and Privacy for Female Veterans at a Chicago, Illinois, Homeless Grant Provider Facility*, September 6, 2011).

#### Management and Oversight of Medications Issues

During our field visits, we found that 23 percent of GPD program providers did not ensure safe storage of homeless veterans' prescribed medications, to include controlled narcotics such as oxycodone and Vicodin®. VHA does not provide a standard for ensuring the storage of medications prescribed for homeless veterans, nor does VHA require grant applicants to address the management of medications as part of the application process. Without standards for ensuring providers adequately manage and store medications, unnecessary risks, such as the misuse or the overdose of medications, may occur to a veteran's health and rehabilitation if needed medications are lost or stolen.

#### Dietary Needs Issues

VHA requires medical facility nutritionists to ensure that meals served by community agencies funded under the program are nutritionally balanced and appropriate for homeless veterans. VHA requires annual inspections and provides an inspection checklist. However, our results show that VHA lacked assurance that those veterans requiring special meals to meet medical concerns, such as hypertension, high cholesterol, or diabetes, were addressed consistently.

VA medical facility nutritionists did not ensure 12 percent of GPD program providers offered adequate meals that were nutritionally balanced and appropriate for homeless veterans. For example, one GPD program provider was not providing meals according to their published menu plan and special dietary meals were not provided to four veteran residents who had special dietary restrictions due to hypertension or diabetes. Veteran residents told us the provider had never served the meals described in the plan or provided special dietary meals. The nutrition clinician did not interview resident veterans or the medical facility's GPD program staff or conduct subsequent inspections and visits to ensure that the provider was following the approved menu plans or providing special dietary meals. Therefore, VHA did not detect that the provider was inconsistently providing the meals required by the grant.

We also confirmed veterans' allegations that the provider did not serve three daily meals during the weekend, as required by the GPD program. After discussing this

issue with VHA program officials and the VA medical facility director, the provider implemented significant remedies, such as conducting weekly inspections of food service operations, providing three meals daily, and soliciting feedback from veteran residents to address our concerns.

#### Grant Evaluation Process and Monitoring Program

VHA needs to strengthen the grant evaluation and the oversight process of the GPD program. Lapses in oversight and grants management are related to an application evaluation process that does not identify or analyze risks in the applications.

VA does not require grant applicants to document their policies and procedures or VA medical facility staff to review veterans' safety, security, and privacy issues prior to Government funds being awarded, such as access restrictions at multi-gender facilities. Additionally, VA medical facility staff do not consistently review these issues during their annual inspections because it is not addressed on the GPD program inspection checklist.

The GPD program's application process did not ensure grant applicants clearly identified the group of homeless veterans for whom the provider planned to provide support services or address safety, security, and privacy issues, especially for homeless female veterans. Without requiring grant applicants to clearly address these issues in their applications in relation to standards that help ensure the quality of services to be provided, VHA cannot assess the potential risks to homeless veterans residing at the provider facilities. In addition, GPD program staff cannot fully or effectively measure the providers' performance.

GPD program staff visited provider facilities regularly, however, the staff often overlooked conditions and failed to identify potential risks to resident veterans, such as adequate lighting and gaps in building security. At one site, for example, our auditors observed that electrical outlets were overloaded increasing the risks of electrical fire.

Another example of poor grant evaluation is apparent in the dietary needs issue discussed earlier. GPD program application procedures do not require a description of how they will provide meals or meet special dietary needs. According to VHA, the purpose of the annual inspections at provider facilities is to ensure providers carry out activities as detailed in their original application or approved changes to scope. However, when applicants are not required to describe how they will provide meals or meet special dietary needs, VHA has no criteria to evaluate performance or to make informed decisions regarding whether the needs of homeless veterans will be met effectively. Without a comprehensive inspection checklist, VHA lacks an effective monitoring tool to ensure adequate meals are provided and appropriate for veterans needing and relying on their support services.

## **Program Evaluation**

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

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

## **Bed Capacity**

VA's FY 2011–2013 Homeless Initiative Operating Plan identifies GPD program deliverables, such as creating an additional 1,500 transitional beds and serving approximately 18,000 veterans in FY 2011. VHA establishes funding priorities to ensure geographical dispersion of support services, prevent duplicate services, and bolster capacity in underserved regions, such as in rural areas. However, the GPD operating plan does not provide detailed goals for increasing transitional bed capacity for specific funding priorities. An example of a funding priority is providing services to women veterans and women veterans with care of dependent children, which VHA designated as their highest funding priority for the past 3 years.

VHA did not adequately assess or manage transitional bed capacity against their funding priorities and underserved geographic areas, such as female veterans and homeless veterans living in rural areas. More importantly, the GPD program did not maintain reliable data that would enable GPD program officials to accurately assess the program's effectiveness toward achieving sufficient bed capacity for their priorities or other specific homeless populations, like homeless rural veterans. Reliable data on the gender of the population being served, the number of beds available for use by gender, and geographical description (rural or non-rural) are necessary to compare and assess current transitional bed capacity with projected transitional bed capacity needs for homeless women and veterans, including homeless veterans residing in rural areas.

VHA did not have an effective mechanism to assess the GPD program's progress toward achieving sufficient bed capacity for funding priorities or specific homeless populations. Information was not available to identify bed capacity goals and the data to measure progress toward those goals. Without this information, VHA cannot make sound policy adjustments to funding priorities to ensure bed capacity where support services are needed most.

## **Accurate Reporting of Program Outcomes**

The GPD program did not accurately report discharge outcomes of veterans from the program. Our review found that 26 percent of veterans' discharge information was inaccurate. Reporting program outcomes, such as the reason the veteran ended residential treatment and the veteran's living situation at the time of discharge, were

inaccurately reported to VA's Northeast Program Evaluation Center (NEPEC). This information was generally relied upon to determine the success of each GPD provider and the overall success of the GPD program. NEPEC conducts evaluations for several VHA programs including the GPD program and tracks care provided to homeless veterans from admission to discharge.

A 2006 report from the OIG, *Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program* (September 20, 2006), revealed that in 24 percent of the records reviewed, VHA could not support submitted discharge information and in some cases, provided a different or contradictory outcome. We have a significant concern that the quality of the program information has not improved in more than 5 years; clearly, management attention is needed to correct this issue.

In more than half of the cases, VHA case managers inaccurately reported to NEPEC that the veteran successfully completed the program. However, our recent work estimated 13 percent of the case files inaccurately reported the reason a veteran ended residential treatment. Program documents stated veterans were removed from the GPD program for violating the provider's program rules or the veteran left without completing the program. In some cases, the medical facility's GPD program clinician entered the data incorrectly.

We also found 20 percent of case files inaccurately reported the veteran's living situation at the time of discharge. Clinicians select from seven choices, such as single room occupancy and apartment, room, or house. The response, "apartment, room, or house," accounted for 63 percent of the errors. For example, one GPD program grant had 12 instances where veterans completed their current rehabilitation program and were discharged to a supportive housing situation at a residential treatment program. The program documentation and NEPEC data stated the veterans had been discharged to an "apartment, room, or house" rather than the correct choice of "residential treatment program." VA medical facility GPD program clinicians did not report program outcomes accurately because NEPEC's data collection form did not clearly define the meaning of the questions' choices. The lack of more specific definitions or elaboration of the terms used in the questions increased the risk of misinterpretation by medical facility GPD program clinicians.

Reporting of inaccurate program outcomes also occurred because of the lack of an effective monitoring system to improve the quality and reliability of information used for making policy decisions. VHA needs to establish better controls to ensure the reporting of accurate outcome data. Without quality and reliable data, policy makers cannot effectively perform their oversight responsibilities to ensure that program funding is effectively aligned with program goals and that program goals are met.

### Eligibility Requirements for Homeless Veterans

To be eligible for the GPD program, VHA requires veterans to be homeless and defines a “homeless” veteran as a person who lacks a fixed, regular, adequate nighttime residence and instead stays at night in a shelter, institution, or public or private place not designed for regular sleeping accommodations. We found that participating veterans took leaves of absence from work and temporarily left their homes to participate in the substance abuse program. Thus, these veterans were incorrectly identified as homeless and receiving GPD housing support services. *For one GPD program grant, we found that 23 percent of veterans had not been homeless when admitted to the GPD program.*

Ineligible veterans using these program support services were not identified because VA medical facility staff believed these veterans were experiencing difficulties that could lead to homelessness, such as substance abuse or the veterans were considered to be at risk of becoming homeless. However, the veterans were clinically managed by the VA medical facility substance abuse program staff rather than the GPD program staff. As a result, VHA incorrectly spent approximately \$6,000 during a 6-month period to provide housing to veterans who were not homeless and reduced the opportunity for other eligible homeless veterans to receive supportive services that could improve their lives and end their homelessness.

### **VETERANS BENEFITS ADMINISTRATION ISSUES**

*The Homeless Veterans Comprehensive Assistance Act of 2001* (P.L. 107-95) authorized at least 1 full-time employee to oversee and coordinate homeless veterans programs at each of the 20 VA regional offices (VAROs) that VA determined to have the largest veteran populations. The Veterans Benefits Administration (VBA) directed that the public coordinators at the remaining 37 VAROs be familiar with requirements for improving their communication with homeless veterans. These requirements included attending regular meetings with local homeless shelters and service providers. VBA staff provides valuable services to homeless veterans by assisting homeless veterans with filing of claims for medical disabilities and other benefits.

OIG Benefits Inspectors have issued nine inspection reports that included our independent assessments of the VAROs’ communication with homeless veterans. Four (44 percent) of the nine VAROs did not consistently communicate with homeless veterans. The overarching issue at the three VAROs was the lack of a clear mechanism to assess the effectiveness of their communication with homeless veterans, and the staff responsible for these activities did not always understand their duties and responsibilities. As a result, we made recommendations to VBA to strengthen their communication efforts with homeless veterans and provide training to staff assigned these communication responsibilities. We will continue to review this important VBA responsibility during future VARO inspections.

## **CONCLUSION**

Throughout our audit we held productive discussions with VHA homeless program officials and they have demonstrated significant interest in improving the GPD program. VA is taking actions to strengthen controls to ensure the safety, security, health, and welfare of veterans participating in the GPD program. In response to our recommendations, the Under Secretary for Health agreed to strengthen the grant application process and evaluation process by publishing policies and standards, updating their inspection checklist, and implementing procedures to ensure grant providers have the capability to deliver services where these services are needed. Further, the Under Secretary agreed to establish bed capacity goals, maintain program data, implement procedures to improve reliability of program information, and provide training on program eligibility. We plan to monitor the implementation of VHA's action plan and follow up to assess the effectiveness of future program management. We expect these efforts will help to ensure that this program delivers effective support services to homeless veterans and that the program funding is used as intended.

Madam Chairman, thank you for the opportunity to discuss the OIG's work related to VHA's Homeless Providers Grant and Per Diem Program and VBA's communication with homeless veterans. We would be pleased to answer any questions that you or other members of the Committee may have.